FISCAL YEAR 1996 DEPARTMENT OF VETERANS AFFAIRS BUDGET

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

FEBRUARY 24, 1995

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FISCAL YEAR 1996 DEPARTMENT OF VETERANS AFFAIRS BUDGET

FRIDAY, FEBRUARY 24, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to call, at 9 a.m., in room 334, Cannon House Office Building, Hon. Bob Stump (chairman of the committee) presiding.

Present: Representatives Stump, Bilirakis, Spence, Hutchinson, Everett, Buyer, Quinn, Bachus, Stearns, Ney, Fox, Flanagan, Barr, Weller, Hayworth, Cooley, Schaefer, Montgomery, Evans, Kennedy, Edwards, Waters, Clement, Filner, Tejeda, Gutierrez, Baesler, Bishop, Clyburn, Brown of Florida and Doyle.

OPENING STATEMENT OF CHAIRMAN STUMP

The CHAIRMAN. The committee will please come to order.

Today we are meeting to hear testimony on the budget for fiscal year 1996. As you know, this meeting had been scheduled for last Wednesday, but because there are eight Members on this committee, the meeting overlapped with the Armed Services Committee, so we changed it to today; and I appreciate everybody's indulgence.

I especially want to thank the Secretary and the rest of our witnesses for being able to change their schedule on such short notice. Unfortunately, there are two witnesses that couldn't do that and will not be with us, the Honorable Frank Nebeker and the Honorable Preston Taylor, Assistant Secretary for Veterans Employment and Training, could not be here. So without objection, I would like to include their presentations in the record.

[The statement of Mr. Nebeker appears on p. 93.]

[The statement of Mr. Taylor appears on p. 97.]

The CHAIRMAN. We will have three panels before us today. First, Secretary Brown. Next, the Independent Budget Panel with representatives from the Veterans of Foreign Wars, the Paralyzed Veterans of America, the Disabled American Veterans, and AMVETS; and third, we will hear from the American Legion and Non Commissioned Officers Association.

I was going to introduce Dan Schaefer, but I don't see him out here. Later, we have a new Member to introduce.

Since we do have so many new Members here, I would like to say a few comments about our Secretary, if I could, please. Jesse Brown is a Marine, a combat veteran of Vietnam, wounded in Vietnam, and he has been a tireless advocate for veterans' problems his entire professional career.

He joined the staff of the Disabled Veterans Association in 1967, working his way up to Executive Director through 1989; and then, of course, he was sworn in as Secretary in January of 1993.

Mr. Secretary, I understand that you personally appealed to the President for a better budget than came out of OMB, and we want you to know that we are very grateful for that. I commend you for your efforts and observe that the overall increase of nearly $1.3 billion is certainly an improvement over last year's budget request; and once again, we thank you for that.

Before we turn to you, Mr. Secretary, I would like to turn to my good friend, Ranking Member Sonny Montgomery.

[The prepared statement of Chairman Stump appears on p. 65.]

OPENING STATEMENT OF HON. G.V. (SONNY) MONTGOMERY

Mr. MONTGOMERY. Thank you, Mr. Chairman. I join you in welcoming Secretary Brown and the other people at the witness table. I want to commend you. I was one of two Members of Congress at the ceremony of Iwo Jima last Sunday, and you certainly made some very fine comments, and I want to commend you for that.

I want to say that we all agree with a common belief that benefits for veterans are among the most important functions of government. What else can you give your country when you march off to war and you really don't know whether you will come back?

When the administration looked to cut the number of VA personnel providing direct health care for our new members, we successfully turned this policy around, so that we didn't lose that many FTEs out of our hospitals, that couldn't have functioned if this Reinventing Government had been pushed onto our veterans' programs. We have also worked together to fight for adequate budgets, and I believe this budget is fair.

Mr. Secretary, I hope you will cover it today. Coming out of the Appropriations Committee of the House last night—some rescissions were made that show $50 million coming out of medical equipment and $156 million out of VA construction; and I hope you are prepared to maybe make some comments on these rescission cuts. We would like to hear from you about that.

I want to express my strong opposition to the administration's proposal which would deny half of the future cost-of-living adjustments, COLAs, to persons going to school under the GI bill. I feel very strongly about this. There is a good possibility that the Pell grants, where you don't have any obligations to your country; the Perkins loans, that they don't even pay back; and then the National Service Program will receive increased funding. Yet the young men and women who march off to military service and serve for 3 years, may receive a reduced budget. This also affects the National Guard and Reserve GI Bill. This is one of the best recruiting tools we have for the military, the GI bill, and it hasn't cost the taxpayers a nickel up until this year. It cost $1,200 to the seviceman and woman; who enrolled in the program and that has paid for this program.

I think this is a fair budget. I am hopeful that we can do a little increase in medical care, and help out on research and also the national cemeteries. But I do hope you would touch on the rescissions

that have come through from the Appropriations Committee. We are concerned about that.

And thank you, Mr. Chairman.

[The prepared statement of Congressman Montgomery appears on p. 70.]

The CHAIRMAN. Thank you, Sonny.

Mr. Secretary, we are going to change procedures just a little bit. Rather than going to individual Members now, we are going to go to you and let you proceed in any way you see fit; and then we will go to the Members for opening statements and/or questions under the 5-minute rule in the order that they were in the room when the gavel came down.

[The prepared statement of Congressman Weller appears on p. 75.]

[The prepared statement of Congressman Filner appears on p. 76.]

The CHAIRMAN. Mr. Secretary, we ask you to proceed as you see fit and we welcome you this morning.

STATEMENTS OF HON. JESSE BROWN, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY HERSHEL GOBER, DEPUTY SECRETARY; KENNETH W. KIZER, M.D., UNDER SECRETARY FOR HEALTH; R.J. VOGEL, UNDER SECRETARY FOR BENEFITS; JERRY W. BOWEN, NATIONAL CEMETERY SYSTEM DIRECTOR; D. MARK CATLETT, ASSISTANT SECRETARY FOR MANAGEMENT; AND MARY LOU KEENER, GENERAL COUNSEL

Secretary BROWN. Thank you so very much, Mr. Chairman. I really do appreciate those kind remarks that you made about me and my life's work.

The CHAIRMAN. Mr. Secretary, would you pull the microphone a little closer, please?

Thank you.

Secretary BROWN. Again, thank you very much, Mr. Chairman. I do certainly appreciate those very kind introductory remarks. Before I present my oral testimony, I would like to respond to Mr. Montgomery's question with respect to the rescissions that were reported in *The Washington Post* this morning and also in the Congressional Record, where there is a proposal to rescind the Columbus, Missouri project; the Gainesville project; Hampton, VA; Orlando; Puerto Rico; West Haven, CT, for a total of $167 million. Quite frankly, I was very, very shocked to see that. And I was shocked because, in my view, it undermines our ability to be where we should be.

As you know, VA has to be as flexible as it can in order to take advantage of changes in treatment modalities. We can look at VA's pattern of providing care and we see consistently that the number of inpatients is going down each and every day, and at the same time, the number of outpatients is increasing; and that represents a tremendous savings.

That is what is happening all throughout America. And, unfortunately, if we do not have these projects, we are not going to be able to accommodate the people coming to us for care in an outpatient or ambulatory care setting.

I was just in Wilmington, DE at our hospital yesterday and there were hundreds of people in the hallways coming to take advantage of outpatient care. We are moving toward primary care, and as a result, it is putting a tremendous strain on our system. And therefore, I believe that to rescind these projects, quite frankly, is wrong. And I must say that this is the first time that I have seen an approach like this—in my view, it comes right at the veteran. This is the first time that someone is actually proposing to take something away that is good for our veterans; and I hope we are able to reverse this proposal, because it is certainly not in our best interests.

Also, there is an effort to reduce by $50 million funding to reduce our equipment backlog. With respect to that, I am concerned. We have somewhere around $800 million in equipment backlog and we took $50 million out of the $111 million that the Congress was kind enough to provide to us in the 1995 budget and allocated that to reduce this equipment backlog. We are doing the same thing in our 1996 budget. I hope we do not see a trend about to develop with respect to reducing veterans' programs.

Mr. Chairman, I certainly do appreciate this opportunity to present to this committee the President's 1996 budget request for the Department of Veterans Affairs.

I am excited about VA's budget of $39.5 billion, which is an increase, as you have mentioned, of $1.3 billion over fiscal year 1995. In a nutshell, it is a good budget. Again this year, VA fought hard for the resources we need to provide adequate services for our veterans. As you again pointed out, I met with the President twice about the VA's budget and the result was a substantial increase.

VA continues to provide three basic services to this Nation's nearly 27 million veterans. These services are very simple, but they are very important. They are: providing quality health care, delivering timely benefits, and burying our veterans with dignity.

The VA's budget contains $17 billion for medical care, an increase of $747 million over the current year. This $17 billion will support 201,254 employees and provide care to 2.9 million patients. With this funding, we will provide more than 1 million episodes of inpatient care and 26.3 million outpatient visits. That, again, is an illustration of why we need to expand our ambulatory centers throughout the country if we are going to take care of our World War II, World War I, Korean War, Vietnam veterans, and all of our veterans who have served and are eligible for care from VA.

We will furnish care to 43,000 more veterans in 1996 than we will in 1995. We will open three nursing homes, a replacement medical center in Detroit, a spinal cord injury center and a 240-bed psychiatric facility.

The challenge is clear. We must continue our commitment to provide quality care to our veterans. That is why we are developing a new health care management structure.

Our new Under Secretary for Health, a great man, Dr. Ken Kizer, has been working hard on a system designed to meet the needs of veterans rather than the needs of individual facilities. It is based on networks that will function as planning, budgeting and operational units. Structuring management in this way will pro-

mote creativity, help us meet the expected workload, and generate savings through efficiency.

I will be submitting a reorganizational plan for your approval, Mr. Chairman, in the very near future.

Funding for research will increase from $252 million to $257 million in 1996. As one who understands the importance of research to the quality of care VA provides, I am extremely pleased with this proposed increase.

Major construction is increased by 45 percent to almost $514 million, and minor construction has increased by 50 percent to $229 million. The major construction funding fully meets our long-term commitments to build another new medical center in Brevard County, Florida, and a replacement facility in California at Travis Air Force Base. The minor construction increase focuses on badly needed improvements in inpatient environment.

Since becoming Secretary for Veterans Affairs, Mr. Chairman, I have traveled to more than 37 States, and I must tell you, sir, that I am very upset by having observed, firsthand, the unacceptable living conditions I have found in a number of our facilities. I am talking about things like the lack of private bathrooms for our women, and veteran patients receiving their care in 16-bed wards instead of private and semiprivate rooms, and the lack of bedside telephones for our patients. We need to bring our facilities up to community standards.

The 1996 construction budget will fully fund—fully fund, sir, five projects that address these deficiencies and will allow us to bring, as I have said, our facilities up to community standards.

The compensation and pensions account reflects an appropriation request of $17.6 billion. This includes $170.9 million of the projected costs of the U.S. Supreme Court decision of *Gardner* v. *Brown*. That decision, as you know, sir, invalidated one aspect of VA's interpretation of the law authorizing compensation for veterans disabled by medical treatment.

In the area of claims processing for benefits, I am happy to report that we have made great progress in reducing our processing time. With this budget, we will reduce processing time for original compensation claims from 212 days in 1994 to 140 days in 1996. That is a reduction of more than a third; and I also, sir, want you to know that we are working toward a goal of 106 days by 1998.

The Board of Veterans' Appeals is working hard. They are working hard and will continue to address the unacceptable amount of time it takes to process an appeal. In fiscal year 1996, we are requesting 28 additional positions which would increase the Board's staff to 477. We expect a reduction in average response time from 745 days to 687 days. Now, I recognize that this is still unacceptable, but the point here is that we are moving in the right direction; and I think we must continue to have the resources that will allow us to continue to manage this problem, as opposed to having the problem manage us at the Board of Veterans' Appeals.

As you will note, the Administration has also proposed legislation to extend through fiscal year 2000 the VA's provisions enacted in OBRA 1993. This will result in savings of nearly $3 billion.

In summary, Mr. Chairman, the challenges before us are great. Our goals remain the same, however: the best service we can give

to our veterans. I look forward to working with you, as I have in the past, and the members of this committee to honor the commitment we have made to our Nation's veterans.

Mr. Chairman, this concludes my statement and I now will respond to any questions that you or members of the committee may have.

[The prepared statement of Secretary Brown appears on p. 110.]

The CHAIRMAN. Thank you, Mr. Secretary, for that presentation.

Before we go on, I would like to take this opportunity to introduce our newest member of the committee, Dan Schaefer from Colorado. Dan has been a hard worker on behalf of the veterans in this country, and we welcome him to this committee. We know that he will be an asset.

OPENING STATEMENT OF HON. DAN SCHAEFER

Mr. SCHAEFER. Well, I thank you, Mr. Chairman, and certainly the Ranking Member, Mr. Montgomery. As both individuals know, I have been trying to get on this committee for a long period of time.

On behalf of the 400,000-plus veterans in the State of Colorado, I was glad to hear the Secretary's statement this morning pertaining to health care, particularly when we are looking at that possibility of closing Fitzsimons Army Medical Center in Denver which serves 12 States. As the Secretary also knows, we have been working very hard on the parking facilities at our veterans' hospital in downtown Denver which are atrocious. We hope that we can solve some of these problems, and I do appreciate the Chair. Also, thank you for your efforts and Mr. Montgomery's efforts in getting me on this committee.

The CHAIRMAN. Thank you. And welcome again to the committee.

In order that we can proceed as rapidly as possible this morning, we are going to adhere strictly to the 5-minute rule, both for your questions and your answers. If you would try to abide by that, we will move along. The Secretary is under certain time constraints. As you know, we have gone in an hour earlier this morning in anticipation, and hopefully we can finish this hearing before noon with our three panels.

Before turning to my Ranking Member, Mr. Secretary, let me ask you a question. Would you agree with estimates indicating that as much as 40 percent of VA hospital admissions, may be inappropriate?

Secretary BROWN. I can't respond to that. I am going to ask Dr. Kizer to respond to that one.

Dr. KIZER. Sir, in the review that I have been able to complete so far, in my short tenure in the position, that figure may apply at some facilities. I know that at other facilities that would be markedly less. And, of course many of these inappropriate admissions relate to the unusual requirements of eligibility rules that favor inpatient care over often more medically appropriate and more efficient delivery of the same service in an outpatient setting. But that option is not available for many VA patients, depending on the individual veteran's eligibility status.

The CHAIRMAN. Thank you.

Well, the Secretary mentioned in his opening remarks that the inpatient percentage is down, outpatient is up; and of course, that is what we are going to try to strive for up here. But would you, Mr. Secretary—one more quick question—explain how eligibility reform could help this situation?

Secretary BROWN. Yes, sir. I think Dr. Kizer gave an example. Let me give a couple of examples to illustrate that the way we conduct business and our lack of flexibility really doesn't make sense in a modern society.

Let us say, for instance, an individual who is eligible for care from VA breaks his foot and he comes to the VA and we put a cast on that foot in an outpatient clinic. In order for us to legally give that individual crutches, we have to admit him to the hospital. That doesn't make any sense at all. So that is an indication of why we need eligibility reform—so that we can take advantage of modern efficient ways of delivering health care.

One other example. Let us take, for instance, a veteran who lost his leg below the knee in World War II, or Vietnam—it doesn't matter—Korea. He breaks his prosthetic device. He can come to VA and say, I need a new prosthesis. While he is there, the doctors say, let's take a look at you, and they give him a blood pressure test to check for hypertension. They find, let's say, his blood pressure is somewhere around 150 over 100. It is high, but not high enough for him to be hospitalized. They can only say to that man, find yourself a physician to look out for you and to manage your blood pressure.

And let's say for the purpose of this discussion that he walks out of the VA building and has a stroke right there. Then we can bring him into the hospital and give him everything he needs. It would have been much cheaper to have said, look, you have hypertension and we need to manage it, minimizing the potential of you ending up having a stroke.

The same thing with diabetes and so forth, particularly to our patients, who tend to be much older than the average patient in our society.

So those are examples of why we desperately need to have eligibility reform and we desperately need to move away as rapidly as we possibly can from inpatient care to outpatient care. That is where the savings are, and that is really what is good medicine in this country and, in fact, I think good medicine throughout the world.

The CHAIRMAN. Thank you, sir. As you know, that is going to be probably the number one priority of this committee, to try to move towards outpatient care, because we can save many, many dollars by doing that.

I apologize to you, sir, for not allowing you to introduce your assistants with you. If you would, before we go on to Mr. Montgomery.

Secretary BROWN. Yes, sir. Mr. Chairman, I have Mr. Vogel, our Benefits Director; Mark Catlett, our resources and money man; we have Mr. Gober, he is our chief executive officer; and Ken Kizer, the newest member of our team. And I am so proud of this man; he is Under Secretary for Health. He has brought us so much won-

derful experience and background, and a whole, new, refreshing approach to VA. I feel very proud to have him on our staff.

And we have Jerry Bowen, who is the Director of our Cemetery Service, Mr. Chairman.

The CHAIRMAN. Welcome, gentlemen. Mr. Montgomery.

Mr. MONTGOMERY. Thank you.

Thank you, Dr. Kizer. I have got a problem for you in just a few minutes here. I have two questions and then brief answers to stay within my 5 minutes.

Mr. Secretary, you, like I and others on this committee, are concerned about the rescissions that the Appropriations Committee has brought forward. We will probably need your help on this side, maybe on that side, too, because it will affect some of our Members; there have been recommendations of not going ahead with construction. So I assume you will help us and give us the information that we need.

Secretary BROWN. Yes, sir. You have my 100—no, my 1,000 percent support on this. This is so important to our veterans. It is important to do what is right for these guys.

We have spent the last 50 years talking about how well they performed for us during World War II, when we lost 400,000 of them on the fields of battle, and 700,000 came back home wounded and disabled. We need to show our respect to them and we need to show that we appreciate the contributions and sacrifices they have made to the Nation. And we can do this by providing them good, comprehensive, quality care.

Mr. MONTGOMERY. Thank you.

My second question really follows up on regulations you have that you have to put an individual from outpatient into the hospital if the individual needs crutches. Now, my own VA hospital in Mississippi gave a penile implant to a child molester who had just gotten out of jail for child molesting, a 4-year sentence. Maybe the veteran was eligible. But the people are quite upset about that, that this procedure has been done. And it leaves the hospital in Mississippi setting up a committee to look at procedures like this. And I certainly hope it won't happen again in our other 170 hospitals where a child molester would get this penile implant, and you don't know what might happen after that.

So I hope you will take care of it and notify the other 170 hospitals, let's don't let this happen again. I know you are going to tell me, under the law this individual is eligible. I don't think he ever heard a shot fired in combat, but because of a diabetic condition he becomes eligible.

But we just can't let this go on, and I hope we don't have to move the legislation, but this shouldn't happen again.

Secretary BROWN. Mr. Montgomery, let me just make a couple of observations about that. There are three things that really bother me in our society today. When I was a young boy coming up, the three groups of people that were always safe on our streets—and I came up on the streets of Chicago—were the elderly, our children, and those disabled. It appears now that we are living in a time when they are the most vulnerable. We as a society have an obligation to protect them.

And having said that, I would also say with respect to this particular individual that I am sure he is very happy that I am not a doctor and that it was not my right hand that performed the surgery. But we have to place this in its proper context, and that is, as you so rightly pointed out, he is entitled to this care by virtue of his service-connected disability. As such, we have a responsibility to separate his crime and his conduct, unacceptable conduct, from what he is entitled to from the VA. But I would be very, very cooperative in talking with you and members of this committee to try to find a solution that would be satisfactory.

The CHAIRMAN. Let me say to the Members that if you don't have enough time to get all of your questions in the 5 minutes, we will try a second go-round if time allows, or you are welcome to submit them for the record. Mr. Bilirakis.

OPENING STATEMENT OF HON. MICHAEL BILIRAKIS

Mr. BILIRAKIS. Thank you, Mr. Chairman. These are the rescission areas involving Florida's projects, although it includes a few others too.

Well, in the interest of time, sir, I have an opening statement that I would like to ask unanimous consent be inserted in the record and join you, of course, in welcoming the Secretary and his staff.

The CHAIRMAN. Without objection.

Mr. BILIRAKIS. I would like to apologize in advance. I have to testify before the Rules Committee on risk assessment and will be leaving when I have to, but certainly not before then.

Mr. Secretary, I was advised just about the time that you started to testify that part of the rescission is going to be the spinal cord injury working drawings, the construction drawings for the spinal cord injury center in Tampa, FL. We have been trying to get that on course for many, many years, as you know. You and I have talked about it before—and this, of course, is not your doing, but the center isn't part of your next year's budget. But that is okay, because we are really not at the point where we need that money anyhow. But that $4 million, as little as it is, is very, very important to us. I am hoping you will be able to help us there.

Mr. Chairman, last year I was part of, as you know, the bipartisan coalition to work up a health care plan. I was just amazed, and maybe I shouldn't have been, but I was amazed at the attitude of some of the Members of my coalition committee when it came to talk about veterans' health care. Why should they be treated any differently and that sort of thing; that is what the hell we are going through.

And I know when we had the national commander here last week to testify, only a few days ago he talked about the special category that veterans are in. And unfortunately, we have too many Members of this Congress who continue to pay no attention to that.

Nobody in our society—I mean, you rate social security, and I will defend it to the death, obviously; and you rate medicare because we put into it because you reach a certain age. You haven't really done anything to deserve it; you reach a certain age, you get it, because we set it up as a contract a long time ago and we should continue with that.

But when it comes to veterans, by God they rate it by what they have done, the hardships and that sort of thing. But we forget that the cost of war continue after the end of that war.

I would ask you, sir, getting back to the eligibility reform—in some of these instances that I still call him "Chairman," I know Bob doesn't mind if I continue to call Mr. Montgomery "Chairman." The need for eligibility reform, how much of that is the fault of legislation? I mean, is it just that we have set up eligibility in such a tight manner that in spite of the fact it catches situations such as these you mentioned, and Mr. Montgomery mentioned, there is no flexibility, there isn't enough flexibility to do what common sense dictates?

Secretary BROWN. You actually stated it correctly. It is a direct result of legislation, a patched approach in legislation that has taken place over the last 30 or 40 years. And as a result, we are now seeing it becoming very restrictive in allowing us to be able to take advantage of the advancements that have been made in medical technology and the new techniques that are used in delivering health care in the Nation.

The CHAIRMAN. Well, now, I may be wrong, but I note—with all due respect I say this—the budget does not contain a strategic plan, if you will, if you could call it that, that would present the VA's suggestions and recommendations regarding eligibility reform. Isn't that true?

Secretary BROWN. Yes, sir. We are now in the process of working on eligibility reform. We are working very hard to try to pull together all the information. As you know, we thought we had a good package last year in the national health care reform, and the veterans' portion of that was outstanding. But since that fell through the cracks, we had to go back to the drawing board. Now we are in the process of pulling together all the information we need, so we can come together with all of the interested parties and try to figure out which is the best way to proceed in the future.

Mr. BILIRAKIS. Well, you know, these terms are only 2-year terms, unfortunately—although some people would think, fortunately—and we don't know what your term is. God willing, you will be there at least another couple of years. I won't say that I would like to see you there more than a couple of years, as good as you are.

But the point is, time is always a factor here. So I am hoping, sir, that you all would come up with your recommendations as quickly as you can, so that we can maybe organize a task force or, as our Chairman pleases, really concentrate on that area, because an awful lot of wrong is taking place out there that we should right.

Secretary BROWN. Thank you. And I do also want to say for the record, I really appreciate the support you have given us over the years.

Mr. BILIRAKIS. Thank you, Mr. Secretary.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

[The prepared statement of Congressman Bilirakis appears on p. 81.]

The CHAIRMAN. Mr. Edwards.

Mr. EDWARDS. Thank you.

Mr. Secretary, thank you for being here—all of you being here—and for your service to our Nation's veterans. Mr. Secretary, I was not privy to the process that the Appropriations Subcommittee went through in listing these rescissions. Could I ask you, have these particular projects been put on some sort of prioritized list? For example, is it possible for this committee to get a list of how these various projects, both those that were rescinded and those that were not, where they ranked on a list to see if there was some logic to which ones they picked out?

Secretary BROWN. Yes, sir. And keep in mind that these projects were the ones that we had in the 1995 budget. We felt so strongly about them that we originally tried to get them in the 1995 budget with their own appropriation line. However, since we were not able to do that, we put them in the investment package, that $3 billion, and we were going to pay for them out of that because that is how strongly we felt about it.

We can see exactly what is happening. The demands being placed on our outpatient facilities are just staggering. As a result, we are going to have to move forward.

But to answer your question, yes, they have been prioritized and we can provide you with information to show that they score very high in terms of projects that we need to move forward on.

Mr. EDWARDS. Okay. Thank you. Thank you very much.

Dr. Kizer, I would like just to welcome you here. I believe this is your first hearing as Under Secretary before this committee, and I welcome you and look forward to working with you, as I know all other members of this committee do.

Could I just ask you your understanding of the fiscal year 1996 budget? Does it allow the funds you would like to have to really accelerate this reprioritizing of resources toward outpatient care? Or maybe, perhaps put a different way, if you had additional monies, what could you put those resources into to help us expedite that process, which I think will allow us to provide more care to more veterans at a lesser cost to the taxpayers?

Dr. KIZER. Thank you, sir, for your kind comments, and I also am appreciative to be here this morning.

With regard to your question, as has already been stated this morning, we think this is a very good budget, and the restructuring or the reorganization proposal that I am working on will complement the budget. The budget does give us a lot of room to do what needs to be done. But, as has already been commented upon this morning, we do have substantive needs that far exceed what is in the budget—that is, capital needs for patient environment improvements, for more ambulatory care facilities, and to address a large equipment backlog. So while this is a very good budget and a realistic budget, given all of the fiscal exigencies that are present today, it by no means addresses all of the needs that exist within the system.

Mr. EDWARDS. I appreciate that. The reason I asked that question, we may be a small number, but I think there are a number of us in the House that think it perhaps is inappropriate to have $700 billion in tax breaks at a time when we have a $200 billion deficit. My proposed idea, such as not having those kinds of tax

breaks and applying most of that savings to deficit reduction, but perhaps saving some of that money for application to needed veterans' health care programs.

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

The CHAIRMAN. Chairman of the Subcommittee on Hospitals, Mr. Hutchinson.

OPENING STATEMENT OF HON. TIM HUTCHINSON

Mr. HUTCHINSON. Thank you, Mr. Chairman. And let me thank the Secretary for being here today. I have kind of a cold, so forgive my voice.

A special welcome to Dr. Kizer and always Hershel Gober, my fellow Arkansan. We are glad to see you again and have you here. In Arkansas we end up on different sides of the political fence a lot of the time. We certainly are united in our support for veterans and in our opposition to Bob Dole's suggestion that we ought to sell Arkansas to balance the budget. There has got to be a better way.

While we are all concerned about the rescission list, one of those concerns I think ought to focus on the fact that they had targeted ambulatory care additions in those rescissions; and so, Mr. Secretary, the VA has stated on numerous occasions that a shift to the delivery of health care services in the ambulatory care setting is a VA priority.

Your fiscal year 1996 major construction submission appears, at least to me, to be a little inconsistent with that goal in that two-thirds of the requested dollars are directed toward two facilities. So how will the construction of those two projects contribute to the VA's stated goal of achieving more ambulatory care facilities? And describe for me the construction prioritization process that resulted in the selection of those two hospital construction projects, please.

Secretary BROWN. Thank you. I am so glad that you asked that question.

First of all, let me simply say that we do not believe they are inconsistent. Let me give you a backdrop on that. There is no relationship whatsoever between our efforts to continue to expand the care we provide on an outpatient basis and the two construction projects you are talking about.

I am assuming you are talking about Brevard County in Florida and the Travis Air Force Base project.

The Brevard County project has been on the books for about 10 years, and it scores 9.80 our priority score, which I can explain a little later. But it is based on our efforts to expand care in that area. Florida has one of the lowest bed rates per thousand veterans in the entire Nation. It has 1.72 whereas the Nation's average is 2.49. The supply of VA services should be comparable to the national average, and we must also take into consideration that there is a growing, ever-growing population of veterans moving to Florida who are retired and living on limited, fixed incomes, which would automatically make most of them eligible for care at our VA facility.

Another point, too—it is my understanding that the Air Force has now backed out, but we were moving to try to have a joint venture there with the Air Force. This particular project was based upon the conclusion that there were more and more veterans mov-

ing to Florida, and they did not have access to a primary care facility there in the central part of the State. So that is one of the reasons we put that project there. It has a catchment area that would serve about 258,000 veterans. We plan to complete the design in February of 1996, and we would like to complete construction in December of 1999.

With respect to the project which is a joint venture there in Travis Air Force Base—that is a replacement hospital for the hospital that would have been unsafe in an earthquake in northern California. I think that makes it very, very clear. One other point there—this catchment area is larger than 26 States. So our veterans who live in that area—an area larger than 26 States—do not have access to a VA hospital. In both instances, the project is based on need. So that is the reason we are moving forward with those two projects.

Mr. HUTCHINSON. Mr. Secretary, the GAO, according to figures that I have, estimates that there are 2,000 empty private hospital beds in the Brevard area. Was that reality taken into consideration as you considered the need in Florida?

Secretary BROWN. Well, there was a shortage of long-term care, psychiatric and NHC beds in Florida, and that is the reason we wanted to proceed. I am going to ask Mark to give us some additional information on that.

Mr. CATLETT. Those figures you cite have been recognized in the study, and as the Secretary mentioned, the emphasis is for a primary care facility. This is a case where we are putting a large number of psychiatric beds and nursing home beds in this facility; this is not tertiary care for this facility. It will be the hub for the outpatient care that we intend to provide in that area. And even with the emphasis on primary care, there needs to be a referral point when there is inpatient care needed, and that is the basis for our decision to continue with this project.

Mr. HUTCHINSON. All right.

Before my time runs out, I think there will be probably be an ongoing debate about some of those priorities. My understanding also is, though, that the length of stay at VA facilities is continuing to increase, and it is approximately twice the national average. I am thoroughly committed to the VA health care system, but we get all of these articles that are written and the editorials that are written now, calling for privatization and vouchers, and I think this is one of the things that fuels that.

Why is the length of stay continuing to increase, and why aren't we closer to the national average?

Secretary BROWN. Well, I am going to ask Dr. Kizer to respond to that; but before I do, let me just simply say, first of all, I think we have to take into consideration that most of our veterans are sicker than the average patient here in America. So when they come to us, they are already sicker, they are older, they have more problems. And so it just required us longer to deal with those particular problems.

I am going to ask Dr. Kizer to give you some additional information on that.

Dr. KIZER. Actually, sir, I would like to see the source of those figures. Information that I have been given during my time at the

Department is that while the average length of stay in VA hospitals is longer than the national average, it is decreasing; and so I would like to see the source of those figures.

I would also add that so many of the patients that are treated in the VA facilities have additional social or other problems that complicate their stay. They are homeless, or they have other problems that make it harder to find placement.

We do have shortages of extended-care beds. We have less availability of home care. We lack a number of other options. I am hoping, in part through my efforts to restructure the organization, to provide a wider menu of available options than just a traditional inpatient stay. And again, this is also complicated by the eligibility rules that, in effect, preclude some of the options that are available to private facilities. Our population could benefit from residential care and other options that are often more efficient than a typical inpatient hospital bed.

Mr. HUTCHINSON. Thank you.

The CHAIRMAN. The Chair recognizes Mr. Tejeda.

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

Good morning, Mr. Secretary and welcome once again. I have a couple of questions.

You mention in your prepared testimony that the VA will be moving forward with its consolidation and integration proposals along with the VISN proposal. Will each medical center that generates savings from the integration be able to retain a portion of those savings to improve direct patient care?

Secretary BROWN. I am going to ask Dr. Kizer to respond to that.

Dr. KIZER. Under the proposal that we hope to be advancing in the very near future, the answer to that would be yes in some cases; in other cases, we would be looking at how the costs in that area compare to costs elsewhere.

One of the things that has become obvious in my review of what it costs to take care of the, quote, unquote, "average veteran patient" in our facilities is that cost varies substantially from region to region—often not entirely on the basis of risk adjustment, severity of illness or other obvious things. And insofar as those differences in costs can't be accounted for, and we know we have shortfalls in others, then we might look at moving some of those funds elsewhere in the system, but still directed at patient care.

In other cases, I would see, as you say, that savings would be turned back to the VISN to enhance patient care in the geographic area and the patient population served by those facilities.

Mr. TEJEDA. Thank you.

Mr. Secretary, will the $2.7 million increase in the National Cemetery System budget enable the cemetery system to keep up with the increased demand, while not sacrificing maintenance or equipment backlog?

Secretary BROWN. The increase, the $2.7 million increase in the 1996 budget really is, sir, basically current services. It provides for some growth. We try to make sure we are as lean as we possibly can be, We have kind of broken this down in terms of expansion into two areas.

Number one, wherever possible, we try to expand open cemeteries. The second thing we do, if we can't do that, is look at possibly opening new cemeteries.

And we have about five of them now on the rolls. They are Seattle, Dallas, Chicago, Cleveland and Albany. Of those, we have already acquired the land for three of them, and those are in Seattle, Dallas and Albany.

I am going to ask Jerry if he has anything additional to add to that.

Mr. BOWEN. Essentially the budget that we have for 1996 will be a current services budget. We will be able to do the same things that we did in 1995. However, as a result of our streamlining efforts, we are moving seven FTE from our Central Office elements to the field in 1995. We are also going to move some FTE from our area offices to the field in 1996.

The budget does permit us in 1996 to place into service an additional 292 acres at our existing cemeteries, and to develop an additional 100,000 gravesites. So this budget is adequate to meet our needs in 1996.

Mr. TEJEDA. And it is adequate again to where you are not sacrificing maintenance or equipment backlog?

Mr. BOWEN. Our equipment backlog will increase slightly in 1996. But if I may, let me tell you why we are doing that.

During my teneure here, slightly less than 2 years, I have visited 61 of our 114 national cemeteries. When I talk with our directors, I ask them, if you could have more FTE, if you could have newer and better equipment or if you could have the M&R (maintenance and repairs) projects, which of those would you choose? Invariably they will respond give us the people. We will make the equipment last longer and we will do some of the work ourselves concerning the maintenance and repair projects.

Mr. TEJEDA. Mr. Secretary, what are your thoughts or what is your position on the use of leasing to provide quicker or more portable outpatient care?

Secretary BROWN. I think that is the way to go. We are not necessarily in the business of always looking to build facilities for the VA. Where we can lease, that is what we are doing, and that is part of our plan. We can actually bring them on line much faster, much more efficiently. They are much more flexible for us in terms of expansion or shrinking services as needed based on actual experience. So that is the way to go, sir.

Mr. TEJEDA. Just one last question. I heard Chairman Spence on the National Security Committee ask this same question the other day to some of the chiefs who were there.

If you had an additional $1 billion in your budget, how would you use it? Where would you put it?

Secretary BROWN. I would, of course, take some of that money and I would put it directly into medical care. We set aside about $767 million there. I would put some there to expand, give us some increased flexibility. As Dr. Kizer mentioned, there are going to be more creative ideas coming out of this whole process under his reorganization plan.

With the rest of it, I think I would respond to the needs. I have been to 37 States, I have visited 144 cities, over 330 various activi-

ties, around the country over the last 2 years. One of the things that bothers me most is when I go to these hospitals that were built in the 1930s, and we have 16 men in one room, and all of them get up at the same time and they are trying to take care of their physical needs and they have to go to bathrooms all the way down the hall.

If there are women in the hospitals, we have to bring all the men out of the bathroom and put somebody there to guard it so that the lady can go in and take care of her needs.

I would bring our hospitals up to community standards. Each and every one of them will look very, very nice, when you walk in; it would be open, everything will be clean. That is not to say that our hospitals now are not clean, but they are just old.

And we would have TV in each room, we would have telephones in each room, we would have modern equipment that we now put in modern hospitals. But in many of our old hospitals we did not retrofit them. So those are the kinds of things I would do with the rest of that money. I would bring every one of these hospitals up, particularly many of our older nursing homes.

The thing that hurts me the most is, I went to one hospital yesterday in Delaware, and I visited a nursing home and we see these guys that are 70 and 80 and a couple of them 100 years old, some of them have been there 15 and 20 years. They are sharing the room with five or six other people. I don't think I would want to stay in a room with five or six other people for 15 years.

And then you have to go out to take a bath. I think our veterans deserve better than that. I really do.

You know, a lot of people are talking about, well, maybe if they were not hurt. You know what I think about? I think about the guy that served during World War II, who served for the duration of the war. He could have spent 4 years being shot at every day and didn't get hurt and then he came home and it so happened he didn't do very good in terms of making a living for himself, and now he is able to get into the hospital because he is poor. I think he deserves the best that this Nation can give him. He gave everything that he could give during a time of national crisis.

So that is what I would do, sir, with the rest of that money. I would make sure that these hospitals meet community standards.

Mr. TEJEDA. Thank you, Mr. Secretary.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Everett, the Chairman of our Subcommittee on Compensation and Pension.

Mr. EVERETT. Thank you, Mr. Chairman. Thank you also for having this hearing. And I want to thank Secretary Brown and his group for appearing here today.

Mr. Chairman, I have a statement that I would like to submit for the record.

The CHAIRMAN. Without objection.

Mr. EVERETT. Secretary Brown, you stated that the VBA had made significant strides in decreasing the processing time for adjudicating claims. What percentage of this decrease was attributable to staff overtime?

Secretary BROWN. I asked that same question to Mr. Vogel, and he told me at the time that he was not actually able to break it down. But we did spend somewhere around $9 million in overtime.

But I am convinced that when you combine the overtime with our modernization approach, our reengineering, and a number of other improvements, to include moving more people into the decisionmaking, that it is going to allow us to continue this downward trend we are seeing. So I think it is permanent, and I think it is a combination of things, including the overtime we did, which I don't think we are going to have to do in 1996. So I am very pleased with that.

Mr. Vogel, would you like to add something else to that?

Mr. VOGEL Mr. Everett, I think that the Secretary covered it well. There is a dynamic that happens. If we fixed the organization today, the operational mode, and infused a measure of overtime just for this one week, we could see the effect that would have right away. But, in fact, we are being—our people are being much more creative, they are much more responsive. We have more people in decisionmaking modes than we had in the past. So just to attribute our progress to one aspect is impossible to do.

The good news is that we have become much more efficient. We have many, many more people in direct service to veterans, but less people involved in the augmenting and clerical functions that support it.

We are very proud of our accomplishments. We reduced the backlog by 11 percent last year. I told the Secretary I will have it down 18 to 20 percent again this year. That is just the backlog, but we will make the improvements in timeliness as well.

Mr. EVERETT. Mr. Secretary, what was the basis for the General Services Administration's suspension of the delegation of procurement authority for the acquisition of VBA modernization, Stage 2, the computers?

Mr. CATLETT. Mr. Everett, I would like to answer that question. That is a responsibility that I have, and we deal directly with GSA.

Overall, the delegation was restored within the week for Stage 2 modernization. That withdrawal was based on a misunderstanding between staff about the data that GSA was expecting. They are tracking this progress that Mr. Vogel is talking about, as they should in their oversight role, and that information was supplied; and whereas the delegation was withdrawn on a Monday, we had that restored by Friday.

It is just a matter of making sure that our staffs—certainly we don't want to have that happen again, and we are making sure the staff is in touch and making sure the information is provided.

Mr. EVERETT. In other words, strictly due to miscommunications?

Mr. CATLETT. Yes, sir. They were expecting information on our progress sooner than we had provided it, and decided to withdraw the delegation to get our attention, I expect. I have encouraged them also to call us whenever there is a problem among staff in terms of getting the information they expect, because we have had a good working relationship over the last 6 months.

GSA has been very involved with this project, as OMB has, and the support they have given us—we appreciate it, and their roles, we respect; and we are just making sure that the staff, when there

is a problem—and in this case, I considered it a minor one, because, as I said, I was able to get them the information they were looking for and by Friday we had it restored.

The progress on that project is continuing. The negotiations and the procurement process is under way as it should be.

Mr. EVERETT. What importance does VA give to Stage 2 and Stage 3?

Mr. VOGEL. Mr. Everett, we believe that Stage 3 clearly will be the completion of the project. Stage 2 will give us an opportunity to image and to use imaging. If you have ever visited one of our benefits offices, we are involved in claims folders, we are in paper processes, we exchange paper between us and the VA medical centers, between ourselves and the Department of Defense and the respective military services departments.

We want to get involved in imaging overall as much as we have been involved in imaging in administrating GI bill benefits at the St. Louis regional processing office. The technology has become very important to us. What it really does is get us out of having to use so many of our personnel to carry paper from one decisionmaker to the next, while providing more personnel to ensure that some value is added on and the decision is made. These things are very important.

It is a signal to our employees, as well, because we had such a very good year in 1994, and they are certainly in tune with what we are doing. It would give our personnel in the field a great deal of confidence and hope that we are, in fact, continuing to modernize and are getting out of the 1940s and 1950s mode of operation.

Mr. EVERETT. What is the total dollar amount of this procurement allocation?

Mr. CATLETT. I am sorry, sir. Could you repeat the question?

Mr. EVERETT. The total dollar amount of this procurement allocation? What is budgeted?

Mr. CATLETT. Are you talking all three stages of modernization, sir?

Mr. EVERETT. Right.

Mr. CATLETT. All three stages are around $100 million, sir. We have completed Stage 1 and that procurement has been made. Stage 2 we expect this spring; it is the smallest of the three. As Mr. Vogel indicated, Stage 3 will be awarded next summer, the summer of 1996. The total of those for the hardware and installation is around $100 million.

Mr. EVERETT. Thank you very much.

Mr. Chairman, I have additional questions I would like to submit for the record.

(See p. 360.)

The CHAIRMAN. Mr. Doyle, before we have to take a recess.

Mr. DOYLE. Thank you, Mr. Chairman.

OPENING STATEMENT OF HON. MIKE DOYLE

Secretary Brown, it is a pleasure to have you here today. I am one of the new Members on the committee, and also was the—my age saw the Vietnam War end about 2 or 3 months before I was going to be drafted, and I was thankful for that.

My father served in World War II, with a 100 percent service-connected disability, and was taken from our family at far too young an age due to his injuries in World War II. So I have a healthy respect for what the veterans' hospital system has done for my family.

I represent a district in Pittsburgh where we have one of the highest veteran populations in the country, and I have three VA facilities servicing my district. I have recently had the opportunity to tour those facilities, in Oakland, Highland Drive, and just very recently, the new state-of-the-art facility we have in Aspinwall; and I can tell you, it does make a difference when you talk about having a facility that is updated and new. I was just there meeting with a lot of our veterans there, and it does a lot for their spirits and their morale and also for the people serving them there.

When I met with some of the directors, one of the things that came across as I spoke with directors at the VA hospital system is this need to decentralize the system and give them some more flexibility to do some things within their budgets. So I was very happy to see this Veterans' Integrated Services network that you are working on. I think it is a step in the right direction.

I have had directors tell me that sometimes because of this restriction they have on FTEs—and I am just learning this process—but apparently it doesn't distinguish the difference between a nurse and a doctor or someone that is doing janitorial services; and FTEs—you know, it is a swap—and that sometimes they found themselves going out of the system, outside contracting work at actually a higher expense than what they could have done it at within the system, but they didn't want to use an FTE slot because they were so restricted in how that process worked, and that actually they could be more efficient and do more with their budgets if they just had some flexibility.

So I think what you are doing here is a step in the right direction; it is what your directors in the field are looking for, so that they can be more efficient and do more for our veterans with their budgets. And I want to commend you and offer you my support as you move in that direction.

Secretary BROWN. Thank you very much, sir.

The CHAIRMAN. Mr. Secretary, we will recess for a short 10 minutes and be right back. We apologize.

Secretary BROWN. Thank you, Mr. Chairman.

[Recess.]

The CHAIRMAN. I might have been too premature, Mr. Secretary. We don't have anybody to ask questions yet.

Here comes someone.

The committee will please come to order. Let me say, I know, Dr. Kizer, that you have to leave in a little bit, but I want to welcome you aboard—I neglected to mention at the beginning, but I have heard nothing but very good remarks about you—and I want you to know that and the record to show that. We welcome you.

Dr. KIZER. Thank you very much, sir.

The CHAIRMAN. Mr. Buyer.

Mr. BUYER. Thank you, Mr. Chairman. And Jesse, thanks for coming over.

Secretary BROWN. Sure, Steve.

Mr. BUYER. I have some specific questions, and I think Sonny was right when he brought up the questions in regards to the reduction of the COLAs. We can't satisfy my heart here this morning, but just to let you know where I come from, I am one that was not in support of the Americorps. I think of how it undermined volunteerism and the problem of how it would pay people to do something that millions of people do in our society anyway, and it bothers me that when the Administration bumps up Americorps really as a jobs program, it has a perverse effect in undermining what we seek to do in recruitment and education and training of veterans with the GI Bill. So I just want to let you know that.

And bumping up Pell grants. It is difficult for me to justify in my mind why, really, to go back to Indiana and go to the VFW and American Legion and talk with my veterans—veterans that are going to take a hit—we are going to bump up some other things. I think that President Clinton had a very good theme a couple of years ago when he opened up in his State of the Union address in regards to deficit reduction and he talked about shared sacrifice, and I am sure he has talked about that with you often at Cabinet meetings, and hopefully still does, because I think the theme is correct.

But it is very difficult. I found it difficult when I went back to talk to farmers, when I said, well, you are going to take a $3 billion cut in USDA, but they are bumping up food stamps by $7 billion. It is difficult to try to justify some of those things.

So help me here right now. Why did the administration propose the half-cut in COLAs, try to explain that to me. Believe me, I am one that thinks that, you know, there is no constitutional right to COLAs, okay? But help explain this one to me, please.

Secretary BROWN. Well, as you know, these are merely extensions of the provisions that were already in law. Most of them would have expired in 1998. There were three of them that were scheduled to expire in 1996: the C&P rounddown, the DIC limitation of the COLA, and the one that you mentioned in the GI Bill.

Now, the thought here was that deficit reduction is very important, and since we wanted to see what we can do in order to be able to show we were doing our fair share, or doing—I don't want to call it "fair share," because quite frankly, I tend to agree with you, if I had my way, veterans would not have to take any cuts. We should be given more.

But in this instance, these were already on the books, and it was felt that it would not pose a tremendous hardship on veterans to extend three of them.

Mr. BUYER. I guess in your answers to some prehearing questions, I will highlight—what bothers me is—and we are going to struggle with this on the Armed Services Committee; I serve on the Personnel Subcommittee, and as we struggle with force structure issues and recruitment and the Marine Corps, former Marines have some concerns right now in accessions and recruitment.

In your response here you said, in comparing the Montgomery GI Bill benefits of the 2-year to 3-year enlistees to those available to individuals who do not participate in the military, but choose the Americorps program. A 2-year enlistee who completes his term of service is eligible for $328.97 per month for 36 months, which

works out to around $2,960.73 per academic year. Someone could serve in the Americorps and get $4,725. Add to that health care and child care, which a veteran is not going to receive.

So I want to let you know, Jesse, that this one doesn't sit right with me, and we are going address Americorps. You don't have to address Americorps; we are going to address that, because I am one of them that was very uncomfortable in extending benefits that far exceed the veterans', and especially those who have walked the walk. So I want you to know where I come from on that issue.

The other question that I have really deals with that $70 million in conversion money that got shifted over to the VA. The SMOCTA, the Service Member Occupational Conversion Training Act, placed over 13,200 veterans at an average obligation of 5,505 per veteran process.

Tell me, do you think this is a good program? Do you think it is going to extend, or do you think the Secretary, with the vets, can pretty much handle it?

Secretary BROWN. I think it was an outstanding program, and I think we still have a little bit of that money left. We actually wrote to the Department of Defense to see if they would make those funds available to us, because we believe that it was very, very beneficial to our veterans.

I am going to ask Mr. Vogel to comment on that. But before I do, I just want to say one last point about these extenders. I want you to know that I am not totally committed to this. I mean, I am willing to sit down and talk about what else we can do. I just want to make sure that we don't end up hurting our veterans. I don't want to see any major cutbacks on basic programs, for instance, like we had with DIC. It was a major cutback when we actually made it impossible for a remarried widow to come back onto the rolls.

I don't want to see that. So I am willing to sit down and talk with you and members of the committee on trying to figure out a way that we can kind of work this out.

Mr. BUYER. Mr. Chairman, was this included in the armed services budget? You said you asked—did you write Secretary Perry and ask him? I don't recall.

Mr. VOGEL. There was a question about whether or not the funds had to be obligated or made available beyond one fiscal year. We had to get a clarification on that congressional action, which in fact freed up some monies to be used essentially until they are exhausted. Otherwise, we would have shut the program off in October without having expended all of the money. Now we are going to carry it on through. That is what the Secretary is referring to.

We have had conversations about the availability, and this is really in the preliminary stages, of conversion monies that may in fact be available through labor sources for displaced civilian employees in defense industries to try to see whether or not some of that might be available for those who wore a uniform and were members of the actual military force during the downsizing and the conversion. But those discussions are rather preliminary. But I would be pleased to keep you informed of progress on that.

Mr. BUYER. All right. Thank you, Mr. Secretary.

Thank you, Mr. Chairman.

The CHAIRMAN. The gentleman from Illinois, Mr. Gutierrez.

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

OPENING STATEMENT OF HON. LUIS V. GUTIERREZ

Mr. Secretary, welcome once again here. Last year we had a—I went out to a hearing in San Juan, Puerto Rico which our department was advised about and then Chairman Montgomery of the Veterans' Committee wrote a letter and was well-advised about, and we got back a report about the outpatient care and about how in San Juan there was going to be some $30 some million that we put in the bill last year so that we could do, because of all of the overcrowding, there is really only one major center in San Juan for all of the veterans.

Just in case, for the edification of the Members, everybody in Puerto Rico is eligible for the draft and we are all American citizens, even the Island of Puerto Rico, while it is a colony, we are all American citizens there, and there is a high percentage of veterans living on that island. That is just in case, Mr. Chairman, because since the U.S. Immigration and Naturalization Service was telling different corporations that we were permanent residents of this country, I just thought we should make that absolutely clear to everybody.

So we went out in Puerto Rico, we had that hearing out there, and I would just like to ask you, I understand there was some flaw in the Appropriations Committee last year that really screwed up the money for the VA Hospital in San Juan. Can you tell me a little bit about that, and answer the question, if you might, does it make sense to you that the Congress should invoke in the name of deficit reduction to cancel these projects, one of which was canceled yesterday in the Subcommittee on Appropriations, projects like these that are improved—that are targeted to improve outpatient care, which is a less expensive form of treatment than inpatient care?

Secretary BROWN. I would agree with you. No, it does not make sense.

With respect to the funding, as you know, we were prepared to move forward on that project, and it was actually in the 1995 budget. There was a mixup in terms of how the appropriation took place where they actually put all the money into one area.

In order to move forward, we were just going to notify the Congress and actually move—I think it was about $7 million, and then get authorization later to go ahead. So we were prepared to move forward on that project because it is one that we think is beneficial to our veterans.

But, as you have pointed out, at this point, if these rescissions are final or if they become final, then it makes it a moot point.

Mr. GUTIERREZ. Thank you, Mr. Secretary.

Mr. Secretary, in the last budget request of the National Cemetery System, we have—we talked about the much-needed cemetery in Illinois and specifically the Chicago area, and I know you came—your staff came out to a hearing that was conducted by the oversight subcommittee headed by Congressman Evans in Chicago, and we had a hearing there, and we know that it was listed as the number one priority for cemeteries in terms of the whole district,

and I know that you came out and were very emphatic about it. And then we told all of the veterans in Chicago 2 years ago that it would be built by 19—it would be in operation by no later than 1999, 1998, 1999. That would be it.

It would be in operation, we were going to do it, the money was there, that we were ready to go with it. It is my understanding that there is no money in the budget to carry forward on that cemetery in Chicago, and I hope I am wrong, but could you explain to us if what we told the veterans in the City of Chicago who have no cemetery because all of them are full to the max and who is a number one priority, what is it that we are going to do to get them that national cemetery.

Secretary BROWN. Okay. Everything you have said is true in the reverse. We do have money for that project, as I have mentioned in response to an earlier question. We have funds available and plan to move forward on five cemeteries, they are Seattle, Dallas, Chicago, Cleveland, and Albany.

Now, we actually have the land acquired for Seattle, Dallas, and Albany, but I don't see any problem whatsoever at this point with Chicago. I think that is going to move forward; you are absolutely right, it is needed.

We wasted too much time trying to get that land up there in north Chicago at Fort Sheridan, and we couldn't get that because of circumstances that developed. The economics just did not work out. The Army wanted $37 million and we only had about $6 million. So we identified that site, as you know, in Joliet, and it will allow us to develop and move forward and have gravesites that will last us until when?

Mr. BOWEN. The 940 acres would provide space beyond the year 2075.

Mr. GUTIERREZ. When will it be completed, the cemetery? What is the schedule for completion?

Mr. BOWEN. Right now, sir, our effort is to acquire the land. The completion date, is contingent upon when we can acquire the land and obtain construction funds. We do not need land acquisition dollars. We have the dollars.

Mr. GUTIERREZ. When is it scheduled for completion?

Mr. BOWEN. We have no firm scheduled date for completion.

Mr. GUTIERREZ. Well, we gave a schedule for completion last year when we had hearings here, and if my memory serves me correctly, it was 1999 it would be completed and done and ready to go. So I would just urge everyone to try to keep on that schedule, and if there is no monetary problem that we do that, because I think it is very important.

Let me just a question to Chairman Stump. Mr. Chairman, wrapping up my time here, can we have hearings in this committee on the actions taken by the Appropriations Committee in terms of over $200 million that were taken away from the budget in rescissions and what kind of impact that specifically is going to have? Because I know we had the national veterans organizations come in here, we had them all, you know, the American Legion.

I think we should call them all back and say things have changed. There is $200 million less and we should conduct some hearings so that we can exert our authority. I know we are not the

appropriators, the cardinals of the institution, but I think we have a big responsibility in terms of defending the interests of veterans, and I am just asking the chairman if we could have some hearings on that, because I think that is rather important.

The CHAIRMAN. I will assure the gentleman we can and we will in the 1996 construction budget; we have already had a request for a hearing regarding the cemetery in that area.

The gentleman from New York, Mr. Quinn.

Mr. QUINN. Thank you, Mr. Chairman. And welcome.

OPENING STATEMENT OF HON. JACK QUINN

Mr. Secretary and the team that you have brought with you today, I want to compliment you and the team on your efforts with this latest budget go-round and you know that you have a lot of support here. I think in the last year or two we know we have a lot of support from your end of things. So I appreciate your efforts. Thanks.

I have a question for which we might have to rely on, using your term, the money man, Mr. Catlett, in a minute here or two about the PT Phone Home Program. As you know, that project, not for my district, because the phones are already in, but I think for all of the other members in veterans hospitals around the country, you said earlier with the question Mr. Tejeda asked, what would you do with an extra billion dollars. I couldn't agree more with your response that we spend some of that money to bring hospitals up to current standards, with the phones at the bedsides of the veterans in the hospitals all across the country, and I saw that happen in Buffalo last year. We will talk about medicine and we will talk about doctors, but believe me, when a veteran can call his family members, children, wife, whatever, husband, that maybe is the best medicine we can provide for them while they are away and in the hospital.

This is a program, for those Members that don't know about it, that is a great effort—communication workers of America volunteer their time putting in the wires and making sure the hospital is fit. In the Buffalo situation last year, we were able to combine some work the hospital was already doing with computers when we ran some lines. It just seems to me it is a win/win situation for everybody.

My question is, having taken the platform for a minute to talk about the program, the question is that it is my understanding the money for PT Phone Home, whatever amount is there, was available through the minor project construction account.

And my question is, how does that account look for 1996? Can we compare amounts of money that we had last year and will have for next year so that I can get a handle on where it is going to be in the coming year?

Secretary BROWN. Well, let me say as a matter of policy, Mr. Quinn, that I agree with you. It is a wonderful project. I am so thankful for the volunteers who spend time and their efforts in our VA hospitals. We have about 92,000 of them come to our hospitals each and every day to help our veterans and they contribute somewhere around $165 million of their services to us.

This particular project, and I am going to ask Mark to respond, it is going forward like rapid fire, all over the country, and we are going to support it. Any project will be funded. We will find the money, and I am making a commitment, we will find the money if all the other pieces are there. There will not be any projects that are turned down simply because we don't have the resources, because it is, as you pointed out, so very, very important, and it is cost-effective to us.

They are providing all of the expertise, and in many cases they are also providing the materials. So we would be foolish not to take advantage of that while it is made available to us, Mark.

Mr. CATLETT. Mr. Quinn, I don't have the specifics here, we will get those to you right away, but the schedule that we are working towards is completion for the Nation by the end of 1996.

[The information follows:]

Under the Medical Care appropriation, the Veterans Health Administration expects to spend $23 million in fiscal year 1995 and $5 million in fiscal year 1996 to complete the installation of bedside telephones at all VA Medical Centers. The Congress provided $5 million of the $34 million which we will spend in fiscal year 1995. The $28 million will complete the installation of bedside telephones in the remaining 77 medical centers by end of 1996.

Mr. CATLETT. We certainly have an excellent minor construction budget and as have you and the Secretary have noted most of the funding is not Federal appropriated dollars that is making this happen which is a great feature of this program.

So, as Jesse said, we will have, with the excellent minor budget that we propose, any funding that we would need. We will provide those details to you. But overall by the end of 1996, we are to have this completed throughout the Nation.

Mr. QUINN. Thank you. I would be interested to have that information and I will share it of course with other members of the committee and the Chair Monday.

I think it would also be helpful for us to share that information with some of those volunteers, namely the communication workers of America and at the same time the management of some of those phone companies, Mr. Secretary, as you mentioned, who come up with the hardware, the actual telephones and the wiring and the volunteer hours.

If we put a price tag on it and we tried to in our situation last year, it's literally hundreds of thousands of dollars for that one particular hospital. So it is absolutely a win/win. I know with the communication workers when I talked to Frank Fozio a couple of times on the telephone, he is always concerned that he doesn't see a line item in the budget for the money. I told him I would be giving him a call later today or Monday after our discussion today. I think I will hold off, Mr. Catlett, until I have those budget numbers from you, if it is okay, in the early part of next week.

Mr. CATLETT. We will have them to you this week.

Mr. QUINN. That would be super.

Secretary BROWN. Mr. Quinn, I just wanted to thank you for your help and your support of veterans.

Mr. QUINN. Happy to do it.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Ney, Mr. Cooley.

OPENING STATEMENT OF HON. WES COOLEY

Mr. COOLEY. Thank you, Mr. Chairman. And thank you, Mr. Brown, for being here today.

As you probably know, I am the only Korean veteran to be elected to the 104th Congress and I also have a small disability in which I lost part of my hearing in the Korean conflict.

I am looking over your budget figures and I look at the expenditures of $257 million, an increase of $5 million over last year for research. I think that the prosthetic research is quite vital to the American veterans because basically no one else is doing that. But I wonder at the expenditure of funds if we really need to be spending money on aging, mental illness, heart disease, diabetes, cancer, and AIDS research when we have other Federal agencies doing the same thing. If maybe some of that money couldn't be rechanneled into some of the things that we discussed earlier about the possibility of helping veterans at the service level and rechanneling some of those funds, maybe not into these research areas, but back to basics.

Could you give me some comment on that? Because I find that we are duplicating at NIH and everywhere else, every one of the things that you are working on as well, and wouldn't it be better to spend our money, our veterans' money, on veterans and not doing research. In your statement here you don't talk about veterans' health care, but that of the entire population. Well, this seems like a duplication.

Secretary BROWN. Yes, sir. I understand your question, but I don't think I agree with your conclusion. VA is kind of a unique entity within our society.

We have 172 hospitals and I think about 126 medical schools around the country, and we are affiliated with about 106—104 of them. Research helps us attract quality people into our system. Many doctors are not necessarily interested in hands-on care. But if we can attract them into our research effort, many of them stay, and they become hands-on clinicians. They actually end up working with the patient and improving quality of care. They become part of our team in providing quality care through their sophisticated research that is going to benefit our veterans, but not only veterans, but people throughout the Nation.

For instance, the CAT SCAN was invented by VA. Not too long ago VA came out with a study saying VA is doing something a little bit different from many of the other research institutions around the country. Most of them want to get into the real sexy stuff, the high-tech stuff. VA tends to focus a lot of its attention in clinical areas. For instance, not too long ago they came out with a conclusion that you can't treat people of different races and different ages with the same medication to control hypertension. So that not only benefited our veterans, but it also benefited the entire country and people around the world.

So research is very important in allowing us to attract quality people into our institutions which end up serving our own purpose.

Mr. COOLEY. Well, the thing is that I am just questioning if the Department of Veterans Affairs should be spending these monies. Is it possible that the committee could receive a breakdown of the

$257 million in research money is going into these particular areas?

Secretary BROWN. I think the answer to that is yes, but I am going to ask Dr. Kizer to respond.

Dr. KIZER. Sir, if I might respond, one of the things I plan to do is to look in depth at how we make the decisions to allocate our research funds, what our commitments are and what was the process of deciding that. In many cases research relates to health problems of the patients we treat. For example, about 7 percent of all of the AIDS patients in the Nation are treated at VA facilities.

I believe we are the single largest provider of AIDS treatment in the Nation. Many of our patients are diabetics or they have other conditions such as you mentioned before. So doing research in these diseases, particularly clinical, applied types of research, is directly germane to the care that is provided in our facilities.

But having said that, I also have had some of the same questions which I think that you are raising. Over the next several weeks I hope to undertake a more thorough review of exactly how we decide on the research projects that we fund. I will be happy to get back to you after I have completed this review to share with you the results and then perhaps to further address some of the concerns that you have.

Mr. COOLEY. I am specifically interested in how much money we are putting into the prosthetic research, because I think that the Veterans' Administration is probably the leader in that area and that maybe we ought to be putting some more in there, because that is a vital part of bringing people back to normalcy, if we can use that term, when they have severe problems involved in this process.

Dr. KIZER. Well, we can certainly get that information to you, and that is one of the specific areas that I intend to review, particualrly how prosthetic research balances out with other areas that we are funding.

Mr. COOLEY. Thank you very much.

The CHAIRMAN. Mr. Kennedy, Mr. Schaefer, Mr. Flanagan.

OPENING STATEMENT OF HON. MIKE FLANAGAN

Mr. FLANAGAN. Good morning, Mr. Secretary. Thank you for bringing this distinguished panel here.

Mr. Chairman, before I begin, I have a statement and some prepared questions for the record, which I would like to submit, and in the interest of time, I will just ask one of the questions.

The CHAIRMAN. Without objection.

Mr. FLANAGAN. Thank you.

I will once again revisit the horrors of the cemetery condition in Chicago. Mr. Gutierrez has very adequately brought the problem before us again today, and while Lou and I agree on virtually nothing, if you look at our voting records, we certainly agree on this, and that is our love for the city and our need for the cemetery.

Chicago, the statistical area that we are talking about, is between 8 and 10 million people, ranging between 17 and 20 congressional districts. And if my intensity of this seems a little significant, it is because the last national cemetery there, I believe, was closed after the Civil War. We haven't had a place to inter veterans

in that area in 100 years. We need a cemetery. Promises have been made in the past, and I am mildly concerned that in your budgetary criteria you have allocated or put aside enough money to maintain the interment sites, and actually, as we have heard earlier today, are going to develop an equipment backlog in this area of the veterans affairs.

The money you have said is laying there to acquire the Joliet site. The history of it, I think, is a little longer involving the Fort Sheridan site, and I am concerned that short shrift was given to the Sheridan site and continues to be.

Mr. Bowen and I have talked on two occasions now, and Mr. Weller has introduced very important legislation to try to solve this problem, as has Mr. Crane in the past, Mr. Porter, and other Members have taken a very deep and concerning interest in a very specific way.

I wonder if I can ask Mr. Gutierrez' question again; when can Chicago look forward to having a cemetery for that area?

Secretary BROWN. We can't give you an answer right now, but I can tell you, we don't have a problem there. There is no problem. We will build that cemetery. We are in the process of acquiring the rights to the land, and we are going to move forward.

There is absolutely—I see no real major problem, I really do not. And if something should develop, we will certainly be in touch with you and Mr. Gutierrez whom I have spoken with a number of times. He has been out on the lead on this issue, and we will make sure you receive that information. But I don't see a problem.

Mr. FLANAGAN. Well, I appreciate your concern, and the level of concern of Mr. Bowen as well. And we have talked about this again and again in a timetable, and been assured again and again, and yet you still are reluctant to get even an approximate date. And I am not trying to ask you to give me one now or anything like that, because I realize it is impossible in the context of what we are talking about.

Secretary BROWN. Yes.

Mr. FLANAGAN. But I just wish to make it very clear to you the problem that many of these congressional districts and these millions of people have in not having a place to be interred in Chicago.

Secretary BROWN. I agree with you, and I am saying for the record, we don't have a problem there. That is the least of our problems; of course, unless someone takes the money out of the budget.

Mr. FLANAGAN. Well, it is the greatest problem for the elderly vets in Chicago, I assure you, Mr. Secretary.

Thank you, Mr. Chairman.

[The prepared statement of Congresssman Flanagan appears on p. 78.]

Mr. GUTIERREZ. Would the gentleman yield?

Mr. FLANAGAN. Yes, Mr. Gutierrez.

Mr. GUTIERREZ. Mr. Secretary, you have been very generous in coming out and holding hearings with the veterans in Chicago, and with me specifically, and obviously Lane Evans' oversight committee that held a hearing on this. And I just think that somebody has already issued a statement on your behalf.

At the November 6, 1993 field hearing, held under Congressman Lane Evans' oversight committee, we heard from your representative, and I am just going to quote from him quickly and then we can move on: "Let me emphasize that VA Secretary Jesse Brown has taken every opportunity to express his support for a national cemetery for veterans in the Chicago area. We hope to complete this project and be able to dedicate a new national cemetery, a national shrine for this area's veterans by November of 1997, just 4 years from now." That was the statement of the representative of the Veterans' Administration at the oversight hearing.

And I think that is why we are—I wanted to share that with you, because I know you didn't say that there at that hearing and that sometimes people misspeak at hearings. But if we could just have a definite time—not right now.

If you could just respond to us and say this is the track that we are on so that we can go back to the veterans and tell them here is what is going on today in 1995.

Secretary BROWN. Give us a chance to work on it.

Mr. GUTIERREZ. Thank you very much, Mr. Secretary.

The CHAIRMAN. We have about seven people, and the Secretary has to be at another meeting by noon.

Mr. Evans from Illinois.

Mr. EVANS. Thank you, Mr. Chairman.

Mr. Secretary, the VA's Readjustment Counseling Services is one of its best services, it has treated thousands of veterans, helping to make that transition back to civilian life. It has strong bipartisan support in Congress.

What is the budget request for the VA Readjustment Counseling Service and the anticipated caseload during fiscal year 1996?

Secretary BROWN. We don't have that, Mr. Evans, but we will get it for you.

Mr. EVANS. All right. That will be submitted as part of your testimony in the record?

Secretary BROWN. Yes.

Mr. EVANS. I understand Mr. Montgomery raised the issue of the GI bill with the COLA only being about 50 percent in terms of the cost of living that veterans need to go to school on the GI bill. Why are you proposing that and what impact do you think this might have on the use of the GI bill in the next fiscal year?

Secretary BROWN. The reason we are proposing it primarily is because it is an extension of present law, is an extension of the 1993 OBRA provisions. And we felt that in order to make a contribution toward deficit reduction, this would be an area where we would not have to end up eroding any benefits, the basic core of benefits. There were 11 of them.

Of the 11, 9 were scheduled to terminate in 1998; 3 of them were scheduled to terminate in 1995, and they are the rounddown of the COLA, the DIC, and the GI bill. So that is it in a nutshell. I do want you to know, as I have already said, we are willing to work with the members of this committee on that issue.

Mr. EVANS. What would an average GI bill monthly payment be for a veteran on the GI bill, with the 50 percent reduction and the cost-of-living adjustment?

Secretary BROWN. We can get that for you.

Mr. EVANS. All right. I think all of us are concerned that it is not going to be a viable program if it doesn't keep at least pace with inflation, or with regular inflation, much less with the increases that we see in tuition in the last few years, so I would appreciate you getting back to me.

Secretary BROWN. We will.

[The information follows:]

The average GI bill monthly payment for a veteran will be $411.36 in 1996 with a 50 percent reduction in the cost of living adjustment.

The CHAIRMAN. The gentleman from Georgia, Mr. Bishop.

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

Thank you, Mr. Secretary, for all that you do for veterans. We sincerely appreciate your sensitivities.

Moving to your budget proposals, as you know, there is a tremendous backlog in dealing with the processing time for disability claims, and looking at your proposed budget, could you sort of give us in a nutshell how you can reconcile the mission to deliver timely benefits with the 200-day processing time for disability claims, and is there anything in the budget that specifically will help to address that backlog and the time lag in dealing with the disability claims?

Secretary BROWN. Yes, Mr. Bishop. We are very concerned about our timeliness, but for the purpose of your question, I have to break that question down between timeliness and the Veterans Benefits Administration and the Board of Veterans' Appeals.

In the Veterans Benefits Administration, we are extremely happy about what has occurred. In 1994, our backlog was 452,000. In 1995, it was 386,000; and in 1996, 296,000. And we expect to reach our goal of 250,000 in 1998. And that is where we want to be at 250,000, because we have about 13,000 people out there, and that will keep them busy all year-round and we will be able to get the cases out.

So we really do not have a problem in timeliness at the regional office. Where we have the big problem is that if a veteran files an appeal, because at the Board of Veterans' Appeals, the processing time there—give me those numbers, please.

At the Board of Veterans' Appeals, which is what I am really concerned about, in 1991, our average response time was 139 days. In 1992, it was 240 days. In 1993, 466; 1994, 781. In 1995, it dipped a little bit, to 745.

Mr. BISHOP. Is that the number of days?

Secretary BROWN. Yes, sir. And you can see why we are very, very concerned about that. While it dropped down a little bit and we received some help from the Congress in the last session, we have one-man decision authority and there were some other things that we are doing. But we are very concerned about that.

I have asked a special panel to look at it, that consists of the service organizations. We even brought in people from the private sector and other government agencies to help us look at it and try to see how we can streamline that case management. So we are working very, very hard on that, and I hope that we will continue to have this moving south to try to stabilize it.

The other problem is that we still have more cases coming in than going out. So in order to make any headway at all, the first

thing we have to do is to have the same amount coming in and the same amount going out, and then once we get there, then we can begin to see a little light. So we are working very hard on it and we are open, of course, to any suggestions that you can help us with.

Mr. BISHOP. That is the biggest complaint that I get from my veterans, is the tremendous lag time in having their appeals adjudicated. And many times, they call the office saying that I will be dead before I ever get a decision one way or the other.

Secretary BROWN. And some of them are right. If you think about it, some of them are right. It could be as much, in some cases, as 5 years. You take a guy, a World War II veteran, 72 years old, and if he has to wait 5 years, there is a good chance he will be dead. And the bad thing about it, if he dies and we allow his case, we can only pay his widow 1-year retroactive accrued benefits. So we recognize a decision delayed really is a bad thing.

Mr. BISHOP. Is a decision made?

Secretary BROWN. That is exactly right. So we are going to try our best on it.

Mr. BISHOP. You anticipate $170 million in our medical malpractice claims for 1996. What steps have been taken to mitigate the need for malpractice claims?

We have had some complaints about treatment from veterans that they have received and some claims of malpractice in our VA hospitals. How is that being addressed?

Secretary BROWN. This has a little bit different twist in terms of malpractice. What you are referring to is the *Gardner* decision, which was appealed to the Supreme Court. In that decision, we had been interpreting regulations since the beginning of time, that in order for VA to assume responsibility for something that happens to an individual while in a VA hospital as a result of treatment, that it had to have happened as a result of an accident or negligence, basically.

Based on the Supreme Court decision, they said no, that is not how it should be interpreted. Any veteran, basically where the condition is increased as a result of treatment, if it is not the desired result, then it should be service-connected. So this is a direct result of that decision. The first year is $170 million, and then I think the 5 years is $1.8 million?

Did I explain that right, Mary Lou?

Come on up here.

Ms. KEENER. To respond directly to your question; as I heard it, you are asking what, if anything, we were doing to reduce the number of claims that we see in hospitals, whether they are 1151 claims or tort claims? Actually, I think that the answer to that question lies in with some of the things that Dr. Kizer is doing or intends to do in the area of quality assurance. Perhaps Dr. Garthwaite could respond to that.

Dr. GARTHWAITE. Surely. Every medical center's goal is to reduce all variation to zero. It is like running an airline. You want no crashes sustained over time, and I think our goal in health care is no mistakes sustained over time.

Unfortunately, all health care systems are run by human beings who use a lot of judgment. We have instituted a national system

of continuous quality improvement which looks at all of the processes to see if we can improve our processes to avoid instances of poor quality. We review on a regular basis all of the untoward events in the hospital, at least all of the major untoward events, and look to see if there are system problems or people problems and then we try to deal with those based on what we find.

Secretary BROWN. Let me just follow up on that. First of all, did I explain that *Gardner* thing right?

Ms. KEENER. Yes you did, Mr. Secretary. I assume; however, that your cost reference was to $1.8 billion rather than $1.8 million.

Secretary BROWN. After that came into effect, Mr. Bishop—and I know you are a lawyer—so after that was brought to our attention, we did send out guidelines to all of our hospitals saying, this is what you will do in terms of people who come into the hospital. Is that right? You would tell them exactly how and what to expect? Did that go out?

Ms. KEENER. Guidelines from the Benefits Administration went out regarding the manner in which pending claims are handled.

Secretary BROWN. Mr. Bishop, let us get back with you on that. I think I recall what we did——

Ms. KEENER. I think what the Secretary is referring to in conjunction with the *Gardner* decision, is that Dr. Kizer did send out guidelines to the field regarding informed consent to all providers within the system.

Mr. BISHOP. That is not so much——

The CHAIRMAN. If the gentleman would please—other Members have sat here so we can get through this—before the Secretary has to leave, we will get right back to you.

Mr. Secretary, if you would identify the lady that just spoke, for the record?

Secretary BROWN. Mr. Chairman, this is Dr. Garthwaite. He is our Deputy Under Secretary, and the lady that spoke is our General Counsel, Mary Lou Keener.

The CHAIRMAN. Thank you, Mr. Secretary.

I want you to know that people hope you are a little bit wrong in your statistics as relating to age and death.

The gentleman from Pennsylvania, Mr. Fox is recognized.

Mr. FOX. Thank you, Mr. Chairman. It is a pleasure to have before us this morning these honored special individuals who represent our veterans so ably, and Mr. Secretary, I am very happy to have you here today.

Secretary BROWN. Thank you, sir.

Mr. FOX. One facility that serves my district is Coatesville Hospital. I wanted to hand over a newspaper article to you that, unfortunately, occurred, I guess, this week, a veteran choked to death at the hospital. And if you could have someone on your staff investigate it for me. I don't know whether it is a problem.

Following up with Congressman Bishop's questions on suits, obviously, we want to keep our veterans healthy.

To the extent that you can get back to my office and let us know, or the committee, everyone here, just what is being done over here, I don't know whether it is an isolated case or if we have a problem. There is an allegation of staff shortage, and if there is, I would like

to know about it so we can work with the committee to address that.

Secretary BROWN. Yes, sir, we will.

(Subsequently, the Department of Veterans Affairs provided the following information:)

The Secretary has responded directly to Congressman Fox in response to his April 11, 1995 letter (copy attached).

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON
APR 11 1995

The Honorable Jon D. Fox
House of Representatives
Washington, DC 20515

Dear Congressman Fox:

This is in response to your inquiry regarding the care provided to the late Mr. Leonard Gilbert at the Department of Veterans Affairs Medical Center (VAMC), Coatesville, Pennsylvania. The Veterans Health Administration was asked to review this matter and the following information was provided.

As a part of the Coatesville VAMC quality management program, a focused review of the care provided to Mr. Gilbert was conducted. It was determined from this review that Mr. Gilbert's treatment met acceptable standards of care.

The 75-year-old veteran had been a resident on the Nursing Home Care Unit at the medical center since March, 1994. He was diagnosed with Parkinson's disease and dementia, with paranoid delusions and episodes of agitation. Mr. Gilbert ambulated with assistance, had no history of dysphasia or difficulty in swallowing, and was not a choking risk. He was prescribed a geriatric diet and required assistance only with cutting his meat and opening milk cartons. He fed himself during his entire stay on the unit and was able to clean his dentures. Mr. Gilbert was not seriously ill, and did not have a Do Not Resuscitate (DNR) order.

During a treatment team visit on February 14, 1995, Mr. Gilbert expressed his desire to be transferred to a contract community nursing facility near his son. He was considered competent to make this decision, and he was medically and psychiatrically stable. Therefore, the team was pursuing this option for the veteran.

Shortly after lunch on February 18, 1995, Mr. Gilbert was found to be in acute respiratory failure secondary to acute aspiration. Cardiopulmonary resuscitation (CPR) was started immediately, and advanced cardiac life support was not successful. Mr. Lawrence Gilbert, the veteran's son and next of kin, was notified. The coroner was also notified. The veteran's son declined an autopsy. He stated he was pleased with the care his father had received at the Coatesville VAMC.

The Honorable Jon D. Fox

Long-term care standards set forth by the Joint Commission of Healthcare Organizations (JCAHO) recognize "the right of all patients to a quality of life that supports independent expression and decision-making..." Consequently, each long-term care patient in the facility is assessed to determine medical status and needs based on functional ability. Once these determinations are made, the activity status is established based on the patient's ability and desires. Each patient has an individualized interdisciplinary plan of care which is reviewed and revised as needed. Mr. Gilbert's care plan was updated in February, 1995.

Mr. Gilbert experienced an unpredictable medical emergency that could have occurred at home or any other setting. The results of VA's Focus Review conclude that staffing and supervision on the Nursing Home Care Unit were appropriate.

My sincere condolences are extended to the Gilbert family. If there are additional questions regarding this unfortunate occurrence, please do not hesitate to have a member of your staff contact Mr. Gary Devansky, Medical Center Director, Coatesville VAMC, at (215) 383-0218, extension 4303.

Sincerely yours,

cc: VAMC Coatesville (00)
(00IB)
(19)
(60H)
(VHA-645166)

Jesse Brown

JB/ap

Mr. FOX. That is in Bucks County, Pennsylvania.

Secretary BROWN. Yes, I have been there.

Mr. FOX. I have had questions from veterans in my area. Just another one brief area that I wanted to take your time on; what are the qualifications for inpatient or outpatient care with regard to the percent of disability, the percent a veteran is disabled?

Secretary BROWN. If you are service-connected, you are basically entitled to inpatient and outpatient care for that service-connected disability. If you are nonservice-connected—and you correct me if I am wrong, Dr. Garthwaite—if you are nonservice-connected, (1) there is a judgment made if you may need inpatient care, or (2) if you are deemed to be in need of outpatient care as a result of the problems that you were hospitalized for, then we can provide that outpatient care to you. Is that correct?

Dr. GARTHWAITE. Yes.

Mr. FOX. I guess some of the questions that I am getting from veterans in my area is that they may not have the correct percentage of disability or they are not getting the outpatient care or they don't qualify, is what I am trying to say.

Secretary BROWN. Yes, sir. You can run into problems, depending on the disability, when it comes to entitlement for outpatient care.

What is that, Dave—Dave Gorman—what is that?

If you are 50 percent disabled, you get everything. You get everything. So the magic number is to get 50 percent disabled and then we provide you inpatient and outpatient care for all of your service-connected and nonservice-connected disabilities. That is the very important threshold there.

Mr. FOX. Was that created more recently, or has that always been the rule?

Secretary BROWN. That has been created a while. What we have seen here, sir, is there has been a constant shrinking of the eligibility through legislation. At one time, any veteran who received an honorable discharge was eligible for care in the VA. They could just come in and get it.

Now all we are treating, we are treating our service-connected veterans, our poor veterans and our prisoners of war. Everybody else has been locked out primarily through our eligibility criteria.

Mr. FOX. And is there an ongoing quality-of-care system to make sure that each of the hospitals has the level that you want as Secretary and we want as Members of Congress?

Secretary BROWN. Yes, sir. And, in fact, under Dr. Kizer's leadership, we are in the process of strengthening that process to make it much more responsive. We want to be able to really treat our veterans in terms of providing medical care in the same way they would be treated if they went to their private doctor.

You know, a private doctor would not ask you, are you service-connected for this? And you say yes. Or you say no, then he would say, I can't treat you. We need to have a primary care kind of an attitude that any time a veteran enrolls in our system, we should take care of all medical needs, to include preventive care, because that is cost-effective. We are not doing that consistently all across the country, although we are moving rapidly in that direction.

Mr. FOX. I have no further questions, Mr. Chairman.

I thank you very much.

The CHAIRMAN. I think, Mr. Secretary, this points out how desperately we need eligibility reprogramming, because of all of the confusion out there as to who and who is not eligible.

The gentlewoman from Florida, Ms. Brown.

Ms. BROWN OF FLORIDA. Thank you.

Thank you, Mr. Secretary.

Secretary BROWN. Yes, ma'am.

OPENING STATEMENT OF HON. CORRINE BROWN

Ms. BROWN OF FLORIDA. I want to thank you for your attitude, putting veterans first. I had a question about the homeless, and I will just give you that in writing, along with my statement about it. And I want to go directly to this proposed rescission list wherein I see Florida has two facilities on there.

One is the ambulatory care addition at the VA clinic in Gainesville that has been on the need list for 18 years, and then I see the Orlando Outpatient Clinic at the Orlando Naval Training Center, the $14 million, which is an example of how government best works when the Base Closure Committee recommends closing the Naval Training Center in Orlando.

We had a brand-new hospital that you and I visited, the Department of Defense gave it to the veterans, and, of course, we needed that outpatient care clinic there so desperately, and I see that $14 million to renovate that is on this list. I want every member of this committee and Appropriations to understand whatever your veterans problems, Florida is worse. We rank first and second in the country with the number of veterans, but 4th in funding, and this cannot go on.

If you need a cemetery, we need one worse in Florida. We need more facilities. Your veterans are in Florida right now in the winter and we are trying to take care of them with less money. And as these committees develop this list, I want to know when do they contact you on these priorities' lists and have you provided information to these different committees. And I want everyone to know that all of Florida will be jointly together on protecting our veterans.

Secretary BROWN. Can I get you to say the same thing about my Brevard Project in 1996?

Ms. BROWN OF FLORIDA. Yes, sir.

Secretary BROWN. You are absolutely right. I agree with you, ma'am. As I pointed out, the facilities we provide in Florida on a per capita basis are much less than what we provide for the average location throughout the country, and we need to move forward with these projects. They are needed by our veterans.

Ms. BROWN OF FLORIDA. Yes, sir. As I said before, I see two Florida projects on this list. So I am hoping that you will get that information to the Appropriations Committee.

Secretary BROWN. Oh, yes.

Ms. BROWN OF FLORIDA. Thank you.

[The prepared statement of Congresswoman Brown appears on p. 86.]

The CHAIRMAN. Thank you.

Mr. Clement.

Mr. Spence.

Mr. Bachus.

Mr. BACHUS. Thank you.

Mr. Secretary, as I understand it, not every veteran that shows up at the VA hospital gets treatment; is that correct?

Secretary BROWN. What does that mean?

Mr. BACHUS. Not every veteran that shows up at a VA facility wanting treatment, gets treatment; is that correct, especially in Florida?

Secretary BROWN. I would say that would be true, after that veteran has gone through the eligibility process.

Mr. BACHUS. Do all who are service-related get treatment?

Secretary BROWN. Yes, yes. We should not turn any veteran down. In fact, we have a priority program, we issue a little priority card for our service-related veterans.

Mr. BACHUS. So any that are wounded or fall ill during their service, they are being treated?

Secretary BROWN. Yes, sir. Yes, sir. The only veterans that will probably not get treated are the nonservice-connected veterans whose income is excessive. Those are the veterans that are locked out of the process. So that is what we refer to as our high-income veteran, I think the threshold is somewhere around $20,000. We can get that for the record.

Mr. BACHUS. Not a very high income though, is it?

Secretary BROWN. No, sir, no, sir.

(Subsequently, the Department of Veterans Affairs provided the following information:)

Hospital care is considered "MANDATORY", if a nonservice-connected veteran's income is: $20,469 or less if single with no dependents; or, $24,565 or less if married or single with one dependent; plus $1,368 for each additional dependent.

Hospital care is considered "DISCRETIONARY", if a nonservice-connected veteran's income is: $20,470 or above if single with no dependents; or, $24,566 or above if married or single with one dependent; plus $1,368 for each additional dependent. Veterans in this category must agree to pay a deductible amount for their care equal to what they would have to pay under Medicare. The Medicare deductible currently is $716 and is adjusted annually.

Outpatient care *shall* be furnish for any condition to prevent the need for hospitalization; to prepare for hospitalization; or to complete an episode of treatment after hospitalization, nursing home care or domiciliary care to any nonservice-connected veteran whose annual income is not greater than the maximum annual pension rate of a veteran in need of regular aid and attendance. The maximum annual pension rate with aid and attendance for: a single veteran with no dependents is $12,855; or, $15,345 or less if married or single with one dependent; plus $1,368 for each additional dependent.

VA *may* furnish outpatient care without limitation to prepare for hospitalization; or to complete an episode of treatment after hospitalization, nursing home care or domiciliary care to:

Any nonservice-connected veteran whose income is more than the maximum VA pension rate of a veteran in need of regular aid and attendance but less than the thresholds identified for hospital care, no copayment required.

Any nonservice-connected veteran whose income is more than the thresholds identified for hospital care and are subject to a co-payment of $39 for each outpatient visit.

Mr. BACHUS. Let me ask you this; we have been hearing about long delays in getting surgery, especially during health care reform, there were a lot of statistics that came out on the delays at VA hospitals, once you were told you needed surgery—and you know, there is a now kind of famous GAO report that said you had

21 surgeons at 6 hospitals which hadn't performed a surgery in one year. Was that an accurate report?

Secretary BROWN. Let me respond to your first question are there long delays? I would say in some of our specialty clinics, there are. We are very concerned about that, and that is one of the priority areas. We are working to try to reduce those waiting lists down to an acceptable level.

Mr. BACHUS. Is that on a geographical basis?

Secretary BROWN. Basically, yes, geographical, but in some areas it is just the reverse. We do not have waiting lists. So it really just depends on the demand for the services, and so forth, and the specialty.

Mr. BACHUS. And the type of surgeries?

Secretary BROWN. Yes, sir. And the specialty. The other one, with respect to the GAO, I think they said we had about 500 surgeons that we did not need.

Mr. BACHUS. Then let me just talk about the 21 who hadn't performed surgery in a year.

Secretary BROWN. Well, that doesn't bother me that much, depending on the circumstances. I will ask Dr. Garthwaite to respond to this, but we have many physicians that are surgeons, but they do not provide services, they provide internal medicine, they do provide other types of medical services.

Dr. Garthwaite, do you want to respond to that?

Dr. GARTHWAITE. You have to look at the individual situation. Sometimes there are physical disabilities or someone classified as a surgeon may not actually be performing operations. They may be providing outpatient services. We had a personnel physician who had arthritis of the neck and could no longer stand over the patient in the OR.

Mr. BACHUS. Let me ask you this, doctor; should they be classified as surgeons if they don't do surgery?

Dr. GARTHWAITE. I suppose it would depend on what kind of care they are providing. There is a lot of preoperative care, preoperative assessment and postoperative care and assessment that would be indicated. We will continue to take a look at that.

Mr. BACHUS. Did you find that any of these 21 surgeons were capable of performing surgery and were assigned to surgery?

Secretary BROWN. I am not familiar with the circumstances surrounding the 21 surgeons, but I will get that information and provide it to you for the record.

Mr. BACHUS. Do you know if any of them were reassigned or were transferred as a result of that study?

Secretary BROWN. Is there anyone here that knows about the 21 surgeons? Okay.

Mr. BACHUS. If you could get me that information.

Secretary BROWN. We will get it to you.

(Subsequently, the Department of Veterans Affairs provided the following information:)

No, none of the 21 physicians referred to were reassigned or transferred as a result of that audit. The OIG Report asserts that 21 of 153 surgeons at the 6 VAMCs audited "spent no time in the operating room during the year." Although it is not indicated in the Report, we were subsequently informed by the OIG that the year was 1990. The OIG also provided a copy of their summary audit sheets for 153 physicians at 5 of the 6 VAMCs. Obviously the number of individual physicians at the

6 VAMCs was more than the 153 stated in the OIG report. (We suspect their count should have been 164 or 165.)

There are other inconsistencies and a number of discrepancies in the data provided by the OIG compared to analysis of the same data sources by VHA. Although we have informally provided the OIG with our findings, we do not, as yet, have an explanation for the discrepancies. VHA believes the assignments of the 21 physicians cited were appropriate and that their productivity was excellent.

Attached is a White Paper responding to the OIG's allegations regarding these 21 physicians. In it, we review the OIG's assertions, inconsistencies between this portion of the OIG Report and the audit data supplied to us by the OIG, discrepancies between the OIG's findings and our own (despite having the same data sources) and a review of the assignment of each physician cited by the OIG as having no operating room time. For purposes of privacy, the individual physicians are identified in code for this report.

Aspect of OIG's Report on VHA's Surgical Program, 4R4-A01-063: The 21 Who "Spent No Time In the Operating Room"

The OIG's Audit of VHA Surgical Program Workload Reporting, Utilization of Resources, and Construction Planning Practices, (Report No. 4R4-A01-063, dated March 31, 1994) asserts 21 surgeons "spent no time in the operating room during the year." (page 25) Although it is not indicated in the Report, we were subsequently informed by the OIG that the year was 1990 and provided a copy of their summary audit sheets for 153 physicians at 5 of the 6 VAMCs. The OIG did not specify fiscal versus calendar year.

This report will not address our fundamental disagreement with the standards utilized by the OIG in this study. However, VHA believes that they are so flawed as to negate the OIG's conclusions about surgical staffing in these facilities and in the rest of VHA.

There are some fundamental errors in the OIG Report. Specifically, the Report states, "74.43 FTEE at the six surgical activities visited were composed of a total of 153 individual full-time and part-time staff surgeons paid by VA." The OIG audit data shows 153 physicians at 5 of the six sites, accounting for 66.43 FTEE. No data was supplied VHA on the other site, Wilmington, DE. It had 8.00 FTEE composed, we think, of 12 surgeons. In addition, the OIG data sheets reveal some differences in interpretation of "hours available" from station to station. For VAMCs Des Moines, IA, Long Beach, CA and San Diego, CA, full time is translated into 2,000 hours and fractions (such as 1/8) are based on 2,000 hours (i.e., 250 hours). For VAMC Oklahoma City, OK, full time and its fractions are based on 2080 hours. For Wilkes Barre, PA, which the Report notes was based on 3 month data projected for the year, full time and seems to equate to 1952 hours available.

Three of the 21 physicians had left their staff positions before the beginning of fiscal year 1990 (fiscal year 1990 began October 1, 1989.) Eight of the physicians were from Ophthalmology or ENT sections that do surgical procedures in the clinic areas and thus were not captured on operating room logs. But 7 of the eight performed or supervised surgical procedures among their clinical activities; the other is a specialist pathologist, not a surgeon, who works for the eye section of surgical service because that is his specialty. Most of the others were specifically employed to carry out clinical activities in outpatient clinics or to provide other, non-operating, surgical services (clinical, administrative, educational or research). Although not fully audited, VAMC San Diego notes that SD1s' name was listed in the operating room log "multiple times" and thus disputes the OIG's allegation of no OR time.

Below is a summary of the findings of the OIG regarding the 21 physicians followed by a listing with VHA's findings for each of them. We believe the facts fully justify their assignments and

wish to emphasize that an increasing array of procedures, including ever more complex ones, are most appropriately done in outpatient clinics are fully legitimate surgical procedures. As we have pointed out elsewhere, analysis of time spent in the operating room is not a useful way to analyze appropriate productivity of surgeons.

[In Section A, all data is extracted from the OIG Report or OIG data sheets labeled by hand "1990" and by computer "SURGSTAF.XLS." A bold line identifies the station, the number of physicians who were alleged to have spent no time in the operating room, the total number employed by the Surgery Section and the total FTEE they represent. Next come the individual surgeons by code, the "hours available per year" and the specialty]

Section A:

Des Moines, IA	**(none of 15 surgeons, 8.30 FTEE)**	
none		
Oklahoma City, OK	**(4 of 31 surgeons, 1.17 of 11.68 FTEE)**	
OC1	260	Ophthalmology
OC2	1820	Ophthalmology
OC3	90	ENT
OC4	260	ENT
Wilkes Barre, PA	**(none of 11 surgeons, 9.45 FTEE)**	
none		
Long Beach, CA	**(6 of 46 surgeons, 1.32 of 19.40 FTEE)**	
LB1	600	"Other Subspecialties"
LB2	900	Neurosurgery
LB3	500	ENT
LB4	33.4	Orthopedics
LB5	200	Ophthalmology
LB6	400	Ophthalmology
San Diego, CA	**(11 of 50 surgeons, 2.94 of 17.60 FTEE)**	
SD1	250	"Other Subspecialties"
SD2	120	"Other Subspecialties"
SD3	750	Orthopedics
SD4	500	Orthopedics
SD5	15	Orthopedics
SD6	500	Orthopedics
SD7	500	Ophthalmology
SD8	250	Neurosurgery
SD9	500	General Surgery
SD10	2000	General Surgery
SD11	500	General Surgery

Wilmington, DE (presumably none of the surgeons who comprise 8.00 FTEE. Data was not provided from the audit of this station.)

In Section B, VHA provides specific information for each physician identified in Section A. It also includes a line on the FTEE for FY90 according to the Cost Distribution Report (CDR).

Section B:

Oklahoma City, OK (4 of 31 surgeons, 1.17 of 11.68 FTEE)
1990 CDR shows 11.3 FTEE, 3% less than OIG Report

OC1 260 Ophthalmology *OC1 spends all of his time in the clinical setting. His specialty in Ophthalmology is the retina and his time is spent in VAMC clinics overseeing residents using laser techniques for the retina.*

OC2 1820 Ophthalmology *OC2 was the Chief of Ophthalmology and as such had major administrative duties and was instrumental in establishing the Laser Program. He also trained residents in laser techniques for glaucoma in the clinical setting.*

OC3 90 ENT *OC3 was Assistant Chief, Otorhinolaryngology and his time was spent supervising residents in clinical areas.*

OC4 260 ENT *OC4 was Chief of Otorhinolaryngology and basically was in the administrative capacity including oversight of the residency training program.*

Wilkes Barre, PA (none of 11 surgeons, 9.45 FTEE)
1990 CDR shows 9.5 FTEE, 1% more than OIG Report

none

Long Beach, CA (6 of 46 surgeons, 1.32 of 19.40 FTEE)
1990 CDR shows 17.4 FTEE, 11% less than OIG Report

LB1 600 "Other Subspecialties" *LB1 was hired specifically to provide staff coverage in the vascular clinic. The letter requesting his appointment specifically identifies this as the role he is to fulfill. Because of his busy practice, LB1 resigned 7/1/90.*

LB2 900 Neurosurgery *LB2 was only on the part-time staff from 7/28/86 to 7/1/89 at which time he became a consultant. Thus he was not present during FY90 or calendar 1990.*

LB3 500 ENT *LB3 was employed to staff LB's ENT clinic. This was a very active service in 1990, seeing 7938 outpatients and performing 170 OP procedures. ENT is primarily an outpatient specialty.*

LB4 33.4 Orthopedics *LB4 is employed to provide coverage to the orthopedic clinic. This is a very busy area, treating 8933 outpatients in 1990. LB4's employment averages less than 40 minutes per week.*

LB5 200 Ophthalmology *LB5 is an ophthalmologic subspecialist hired to provide coverage in the outpatient clinic. This is the busiest section and saw 13,352 outpatients in 1990. Procedures are done in the clinic.*

LB6 400 Ophthalmology *LB6 is also an ophthalmologic subspecialist hired to provide coverage in the outpatient clinic. This is the busiest section and saw 13,352 outpatients in 1990. Procedures are done in the clinic.*

San Diego, CA (11 of 50 surgeons, 2.94 of 17.60 FTEE)

1990 CDR shows 16.6 FTEE, 6% less than OIG Report

SD1 250 "Other Subspecialties" *SD1 was a senior thoracic surgeon who devoted the majority of his time at VA to educational endeavors of students and housestaff. He provided attending coverage in the OR as required. [VAMC San Diego did a comprehensive review of the Operating Room log for all of 1990 for six of their surgeons in follow up to the OIG report. Although SD1 was not one of those six, "it was noted that [SD1]'s name appeared multiple times. Therefore '0' total hours spent in the OR for the year is hardly correct for SD1." He was also on an "intermittent" appointment. In FY90 he was paid for 182.5 hours.]*

SD2 120 "Other Subspecialties" *SD2 was a full time cardiac surgeon who was at VAMC San Diego from April 1988 to January 16, 1989. She participated in the operating room, educational and research activities while there. She was not present during FY90 or calendar 1990.*

SD3 750 Orthopedics *SD3 was a hand surgeon who participated in clinic, teaching and research activities. [He was also on an "intermittent" appointment. In FY90 he was paid for 662 hours.]*

SD4 500 Orthopedics *SD4 is a senior orthopedic surgeon who rarely operates at the VA. He devotes the majority of his time to a large research effort related to rehabilitation. [He is also on an "intermittent" appointment. In FY90 he was paid for 151.5 hours.]*

SD5 15 Orthopedics *SD5 was a spine surgeon who attended to patients in the back pain clinic. He resigned in October, 1988 and thus was not present in FY90 or calendar 1990. [He had been on an "intermittent" appointment.]*

SD6 500 Orthopedics *SD6 is Chairman of the Department of Orthopedics and Rehabilitation at UC San Diego. He does not routinely participate in the OR at the VA but devotes time to administrative, educational and research activities. [He is also on an "intermittent" appointment. In FY90 he was paid for 350 hours.]*

SD7 500 Ophthalmology *SD7 is a non-operating ophthalmic pathologist who does medical ophthalmology and ocular pathology. [He is also on an "intermittent" appointment. In FY90 he was paid for 214.5 hours.]*

SD8 250 Neurosurgery *SD8 is a senior, non-operating neurosurgeon who participates weekly in Neurosurgery Clinic. [He is also on an "intermittent" appointment. In FY90 he was paid for 250 hours.]*

SD9 500 General Surgery *SD9 is Chairman of the Department of Surgery at UC San Diego. He takes night and weekend call at VA and participates in the operating room as necessary. He devotes the majority of his time to educational endeavors as well as administration. [He is also on an "intermittent" appointment. In FY90 he was paid for 504 hours.]*

SD10 2000 General Surgery *SD10 is a senior, non-operating general surgeon who is assigned full time at the Outpatient Clinic in Mission Valley. He occasionally observes in the OR and actively participates in teaching conferences.*

SD11 500 General Surgery *SD11 is a senior, non-operating surgeon who is Chief of the Non-Invasive Peripheral Vascular Laboratory. [He is also on an "intermittent" appointment. During FY90, SD11's intermittent appointment was changed from 2/8 to 3/8. As a result he had more hours available than listed by OIG. In FY90 he was paid for 758 hours.]*

[In summary, the time available for these 11 physicians at San Diego was 14% less than that reported by OIG due to their intermittent appointments or their having left before the audit. The OIG reported 5,885 hours available for the group for the year. In fact they were paid for 5,072.5 hours.]

Wilmington, DE (presumably none of the surgeons who comprise 8.00 FTEE. Data was not provided from the audit of this station.)

1990 CDR shows 6.9 FTEE, 16% less than OIG Report.

In summary, the OIG Report states that these 21 surgeons represent 5.43 FTEE of a total of 74.43 FTEE. VHA's totals show these surgeons to account for less than 5 FTEE and all physicians attributed to the surgical services of these VAMCs in FY90 to total 70.9 FTEE. At least 6 of the 153 individual physicians listed by the OIG audit sheets had left their stations by the beginning of FY90 (and one more on 10/8/89) and the 11 or 12 surgeons at VAMC Wilmington, DE were not included in the OIG's overall count of 153. Three of the 21 surgeons said to have no operating room time were among those who had left their staff positions before FY90. Eight of the 21 are ophthalmologists or ENT physicians who do most of their procedures in clinics with outpatients. Most of the others were specifically hired to provide coverage to clinics or have non-operative assignments. The claim of no OR time for at least one (SD1) is wrong - and VHA believes it to be in error for one or two of the others. Several have major administrative responsibilities. VHA believes that these physicians are fully justified in the roles they fulfill.

Mr. BACHUS. And you can understand if someone is no longer able to perform surgery, but I would suppose you are compensating them as a surgeon if you are designating them as a surgeon, and I would think maybe a redesignation is in line.

Secretary BROWN. Good point.

Mr. BACHUS. Let me ask you this, this is a difficult question. I know it causes a lot of emotional feelings. But we are beginning to read in the paper, and I guess William Safire is probably the most famous vocal opponent who says that you have a failed system and that you have a veterans medical system that less than 10 percent of the veterans are utilizing; the other 90 percent have decided to go to private health care. And number one; is that accurate? And number two, you have said, according to those articles, that the private sector motivated by profit cannot meet the unique needs of veterans; would you explain that to me?

Secretary BROWN. Yes, sir. First of all——

Mr. BACHUS. Now, obviously, over 90 percent are going to private facilities.

Secretary BROWN. Well, see, that is one of the things. This is a game. You have to discredit VA in order to help perpetuate the idea that it is no good and, therefore, should no longer exist.

Mr. BACHUS. I am not doing that.

Secretary BROWN. I know you are not, sir, because you have always been in our corner. I only said that to say this; because of legislation, we can only treat our service-connected veterans, our poor veterans and our prisoners of war. All the rest of them are locked out of the process. Even if you had a veteran that made $1 million a year and he said, nonservice-connected, and he said I want my care at the VA, we could not provide that individual with care. So when you say that 90 percent of the people go somewhere else, they go somewhere else because the law will not permit us to take care of them. Those are the real facts.

With respect to what do I mean when I say that the private sector cannot respond to the needs of our veterans, I mean this: number one, this is my own view; if you look at the consensus across the country now, you are going to see that our bed vacancy rate, and I think I am correct here, our occupancy rate is higher than the private sector.

Mr. BACHUS. I think it is 23 percent vacant beds?

Secretary BROWN. Yes. It is pretty low. And so, obviously, people are now looking for new markets. But the thing that is dangerous about this is that 60 percent of the people that we treat are poor. So if somehow you figure out to get, let's say, 20 percent of the folks that we treat that can pay for their care in the private sector and then you get rid of the VA hospital, then all of these other folks, they slip through the cracks, because no one is going to take care of them because they can't pay for it.

With respect to the specialized services, let me give you one example of why VA is so important, and this also relates to the question dealing with research—the Persian Gulf. We had about 700,000 people who actually went there, and let us say, for instance, all 700,000 of them came home sick. Now, the private sector will look at that and say, now, how much money do I want to invest in research in taking care of these people, because even if I

find a cure that may cost me millions or even billions of dollars, the marketplace itself is not large enough for us to ever realize a return. The cost of the end result would be just prohibitive.

So you need a system that tries to do the right thing by the people who have given up something in carrying out national policies. And we also have special sensitivity in terms of our spinal cord injury, our PTSD. Who wants to treat people suffering from PTSD?

They are very difficult to manage, and because they are difficult to manage, many of them do not make economic adjustments. So they don't have the ability to pay for their care. So those are the kinds of things that I am afraid the private sector would not want to accept. So you end up fragmenting the system and 80 percent of the people we now provide care to, fall through the cracks.

The CHAIRMAN. The gentleman's time has expired.

Please, we have two more to go. We will——

Mr. BACHUS. I just want to make a brief comment, if I could?

The CHAIRMAN. Very brief.

Mr. BACHUS. I would simply say, Mr. Secretary, I would hope that in the future, those areas where you do have the unique needs, like the Gulf War veterans, and these other things you have identified, that you will put priorities with those. I think there has been some frustration with us that those are the very people whose problems sometimes haven't been addressed.

The CHAIRMAN. The gentleman from Georgia, Mr. Barr.

Mr. BARR. Thank you, Mr. Chairman.

And thank you, Mr. Secretary. I look forward to, as a new member of this committee, working closely with you on these very, very important matters.

In looking over the material that you have presented before us this morning, I would like to ask if you are comfortable with the independent budget that has been presented overall? I know that you are only one vote and one voice among many in the administration that prepares the overall budget, and there are many factors that have to be taken into account, but we have already touched on certain things here this morning that we see as problem areas that the budget proposal has failed to address, the eligibility rules, the decreases in certain COLAs, and so forth, and hopefully, we will be addressing those. But are you comfortable with this budget? Are there areas where you would like to work with us to address these problems and seek increases?

Secretary BROWN. Well, obviously, with respect to the independent budget, I think that it is a great document. I know the individuals who are involved in that whole process, and, in fact, I, myself, was involved in it for a number of years. And therefore, we rely on it in trying to figure out exactly how we should proceed.

But we have a different kind of approach. We have different constraints, different limitations that we have to take into consideration. And this does not mean that we do not agree with the independent budget. Quite frankly, I think the independent budget is one that really moves more toward the ideal.

If we had enough money to do everything perfectly, to compensate for the deficient funding over the last 25 or 30 years, to do all the things we need to do to bring us to exactly where we want to be, then the independent budget is the way to go. But we

don't have those resources, so we have to live within the constraints of the resources that are made available to us.

Mr. BARR. I am not quite sure I understand. There are certain things that aren't addressed in the budget proposals that I have just touched on. Are you comfortable with the failure of the budget that the President is proposing to address eligibility rules? Are you comfortable with the proposed decreases in certain of the COLAs?

Secretary BROWN. That is two questions. With respect to the eligibility rules, we did not address it; that does not mean that we are not working on it. We addressed the question of eligibility reform in its entirety in the National Health Care Reform Initiative. The VA had a wonderful program that really would have resolved just about all of our problems. That fell through.

So now we are working very hard trying to put together another package. I know for a fact that this committee is interested in reforming the whole system, and we will be working with them on that. So while it is not part of the 1996 budget, we are still working on it. So that is exactly what we are doing there.

The other question had to do with——

Mr. BARR. Are you comfortable with the fact that it isn't reflected in the budget?

Secretary BROWN. Yes.

Mr. BARR. I am still not sure I understand.

Secretary BROWN. Yes, I am comfortable with the fact that it is not reflected, because we do not have the conceptualization in a fashion that we are ready to present anything. So in that respect, yes, I am comfortable with it.

We are now reorganizing our whole operation under Dr. Kizer, and so all of that plays a major role in it. And I think you asked about the extenders, what was the second?

Mr. BARR. The COLAs.

Secretary BROWN. That hurts me. These extenders hurt me when they came out in OBRA 1993 and, quite frankly, I feel bad that we have to continue this. And the whole concept here, we just simply said, let's extend what is already in current law, in some instances, in eight instances, we extended for 2 years, and in three, we extended it for 4 years.

As I have said already, I am willing to sit down and talk with this committee about any other options that they feel that would be appropriate.

Mr. BARR. My concern, I mean, I am not comfortable with either of the two areas that I touched on. My feeling of discomfort derives partly from the fact that we look at some other portions of the budget, AmeriCorps spending increasing, and that is why I am very uncomfortable with this. And some of the other materials I have started to go through here this morning, and will have a chance to go through in detail I think touch on some of these also.

But I do look forward, Mr. Chairman, as a member of this committee, to working to address what I consider some deficiencies.

There are some provisions in here, Mr. Secretary, that I think are very good, and I hope that you will press just as hard as you can, for example, to make sure that the, both the major construction and minor construction increases continue.

Secretary BROWN. Yes, sir, we will. We will.

Mr. BARR. Yield back the balance of my time, Mr. Chairman.
The CHAIRMAN. I thank the gentleman.
The gentlewoman from California, Ms. Waters.

OPENING STATEMENT OF HON. MAXINE WATERS

Ms. WATERS. Thank you very much, Mr. Chairman.

I would like to add my words of welcome to the Secretary for being here this morning and allowing me to share with you my real appreciation for your passion, for your job and your work. It is unusual to hear Secretaries and others come before committees and talk about their pain at seeing certain things, and you know, certain kinds of cuts that truly cause them to despair for their constituency, so I really do appreciate your passion.

I have many questions I could ask you, but I really don't know what it means right now. I am concerned about construction. I have to be concerned about construction and rehab, because I know very well that women are not adequately served in the system, because you don't have the bathrooms to accommodate them and other kinds of things.

But why should I ask you about that when yesterday $206 million was cut from the budget in rescissions; $50 million in equipment, and another $156 million in construction.

Now, that decision was made, nobody told us when all of the veterans came before us, the paralyzed veterans, the noncommissioned officers, the disabled, nobody told us that that was in the plan. Everybody sat on this committee and told veterans how much we loved them, how we were going to fight for them, and then they went behind their back and just rescinded what I consider to be an important part of the budget.

And the reason I can't ask you the other questions about what happened to SMOCTA, the occupational conversion, the Service Members Occupational Conversion and Training Act, why isn't it in the budget? I guess I know why it isn't in the budget. The veterans are being squeezed, being asked to cut back, being asked to be a part of reducing the deficit, but that is not all. You are going to get cut some more.

I mean, we are sitting here listening to your wish list or the administration's budget and we are going to hear the independent budget. But the veterans are going to be cut some more. I would feel better if they would just come out and tell us how much they are going to cut you and then let us plead and beg for something.

I don't know where it is going to come. But you are going to be cut some more. And so I am not going to ask you anything about why aren't you doing this and why aren't you doing that; I know why you are not doing it.

You are being squeezed. And the very people who want more services, who want to reduce the backlog, who want to make sure the construction is going on, they are not, they are not asking themselves the correct question: Who pays for this? Where is the money going to come from? Am I willing to stand up and fight for veterans to have the dollars that they need in order to do what I want to be able to do?

I wish you could build all the cemeteries, reduce the backlog, expand medical care for women, put women in the clinical trials. I

got a long wish list. But I am not going through this exercise of asking you why you are not doing it.

What I want to know from those who are going to cut you some more, is tell us now, tell us in advance, give us some advance notice so we will know where to get on our knees and beg you not to do it.

So thank you for coming. I wish it was under different circumstances. But the fact of the matter is, you are going to get cut some more.

Secretary BROWN. Yes.

Thank you so much for that, Ms. Waters. I am going to be howling, too, all the way.

Ms. WATERS. I just want you to scream in the right direction, okay?

Secretary BROWN. Yes, ma'am.

Mr. BISHOP. Will the gentlelady yield for just a follow up?

Mr. Secretary, the gentlelady from Florida asked the question earlier as to whether or not your Department had been consulted with regard to the rescissions. Have you all be involved in that process at all in terms of priorities, in terms of if you got the cut, we are going to cut "X" amount of dollars, and here are our priorities, cut this first, but don't cut this, these are essential priorities? Have you had any consultation at all from those rescission people that have cut it?

Secretary BROWN. No, Mr. Bishop. We were not consulted. We read about it primarily in *The Washington Post* this morning. We had some indications about it yesterday afternoon, but this was the first that we were aware of it. And it bothers me.

I have to say this just for the record, it bothers me in the sense that if you look at just for the last 10 years, veterans have already been cut about $10 billion. And now, we are at a point where there are really no other programs that you can cut without really hurting the veterans, and the institutions veterans rely on. That is what bothers me. This approach is going to prevent us from looking out for these people we talked about; what a great job they did on Iwo Jima and during World War II.

Mr. BISHOP. Do you know whether the VSOs were consulted, do you know whether they were consulted on those rescissions?

Secretary BROWN. I think they are going to be up here next, and I am sure that you can ask that question to them. I am not sure.

The CHAIRMAN. The next panel will be able on answer that, Mr. Bishop.

The gentleman from Florida, Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman.

OPENING STATEMENT OF HON. CLIFF STEARNS

I want to compliment you for having this hearing and, of course, I want to welcome the Secretary and his staff here today. I am probably going to echo a few of the comments made by my colleague, Corrine Brown, who is as concerned about the rescissions as I am.

I have a letter from you dated December 2, 1994, where you indicated that the psychiatric hospital that I had worked for in the 101st, and the 102nd, and the 103rd Congresses, would no longer

be funded and, in fact, you were saying that, the ambulatory care addition would be. Now, of course, I see this is in a rescission package. So I have talked to my colleague from Florida and others and we know that we are going to have to work hard with the Appropriations Subcommittee on VA/HUD to see if we can reinstate the ambulatory care addition in Gainesville, FL, which I am particularly concerned about. It is not in my congressional district, but I do feel that I have been instrumental in helping with this project.

That being said, I wanted to touch on something on which I felt this committee was very forceful in taking a leadership role. Both Mr. Stump and Mr. Montgomery have mentioned this, and that is the Persian War Gulf veterans with Gulf War Syndrome—I don't know if it has been talked about—but how much compensation will the Veterans' Administration pay to the Persian Gulf vets?

Secretary BROWN. Each veteran is eligible for a minimum of $89, to a maximum of single veteran, about $1,800. But if he or she is catastrophically disabled, it could go up to $5,000 a month.

Mr. STEARNS. Is that going to be adequate for the number of Gulf War Syndrome veterans that are coming into the system? I don't mean in, but how many do you anticipate there will be in the system?

Secretary BROWN. Well, we do not know. What we do know, we have about 40,000 on our register. And we have taken a very aggressive approach in terms of outreach. We wrote personally to all of them, and we advised them about this new law that would permit us to provide compensation for undiagnosed illnesses. And so we are going all around the country talking about it; we are establishing a new hotline and for the record, it is 1–800–PGW–VETS.

And any veteran can call and be advised about four things, basically, and these are the four things I am concerned about the most:

Number one, we want them to know they are entitled to priority care at VA. All they have to do is to say, I feel I am suffering from some problem that is related to my service in the Gulf and we are going to take care of them.

Number two, we want them to know that we are going to compensate them for undiagnosed illnesses.

Number three, we want them to know we are moving forward on our research initiatives. We have about 40 research projects out there. We have also established our own research centers in three locations. They are located in Boston; East Orange, New Jersey; and Portland. And we are also looking at everything, nothing is off the table, unlike some areas that are kind of fuzzy.

We come right up front and say we are going at depleted uranium, we are going to look at possible exposure to chemical and biological agents. We are going to look at the indoctrination process to see whether or not that is the cause of the problem. So we are going to look at absolutely everything.

And then the last thing we wanted them to know is this: we wanted them to know that the U.S. Government appreciates their service, that these services are available to them, and we want them to have them. So we are making an all-out effort to get them some information.

Mr. STEARNS. Mr. Secretary, what do you anticipate the additional number coming into the system will be? As a result—what do you project over the next 1, 2, 3 years?

Mr. VOGEL. We—Mr. Stearns, we have made projections—it is very difficult to make projections of undiagnosed illnesses. This is rather new ground.

Mr. STEARNS. But have you set aside some money to do this.

Mr. VOGEL. We have, indeed. About $21 million is the anticipated cost for this year, and slightly more than that next year. Based on the—about two-fifths of all of those who served in the Persian Gulf are still on active duty. We won't see them for a while until they are discharged or whatever.

But the anticipation is that we—there is money in the budget to take care of it. Very difficult to project undiagnosed illness and the relative cost of that. The evaluations that we have seen to date, and they are comparatively few, have been completed through the adjudication process, the evaluations are comparatively low.

The VA medical response is a very, I believe as the Secretary says, is a very healthy one. Just the other day, our President and our Secretary met personally with one of the first individuals that had a claim adjudicated under the undiagnosed illness, and the message there was that the VA responds for medical care, for compensation and research is full and adequate.

Mr. STEARNS. You know, in my congressional district what I hear from the Gulf War veterans. They tell me when they go to the VA hospital, the test is sort of mediocre, it is a quick test. But, I mean, it doesn't seem to be a standardized test for them to say, I qualify. Now, maybe I am just listening to them.

Secretary BROWN. Well, now, we are talking about two things, sir. When you talk about qualification, the test we provide, the protocol test, is primarily for research, for statistical purposes. That is to see if anything is wrong with them. That is kind of a baseline test and it has nothing to do with compensation.

Now, if they file a claim for compensation, then we will schedule an examination for compensation purposes, and then they will come in and we will evaluate the disability they are suffering from.

Mr. STEARNS. Do all of the VA hospitals have that capability, to do evaluations in their hospitals? Has that capability been ferreted out and given to all of the hospitals? Can I say to all of the veterans, our hospitals have that capability?

Secretary BROWN. Yes, you can.

Now, in fact, as a backup, some cases are referred to special hospitals when we are not able to really get a handle on what is happening, on what is the pathological problem. That is why we set up three diagnostic centers. They are located in Washington, DC, L.A., and in Houston, I think. There we send the more difficult person to get a diagnosis.

Mr. STEARNS. Okay.

The CHAIRMAN. The gentleman's time has expired.

Anyone have a real quick question?

Thank you.

I would like to thank the Members for their attendance this morning and for their adherence to, as nearly as possible, to the

5-minute rule. It is very much appreciated, to allow everybody to be heard.

Mr. Secretary, we appreciate your attendance here this morning. You have been very generous with your time, and I think if you will notice the attendance of this committee this morning, 31 of 33 Members, you can see how we are concerned about veterans this year.

We thank you once again for your time.

Secretary BROWN. Mr. Stump, just one last comment.

I want to thank you so very, very much for conducting a fine hearing, sir, and I look forward to continuing to work with you as we have worked together in the past on looking out for our veterans.

The CHAIRMAN. Thank you, sir.

If I could, let me remind the veterans we have two more panels that we have to go through.

The next panel would be on the Independent Budget, if they would come up, kindly.

If we could please clear the room as rapidly as possible, for those that have to leave.

Thank you.

Our next panel consists of Noel C. Woosley from the AMVETS, from the DAV, Richard Schultz; from PVA, Russell W. Mank; and from the VFW, Jim Magill.

Gentlemen, we appreciate your patience. You have 5 minutes, and your entire statement will be put in the record. If you care to summarize shorter than that, we would appreciate it.

I have no particular order; anybody want to volunteer to be first? Mr. Magill.

STATEMENT OF JAMES N. MAGILL, LEGISLATIVE DIRECTOR, VETERANS OF FOREIGN WARS; RUSSELL W. MANK, LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; RICHARD F. SCHULTZ, LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND NOEL C. WOOSLEY, NATIONAL SERVICE DIRECTOR, AMVETS

STATEMENT OF JAMES N. MAGILL

Mr. MAGILL. Mr. Chairman, once again, AMVETS, the Disabled American Veterans, PVA and the VFW are pleased to be able to present to you for the ninth consecutive year the fiscal year 1996 Independent Budget for the Department of Veterans Affairs. As in the past, all of the recommendations contained in this document have the unanimous approval and support of the four VSOs involved. As you know, each VSO has been tasked with a specific area of responsibility.

First, you will hear from Russell Mank, who will discuss health care, followed by Rick Schultz, who will discuss veterans benefits, followed by Noel Woolsey, who will discuss the national cemetery system, and I will conclude with our presentation on the construction portion.

I would also like to bring to your attention, and particularly the new members of the committee, a brochure produced by the Partnership for Veterans Health Care, which addresses some of the

myths and realities with respect to VA health care. There appears to be much confusion surrounding VA health care, and this document clears up a lot of that confusion. And I believe you all have been supplied a copy of it.

STATEMENT OF RUSSELL W. MANK

Mr. MANK. Chairman Stump, Congressman Montgomery, members of the committee, the Paralyzed Veterans of America appreciate this opportunity to testify in conjunction with the colleagues of the Independent Budget. Oliver Wendell Holmes had a quote that will synthesize my comments. He said: "The great thing in the world is not so much where we stand, as in what directions we are moving. To reach the the port of Heaven, we must sail sometimes with the wind and sometimes against it, but we must sail, and not drift nor lie at anchor."

External changes continue to beset the health care system. We, in the veterans service organizations have come here year after year, pleading for more funds. This is an approach that, although warranted, is no longer constructive.

We are here today to say that we can accept the President's budget request, if together we can find the way to achieve the rest of our legislative agenda. We can do this without increasing the limited discretionary funds Congress has to allocate for veterans' medical programs. We can do this as we increase access to veteran patients and selectively allow their dependents to enter the system. But to achieve these goals, we need the cooperation and commitment of this committee.

This year, the Independent Budget coauthors began with your baseline, which was the appropriation the last Congress made to the VA medical care account. In years past, we recommended only an appropriation for medical care. This year, we recommend not only an appropriation for medical care, but also recommended budget authority. Recommending a budget authority allows us to marry our fiscal agenda with our legislative agenda. The two in previous years have been isolated one from the other.

We propose a four-point plan which requires new legislation for the VA to: (1) reform access criteria; (2) treat new patient populations; (3) capture new funding streams; and (4) emphasize the provision of specialized services in which the VA has unmatched expertise. This plan expands access to services for veterans and their families, and does not require increased Federal Government spending.

The Independent Budget recommends that Congress authorize a $19.5 billion for VA medical care, but only $16.6 billion of this funding must come from congressional discretionary funds. With the new authorities the Independent Budget proposes, Congress can appropriate $400 million less than the President has requested from Congress for fiscal year 1996. Without all of the proposed new authorities, Congress must appropriate $18.8 billion for VA medical care, fully $1.8 billion more than the President's request. In other words, Mr. Chairman, the status quo is more expensive than embracing change.

The savings that can be realized, however, can only be realized as part of an overall package. Part of this reform package is allow-

ing the VA to retain third-party payments, including medicare reimbursement. Currently, the VA has to turn over third-party reimbursements collected from insurers to the Treasury. VA estimates that it has the potential to collect at least $800 million next year. We estimate that with more efficient collection practices in place, it would be possible for VA to collect far more. We must see legislation approved by this and other committees allowing the VA to keep its third-party reimbursements, and that is part of the total package.

We are also going to have to see legislation approved by other committees in the House and Senate, allowing the VA to collect and retain medicare reimbursement from current high-income, non-Category A veterans. Medicare reimbursements that could accrue to the system from current higher-income non-Category A veterans are estimated to amount to $133 million. Private sector hospitals can do this; why can't the VA?

The Independent Budget does not say, "cut the VA appropriation by $2.1 billion from our target recommendation of $18.8 billion, and the system will be able to achieve eligibility reform and provide the full continuum of care to all veterans." It does say that you can achieve reductions in domestic discretionary appropriations by making the VA system more efficient, but only by allowing the system the ability to recoup and offset discretionary dollars lost in the annual appropriation by retaining third-party reimbursements.

Mr. Chairman, this is a total package. None of our recommendations are new to you or to this committee. Eligibility reform has been the battle cry of the committee and the veterans' service organizations. To accomplish our goals, we know that we must acquire new funding streams outside of discretionary funds.

In our plan, we ask Congress to allow the VA to capture funding from veterans' insurers and, for some veterans, who VA was not explicitly charged with serving, from medicare. These sources of funding are critical to VA reforms.

Mr. Chairman, I appreciate the opportunity to testify.

Thank you.

The CHAIRMAN. Thank you, Mr. Mank.

[The prepared statement of Mr. Mank appears on p. 124.]

STATEMENT OF RICHARD F. SCHULTZ

Mr. SCHULTZ. Mr. Chairman, I will try and be brief.

It is a pleasure for the DAV to appear here to testify regarding President Clinton's budget and also our views regarding the Independent Budget. In that regard, you have the Independent Budget; I won't go over all of the things that we have said in the Independent Budget. Suffice it to say that we have made a number of recommendations and we would hope that you would give them due consideration.

A couple of things I think of note in the President's budget. One is that while there is a $22 million increase in Veterans Benefits Administration spending, we do have a reduction of 188 employees in the entire Veterans Benefits Administration. I believe Compensation Pension Service remains the same.

The Board of Veterans' Appeals, and we all know it is sorely needed, I think received a 28 FTE increase. There are few things

that came up today regarding some of the OBRA extenders, as they call them, that I would like to comment on.

One, of course, is the rounding down of the cost of living. You know, we in the DAV, oppose that. As you know last year, the cost of living was rounded down in order to pay for the Persian Gulf compensation. We do not believe that one category of veterans should be required to pay the compensation for a new category of service-connected disabled veterans.

There are savings of $580 million, I believe, over 5 years, just by rounding down the COLA and cutting in half the DIC, cost of living. We certainly don't support the reduction in the Montgomery GI Bill. This is a program where active-duty personnel paid into that system; the money is there, and certainly we don't support cutting money out of the Montgomery GI Bill.

Another provision is to repeal the restrictions in current law in cases of what is called "nonjudicial foreclosure" that prohibits the collections for loan guarantee debts. We don't support the repeal of this law.

The President's budget, while it does increase veterans appropriations by $1.3 billion, it does identify an additional $3 billion in savings over the next 5 years. I would like to make a point, that I have heard recently proclaimed by Members of Congress, the Senate Floor, and have also read in *The Washington Post* that somehow veterans are escaping budget cuts.

We have heard reports that the budget ax has fallen everywhere but on the powerful veterans, we never get cut. We have seen these accounts and they are hogwash. It is put forth over and over again that somehow veterans are escaping all of these cuts.

I just want to remind the committee, I know you don't need reminding, but you know, the Decade of the 1980s, veterans programs were cut more than $2 billion. These are real cuts, not just some phoney things. There were cuts in veterans benefits and there were cuts in educational benefits, and there were several cuts over $2 billion that were identified in the 1980s. OBRA 1990 cut an additional $3.7 billion for a 5-year period; OBRA 1993 cut another $2.6 billion.

As I said, the President's budget has another $3 billion in savings in that budget. So I would hope that when you are talking to your colleagues, that you would remind them that the powerful veterans groups out there who never get cut have been cut more than $10 billion over the past decade. I felt compelled to bring this up today because we hear that same misinformation over and over again. And I just want you to know that veterans have been cut. We certainly beleive that any cuts that are identified in VA programs would like those savings to be to plowed back into the VA system.

The Budget Enforcement Act does not allow us to give back some of the benefits that have been taken away because we can't find the money. If we are going to identify savings, certainly we believe they should be used in VA programs. One of them that came up earlier deals with accrued benefits.

We know how long it takes to process appeals. I believe last year over 300 veterans died while their claims were pending at the Board of Veterans' Appeals. Now, if they die and then there is a

survivor and that survivor is successful in the claim, only 1 year of retroactive benefits can be paid. All of the other years, the benefits are lost, and that is something that we put into the Independent Budget, and we certainly would like to see the committee address.

So if there are any savings that we can identify in VA programs, we would certainly wish that we could use those to correct current inequities and not send that money somewhere else, whether it is tax breaks or for whatever reason.

With that, I will just say you have seen our testimony, and certainly if you have any questions about the Independent Budget, we would be more than happy to respond to them.

Thank you.

The CHAIRMAN. Thank you, Mr. Schultz.

[The prepared statement of Mr. Schultz appears on p. 137.]

The CHAIRMAN. Mr. Woosley.

STATEMENT OF NOEL C. WOOSLEY

Mr. WOOSLEY. Mr. Chairman, we, too, are thankful to come before this committee and discuss the Independent Budget and the President's budget. I thought it was interesting this morning, there were many more questions on the cemetery system than I would have anticipated.

I think sometimes this kind of gets buried in the larger budgets. No pun, no pun. That was an accident, believe me.

I think we need to remind ourselves periodically that many veterans come home from their service, never use the GI Bill, never use the Home Loan Guarantee program, never draw compensation, never come to the VA for anything, but spend years telling their families don't worry about me, when it is my time, just contact the VA and I will be taken care of.

And some of the cuts that Rick mentioned throughout the years, the burial allowance, the plot allowance, they changed a small benefit, where you could order a marker and get the equivalent, if you didn't use the VA's. They have subsequently changed many of the burial benefits and eligibility, making them quite restrictive. So this one benefit, many veterans use solely as the only thing they ever receive from the VA must not get treated lightly or disappear altogether.

The cemetery system operates 114 cemeteries, and 34 additional sites such as confederate cemeteries and soldiers' lots. This seem impressive when at first glance, but 56 of these cemeteries are closed already. Another will close this year and seven more will close by the year 2000. NCS has 10,662 acres of land, and 5,355 have been cleared and developed for burials.

Since its inception, during the Civil War, the cemetery system has buried 2.3 million veterans. To meet its future needs, approximately 287,000 gravesites remain available on developed land. Undeveloped acres could accommodate an additional 4.6 million casket sites.

Based on veteran population and usage, the cemetery system will be about 800,000 to 900,000 plots shy of what they will need by the year 2010, if we are to accommodate the, roughly, 10 percent of those who choose to be buried in a national cemetery.

This is not an imagined shortage. It is a shortage of severe magnitude.

The budget that they face for the next fiscal year is 278 full-time employee equivalents short. To provide current services, which was what was stated they thought they could do with the budget they received, it is estimated that they will need at least 13 additional FTEs.

Of major concern is what we have been coming to this committee and others and saying for years, and that is the $8.2 million equipment backlog, it is not going away.

This year's budget will do nothing to improve the modest gains that, through the efforts of this committee and others, were achieved in 1991 and 1992 with reference to this equipment backlog. Most of the required budget information is available in the Independent Budget, and I will just touch on some areas that we feel are extremely needed will have to take place to keep this system going.

We would like to see a total appropriation of $82 million, an FTE increase of 15, a minimum of $2 million additional funding for the equipment backlog, we would like to see the pursuit of an open cemetery in every State, and continued VA progress toward a policy of an open cemetery within 75 miles of 75 percent of America's veterans.

Mr. Chairman, this concludes my statement.

The CHAIRMAN. Thank you, Mr. Woosley.

[The prepared statement of Mr. Woosley appears on p. 146.]

The CHAIRMAN. Jim?

Mr. MAGILL. Thank you.

Inasmuch as you already have been provided a copy of the Independent Budget and my prepared statement, I will just take the remaining time to briefly highlight the construction program.

At the outset, I would like to comment a little bit on the rescission that we learned about this morning. As you know, $156 million is coming out of the construction aspect of it, in what we consider some of the areas of most need in the United States.

Again, I would like to let the committee know, because it was brought up on the first panel. The first we heard about it was in *The Washington Post* this morning.

First and foremost, there must be developed a strategic plan for VA's delivery system that corresponds to State and private sector health care reforms. When it takes approximately 5 years for a hospital to go from design to final completion, in a lot of cases, that hospital is already deemed obsolete.

With respect to major construction, we recommend an appropriation of $490 million, and that would include for leases for outpatient clinics and nursing homes; to dictate selected replacement and modernization projects that provide natural hazard mitigation and modernized and upgrade the physical plant according to an established set of priorities based on competition under State and private sector health care reforms; use new construction to complement bed leasing and new conversions VA-operated beds for nursing home care; appropriate funding for four new 120-bed nursing homes; appropriate funding for two new VA hospitals; construct two new national cemeteries annually until the national cemetery

system meets previously-stated goals of one open cemetery in each State; and appropriate $16 million to acquire land for national cemeteries in States with no available gravesites.

With respect to minor construction, appropriate $269.8 million for minor construction projects; convert 12, 30-bed wards to nursing home care in fiscal year 1996; and appropriate $18 million for existing national cemetery system construction projects.

We also would recommend providing $1.5 million for the parking garage revolving funds, and provide $180 million for grants for the construction of State extended-care facilities. Also, appropriate $6 million to fund grants for the construction of State veterans cemeteries. And finally, appropriate the usual grant of $500,000 to meet the grants with the Republic of the Philippines for facilities that need repair and renovation needs.

This concludes my portion.

Again, thank you very much, and we will be happy to respond to any questions that you have.

[The prepared statement of Mr. Magill appears on p. 119.]

The CHAIRMAN. Thank you, Jim.

And thank you, gentlemen, for your testimony.

I especially want to thank all of your respective organizations for all of the time and effort that you put into this Independent Budget, and I want you to know that this committee appreciates that and we will place heavy reliance on your recommendations.

Mr. Edwards.

Mr. EDWARDS. I will just be very brief, Mr. Chairman, with one question. On third-party reimbursements, I know the stumbling block in the last Congress was some opposition from other committees.

We do have a new Congress now and a new Chairman in place. Have any of you have an opportunity to talk to Chairman Archer of the Ways and Means Committee or other members of the Ways and Means Committee to see if they might have a new outlook on third-party reimbursement?

Mr. MAGILL. Yes, sir. We brought our leadership in the week of January 9th, and met with a number of Chairmen of the committees to include Chairman Archer. We did bring up third-party reimbursement, and at best, I could say he was noncommittal.

The CHAIRMAN. Mr. Barr?

Mr. BARR. Thank you, Mr. Chairman.

I have just been going through some of the prepared testimony of the panel. I have already found several areas that I find very enlightening, but it would be somewhat irresponsible to pose questions at this time.

I would like to thank the panel for being here and give them my assurance that I am going to review this material very carefully and will probably be submitting written questions with the chairman's and the panel's consent. But I very much look forward to working very closely with you to handle the budgetary matters.

I think we do have some problems, some very serious problems in the President's budget. Some of those we have already talked about with the previous panel, and I know all of you gentlemen were here and listened to that, and I intend to do everything I can to follow up on those so that we can address the issues that aren't

addressed in the President's proposed budget, as well as make sure that those areas that are covered, that are worthwhile, such as the major and the minor construction budget increases, remain in there.

And I thank the panel again and look forward to working with you and your organizations in this regard.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Barr.

We encourage you to submit questions. Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman.

I just want to echo your comments, how much all of us on the committee appreciate your independent analysis and how we look forward to getting it and reviewing it.

I want to follow up a little on some of what Mr. Edwards of Texas talked about. You know, we hear over the decades a loss of this $10 billion you mentioned, and I sit here, and this is my fourth term, and I have heard this consistent plea that you folks and others have said; how are we going to come up with adequate financing when the budget requirements seem to be going down and there is less money?

So this sort of thing brings me to just two questions. First of all, just as a statement of a physician, the President's budget, based upon your numbers, is not adequate; right? And you feel that the President's budget is—well, not considerably under budget, but, shall we say, if his budget and the budget that the Secretary offered is implemented, is there going to be a dire situation, in your opinion? I mean, just give me a general feel for this?

Mr. SCHULTZ. Well, I would just say a dire situation. I think overall.

Mr. STEARNS. Why don't you use your term. What do you think—how critical is this? I mean, I am giving you a chance in a public forum to give the downside here. Are we in a crisis situation, are we in a dire situation, do you think this is something we can live with or should we all go out of here just feeling that this can be worked out?

Mr. SCHULTZ. Well, I have to, first off, say that overall we think the President's budget was a good budget.

Mr. STEARNS. A good budget.

Mr. SCHULTZ. It did help in some areas. Other areas we are not so pleased. I think—and it was brought up many times today that we need eligibility reform in the VA health care system. We can actually use less money of appropriated dollars than what is in the President's budget.

As far as dealing with the adjudication and claims backlog and the problems at the Board of Veterans' Appeals, certainly we could use more money, we could use more people. I think the VA is moving in the right direction within their claims adjudication system to try and bring the backlogs down. There is much more work that needs to be done.

As far as with the Board of Veterans' Appeals, that is an area that is, obviously, going to take some more time in order to get those backlogs down. And certainly if there was more money in those two areas, we would be a lot happier.

But it is—as I mentioned, the problem with claims adjudication is the amount of time it takes to process claims. People are dying. They are not, they are not going to receive their benefits, because a lot of these veterans are elderly, and that is the major problem we are up against right now.

Mr. WOOSLEY. On the health care side, it was stated this morning emphatically by the Secretary, and he is correct, the VA does take care of all service-connected disabled veterans. But as a consumer, if I have hypertension that I am service-connected for and I have to wait 3 to 6 months for a clinic appointment, is that health care? Not if I am out of medication.

Mr. STEARNS. Coming from Florida with so many veterans coming in each month, it has always been a puzzle to me why when you go up north, and parts of the Midwest the hospitals have low occupancies. You come down Southeast, and in the South you have so many hospitals that are in need of more facilities. Has there ever been any thought on your part to do a study and try and work out a distribution in terms of either the people that come from the North downward, and would bring down some tax credits, or tax vouchers, or something that could be used in the Southeast, as opposed to where the occupancy is low?

I mean, is there anything in the distribution of veterans benefits—I have a bill called the Veterans Bill of Rights, which it says a geographic location, it doesn't matter, you have to have the same benefits. And we find in the South, we are just not getting the benefits, and you can see from the earlier testimony, Orlando is being cut, Gainesville is being cut, and this is after the Secretary said there is an increase in the number of veterans coming into Florida. So has there ever been a thoughtful, creative process in that area?

Mr. MANK. Mr. Stearns, PVA and the VA are currently working on a project right now to analyze where veterans are actually obtaining their care. I cannot provide you an answer today, but I would be glad to give you some more information about that.

Mr. STEARNS. I think that is very encouraging to hear.

Mr. WOOSLEY. And the other point is still this eligibility problem, because a lot of the veterans you are talking about in Florida, simply aren't eligible on the surface for care.

So turning them away—and it is crowded, I worked down there for a couple of years and I know what you are talking about, they are not denied access to an eligible veteran. But yes, I think we even talked some on the Independent Budget about an enrollment system which maybe for years we kind of opposed. If we had some kind of idea who is going to use the VA and where, then we could have an idea of how you use the funds.

Mr. STEARNS. Thank you, Mr. Chairman.

You know, I just want to thank you. I think as the years go on, and I think I come back and you come back, if we could come up with some creative solutions here, that would be helpful, because I am at a loss. I will be fighting to protect these facilities.

Mr. MAGILL. If I could just add one other thing; we believe it is crucial that eligibility reform be enacted. And I think this is going to eliminate a lot of the problems when you do have third-party reimbursement. And as you heard my response a couple of minutes ago, we brought it up with the Chairman of Ways and Means, and

we were hoping to at least get some indication, and we are still going to pursue that very aggressively.

But when you get third-party, this is going to save money in the long run and it will provide for some of the hospitals in Florida and the sunbelt to retain some funding that they can expand their benefits to veterans through outpatient clinics, et cetera——

Mr. STEARNS. Yield back the balance of my time.

Thank you.

The CHAIRMAN. Gentlemen, thank you very much for your time and consideration, and thank you also for accommodating us in your schedules.

Larry, I understand that you are willing to try to do this quickly—I will abide by your wishes. It is going to take a minimum of 20 minutes, this is a 15 minute vote and another 5 minute vote. I am more than happy to come back and accommodate you, or if you think between the two of you, we can finish it up in 5 or 6 minutes, we will do that. I understand you will be willing to try.

Our next panel this morning is the last panel. Larry Rhea from the Noncommissioned Officers Association and Mr. Carroll Williams from the American Legion.

We appreciate your testimony this morning.

Please proceed. We have 5 minutes.

STATEMENT OF LARRY D. RHEA, DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS, NONCOMMISSIONED OFFICERS ASSOCIATION AND CARROLL L. WILLIAMS, DIRECTOR, VETERANS AFFAIRS AND REHABILITATION, THE AMERICAN LEGION

STATEMENT OF LARRY D. RHEA

Mr. RHEA. Thank you, Mr. Chairman.

First, let me be the first to wish you a good afternoon, and I will be very brief, because at this point, it becomes very difficult not to be repetitive.

The CHAIRMAN. Your entire statement will be inserted into the record.

Mr. RHEA. Thank you. I appreciate that, Mr. Chairman.

Clearly, the points that NCOA are concerned with have been made. First, there is the subject of eligibility reform.

We think it is unfortunate that it was omitted from the budget, but we think it needs review, needs attention this year, not only for its impact on the 1996 budget, but also for its future impact.

And then the real red flag in this whole thing, Mr. Chairman, is the OBRA extender on the Montgomery GI Bill. We are totally flabbergasted by it, it is a nonstarter, it should be summarily rejected and we should, in fact, be looking for ways not to extend that, but to go back and restore the full COLA and increase the value of the educational benefit.

I can talk for hours on that, but I won't. But those are our two points, and we appreciate your consideration.

The CHAIRMAN. Thank you. I am sure this committee in its entirety agrees with you.

[The prepared statement of Mr. Rhea appears on p. 324.]

The CHAIRMAN. Mr. Williams.

STATEMENT OF CARROLL L. WILLIAMS

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

The American Legion appreciates this opportunity to present our views on the administration's proposed fiscal year 1996 budget for the Department of Veterans Affairs, and we just ask that our written testimony be submitted for the record.

We are primarily concerned with eligibility reform, we are also concerned with the continuation of specialized services in the Department of Veterans Affairs, primarily the Veterans Health Administration. And we are also definitely concerned with the tremendous backlog of cases in the regional offices throughout the Nation, as well as those pending at the Board of Veterans' Appeals.

I am available for any questions. But I would just like to just take this brief moment to commend this committee for the issuance of a special order in recognition of those brave Marines and Sailors who fought and died 50 years ago on a small island in the South Pacific known as Iwo Jima. As a former veteran who taught in Vietnam, I was have always taught to never forget the extreme sacrifices made by those brave men, and I just want to take this opportunity to commend this committee for issuance of that special order.

Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Williams, with attachment, appears on p. 328.]

The CHAIRMAN. Thank you very much.

As a young sailor that was at Iwo Jimo, I appreciate those remarks more than you know.

Are there any questions?

Mr. BARR. Not a question. I know we have to leave, but Mr. Rhea, I haven't met you yet, but I like you. I read your remarks in your prepared testimony. It is straightforward, it is hard-hitting, it doesn't pull any punches, I like that and I intend to use every bit of material you can get me.

Mr. Williams, I just was just going through your material and I appreciate the time you put into that and look forward to working with both of you, especially on the areas that you have just identified. I agree in going through all of this that they are critical.

Thank you, Mr. Chairman.

The CHAIRMAN. Once again, we apologize.

We thank you for cooperating. We hate to cut you short.

The meeting is adjourned.

[Whereupon, at 12:20 p.m., the committee was adjourned.]

APPENDIX

Prepared statement of Chairman Stump

THE COMMITTEE WILL COME TO ORDER.

TODAY WE ARE MEETING TO HEAR TESTIMONY ON THE BUDGET FOR FISCAL YEAR 1996.

THIS HEARING HAD BEEN SCHEDULED FOR WEDNESDAY, FEBRUARY 22ND.

IN ORDER TO AVOID A CONFLICT WITH THE COMMITTEE ON NATIONAL SECURITY, OUR HEARING WAS RESCHEDULED FOR TODAY.

I WANT TO THANK ALL MEMBERS FOR THEIR UNDERSTANDING, AND APPRECIATE THEIR ATTENDANCE THIS MORNING.

I ALSO WANT TO EXPRESS MY APPRECIATION TO OUR WITNESSES WHO HAVE REARRANGED SCHEDULES IN ORDER TO BE HERE TODAY.

IN PARTICULAR, I WOULD LIKE TO THANK SECRETARY BROWN FOR ACCOMMODATING THIS SCHEDULING CHANGE ON SUCH SHORT NOTICE.

UNFORTUNATELY, THIS CHANGE IN SCHEDULE HAS RESULTED IN OUR FOREGOING ORAL TESTIMONY FROM WHAT WOULD HAVE BEEN OUR SECOND PANEL.

THE HONORABLE FRANK NEBEKER, CHIEF JUDGE OF THE US COURT OF VETERANS APPEALS, AND THE HONORABLE PRESTON TAYLOR, ASSISTANT SECRETARY FOR VETERANS EMPLOYMENT AND TRAINING IN THE DEPARTMENT OF LABOR, COULD NOT BE HERE TODAY.

WITHOUT OBJECTION, THEIR PRESENTATIONS WILL BE INCLUDED FOR THE RECORD.

THE THREE PANELS TESTIFYING TODAY WILL BE:

FIRST: THE SECRETARY OF VETERANS AFFAIRS, JESSE BROWN.

NEXT: THE INDEPENDENT BUDGET PANEL, WITH REPRESENTATIVES FROM AMVETS, PVA, THE VFW, AND THE DAV.

AND THIRD WE WILL HEAR FROM THE AMERICAN LEGION , AND THE NON COMMISSIONED OFFICERS ASSOCIATION.

AT THIS TIME, I WOULD LIKE TO INTRODUCE THE NEWEST MEMBER OF OUR COMMITTEE, REPRESENTATIVE DAN SCHAEFER FROM COLORADO.

I KNOW DAN WILL DO A GREAT JOB AND WE LOOK FORWARD TO HIS CONTRIBUTION TO OUR EFFORTS ON BEHALF OF VETERANS.

(RECOGNIZE MR. SCHAEFER.)

I WOULD LIKE TO MAKE A FEW COMMENTS ABOUT THE BUDGET BEFORE YIELDING TO MY GOOD FRIEND, SONNY MONTGOMERY, AND OTHER MEMBERS.

FIRST OF ALL, MR. SECRETARY, I UNDERSTAND YOU PERSONALLY APPEALED TO THE PRESIDENT FOR A BETTER BUDGET THAN WHAT HAD INITIALLY COME OUT OF OMB.

I COMMEND YOUR EFFORTS AND WOULD OBSERVE THAT THE OVERALL INCREASE OF NEARLY $1.3 BILLION IS CERTAINLY AN IMPROVEMENT OVER LAST YEAR'S BUDGET REQUEST.

SOME AREAS OF THIS YEAR'S BUDGET SHOW SUBSTANTIAL IMPROVEMENT, WHILE OTHERS REMAIN RELATIVELY CONSTANT OR SHOW SMALL INCREASES.

HOWEVER, THE QUESTION WE ALL SHARE IS WHETHER OR NOT THESE FUNDING LEVELS CAN NOT ONLY MAINTAIN SERVICES TO VETERANS, BUT ACTUALLY IMPROVE THOSE SERVICES.

ADDITIONALLY, THE BUDGET INCLUDES A PROPOSED 3.1 PERCENT COLA FOR COMPENSATION AND PENSION, EFFECTIVE DECEMBER 1, 1995.

THIS BUDGET ALSO EXTENDS PROVISIONS OF PRIOR BUDGET RECONCILIATION ACTS WHICH ARE CURRENTLY SCHEDULED TO SUNSET IN THE FUTURE. THE COMMITTEE WILL HAVE TO REVIEW THESE PROPOSALS VERY CAREFULLY. ADDITIONAL

RECONCILIATION TARGETS MAY ARISE WHICH AS IN THE PAST HAVE BEEN DIFFICULT FOR THE COMMITTEE TO MEET.

REMARKS OF HON. G. V. "SONNY" MONTGOMERY

THE PROPOSED BUDGET FOR VETERANS BENEFITS

AND SERVICES FOR FISCAL YEAR 1996

THANK YOU MR. CHAIRMAN. I JOIN YOU IN WELCOMING SECRETARY BROWN AND THOSE ACCOMPANYING HIM BEFORE THE COMMITTEE.

ALTHOUGH MANY THINGS HAVE CHANGED IN WASHINGTON IN THE PAST SEVERAL MONTHS, WE CONTINUE TO SHARE A COMMON BELIEF THAT BENEFITS FOR VETERANS ARE ONE OF THE MOST IMPORTANT FUNCTIONS OF GOVERNMENT. WHEN THE ADMINISTRATION LOOKED TO CUT THE NUMBER OF VA PERSONNEL PROVIDING DIRECT HEALTH CARE, WE SUCCESSFULLY TURNED THAT POLICY AROUND. WE HAVE ALSO WORKED TOGETHER TO FIGHT FOR ADEQUATE BUDGETS,

AND I BELIEVE THE BUDGET BEFORE US IS A VERY GOOD STARTING POINT.

BEFORE TALKING ABOUT THE GOOD POINTS OF THIS BUDGET, I WANT TO EXPRESS MY STRONG OPPOSITION TO THE ADMINISTRATION'S PROPOSAL WHICH WOULD DENY HALF OF FUTURE COST OF LIVING ADJUSTMENTS (COLAS) TO PERSONS GOING TO SCHOOL UNDER THE GI BILL. THERE IS EVIDENTLY SOME BELIEF THAT THIS IS JUSTIFIABLE BECAUSE I VERY RELUCTANTLY AGREED TO A TEMPORARY REDUCTION AS PART OF THE 1993 RECONCILIATION BILL. AT THAT TIME, I ADVISED BOTH THE ADMINISTRATION AND THE SENATE, WHICH INSISTED ON THE COLA REDUCTION, THAT THE GI BILL SHOULD NEVER AGAIN BE SEEN AS A COST SAVINGS VEHICLE.

THE BENEFIT LEVEL UNDER THIS PROGRAM IS ALREADY FAR TOO LOW. AT A TIME WHEN INCREASES IN FUNDING FOR DEPARTMENT OF EDUCATION PROGRAMS, SUCH AS PELL GRANTS AND PERKINS LOANS, AND FOR THE NATIONAL SERVICE PROGRAM ARE PROPOSED, IT'S JUST WRONG TO REDUCE FUTURE BENEFITS FOR THOSE GOING TO SCHOOL UNDER THE GI BILL. THESE BENEFITS ARE EARNED BY THESE VETERANS THROUGH SERVICE IN THE ARMED FORCES.

MR. SECRETARY, I WANT TO COMMEND YOU FOR NEGOTIATING A PRETTY GOOD BUDGET WITH OMB AND THE PRESIDENT. OF COURSE, YOU WILL HEAR THAT MORE IS NEEDED IN SOME AREAS. HOWEVER, GIVEN THE DEFICIT WE HAVE, THIS IS A FAIR BUDGET FOR OUR VETERANS AND THEIR FAMILIES.

I AM HOPEFUL THAT WHEN ALL IS SAID AND DONE, THE CONGRESS CAN MAINTAIN THE LEVELS THE PRESIDENT IS PROPOSING FOR MEDICAL CARE AND FOR CONSTRUCTION OF HEALTH CARE FACILITIES. I'D LIKE TO ADD A LITTLE MONEY TO THE RESEARCH BUDGET AND FOR THE MAINTENANCE OF OUR NATIONAL CEMETERIES. OVERALL, THE ADDITION OF ONE BILLION DOLLARS IN DISCRETIONARY FUNDS WHEN TOTAL DISCRETIONARY SPENDING IS FROZEN IS VERY REMARKABLE.

YOU'RE PROPOSING TO TREAT MORE OUTPATIENTS, FIX UP OLD PSYCHIATRIC HOSPITALS, AND FUND THE COST OF THE REPLACEMENT HOSPITAL AT TRAVIS AS WELL AS A NEW HOSPITAL IN FLORIDA. I THINK ALL OF

THESE PROJECTS ARE FULLY JUSTIFIED, AND I WILL JOIN YOU IN FIGHTING AGAINST ANY EFFORTS TO REDUCE FUNDS FOR THESE PROJECTS. IF WE'RE GOING TO PROVIDE FIRST-CLASS HEALTH CARE, WE CAN'T HAVE SECOND-RATE FACILITIES.

I LOOK FORWARD TO THE TESTIMONY BEING PRESENTED THIS MORNING.

PREPARED STATEMENT OF CONGRESSMAN WELLER

First of all, I want to welcome Secretary Brown and the staff of the Department of Veterans Affairs, as well as the directors of the Veterans of Foreign Wars, the Paralyzed Veterans of America, the Disabled American Veterans, AMVETS, the Non Commissioned Officers Association, and The American Legion who are appearing before us today. I also want to add my appreciation to that expressed by my colleagues to all concerned for their dedication and hard work on behalf of America's veterans, and I look forward to working with you in the coming months.

I think everyone in this room agrees that we are not only indebted to our veterans for their valiant service to our Nation, but also that we owe them our best efforts to provide competent, efficient and effective service, particularly to veterans in need. I sought to join my esteemed colleagues on the Veterans' Affairs Committee in order to do whatever I could to ensure that America's veterans are given the best possible care and service with the most efficient and effective means available.

As you may be aware, I have introduced a bill in the 104th Congress to convert the site of the Joliet Arsenal to private use, including land for a desperately needed veterans' cemetery. I look forward to working with the Department of Veterans Affairs and all veterans' organizations to see that this project comes to fruition.

In addition, I want to acknowledge and thank my predecessor, former representative George Sangmeister, who also had the privilege of serving on this esteemed committee, for all his hard work and effort in getting approval for the new Joliet outpatient clinic, which should be opening its doors in April, 1995.

As Vice-Chairman of the Compensation, Pension, Insurance and Memorial Affairs subcommittee, I have a particular interest in solving the flagrant problem of the veterans' claims process. Although the claims backlog has now received greater attention in the past year, it remains one of the most pressing problems in the current veterans service system.

Mr. Secretary, I look forward to your testimony and insights into how the veterans system can be improved, as well as to the testimony and insights of all of the witnesses here before us today.

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CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES

PUBLIC WORKS AND TRANSPORTATION COMMITTEE

VETERANS' AFFAIRS COMMITTEE

Opening Statement of Bob Filner

HOUSE OF REPRESENTATIVES

COMMITTEE ON VETERANS' AFFAIRS

February 24, 1995

Mr. Chairman, Mr. Montgomery, Secretary Brown, Representatives of our Veterans' Organizations, my colleagues:

I appreciate the presence today of Secretary Brown and the many representatives of our veterans' organizations to testify on the President's Budget Proposal for the Department of Veterans' Affairs.

I share the enthusiasm of Secretary Brown for the fairness of this Budget Proposal. I believe it reflects the high priority that our nations' veterans deserve! Although I recognize the need for fiscal responsibility, we must "keep the promise" that has been made to our veterans. We all want a balanced budget, but that budget cannot attack the services we owe to our veterans.

This brings me to a point that I would like to raise in the context of our budget discussions. My colleague on the other side of the aisle, the gentleman from the ninth district of Florida, has long been a leader in the fight for equality for disabled career military veterans--and many members have joined in a bi-partisan

manner to call for a change to the way we have done business since the 19th century.

I am referring to the fact that military retirees are the only group of federal retirees who must waive retirement pay in order to receive their VA disability compensation! This is a disgrace--there are many service-connected disabled retirees who cannot get appropriate work to supplement their diminshed incomes. We need to be aware of the sacrifice they have made for our freedom, and we need to be ashamed of the unequity that we have forced upon them in order to save a few dollars.

Although we must be fiscally aware, there are times when ethics and fairness are equally, and maybe even more, important. Members of our nations' fighting forces who have made the ultimate sacrifice should receive full compensation for their injuries above their retirement pay.

I will be working to change this outdated law during the upcoming session of Congress, and I appreciate the opportunity to mention this crucial issue and bring it to the attention of Secretary Brown and the other members of this Committee.

CONGRESSMAN MICHAEL P. FLANAGAN
VETERANS' AFFAIRS COMMITTEE BUDGET HEARING
FEBRUARY 24, 1995

OPENING REMARKS

Thank you, Mr. Chairman. As a freshman member of this Committee, I look forward to hearing from the panelists with us today and getting down to work on the review of the budget proposal before us.

I would like to extend my welcome to you, Secretary Brown, and thank you for coming here today.

As a member of this Committee, it is my priority during the 104th Congress to not only provide the veterans' community with better service, but to determine more **efficient** and **effective** ways to provide for our veterans.

We have been trusted with managing the mandate to care for our veterans in return for their services to a grateful nation. We must be aware of our responsibility to maintain a system that best meets the changing needs of today's veterans. We must not tolerate a stagnant

system that leads to inefficiency and waste. Instead, we must work together to constantly seek new ways to mold Department of Veterans' Affairs services around the changing needs of our veterans.

With this in mind, it is my hope that we can cooperate in bipartisanship to serve those who have so diligently served us.

I am reminded of the need for bipartisan spirit and action in this committee by an act carried out by our World War 2 veterans 50 years ago this week -- the planting of the American flag atop Mt. Surabachi on Iwo Jima. We must commit ourselves to serving our veterans with the same kind of dedication with which they served us.

I thank you, Mr. Chairman, for your leadership in respect to this hearing and the review of the 1996 Veterans' Administration budget proposal.

Veteran chokes to death at hospital; staff shortage blamed

The man, 74, died despite "more than the basic" staffing, the hospital said. Employees disagreed.

By Wes Conard
INQUIRER CORRESPONDENT

An Army veteran of World War II who was a patient at the Coatesville Veterans Administration Medical Center choked to death on a piece of peach while feeding himself lunch at the center Saturday, hospital officials said.

Employees and union officials blamed the death of Leonard Gilbert, 74, on staffing shortages that were the subject of a protest by more than 200 employees outside the hospital Monday.

"I'm very upset about it because it could have been prevented. Someone could have intervened," said Joyce Allen, a nursing assistant on the ward in which Gilbert died.

Allen attributed the death to inadequate nursing supervision.

"We've written to the hospital director, the head nurse, congressmen," she said. "We've been fighting an endless battle. We just don't have enough people."

But hospital spokesman Earl Johnson, in a prepared statement, said Gilbert received quality care and did not require constant supervision. He called the death unfortunate and said the hospital was conducting a standard internal review initiated with all hospital deaths.

Monday, picketing workers said cutbacks in personnel had stretched the staff to the limit, causing excess overtime, work-related injuries, and poor patient treatment.

"I feel this is a classic case of veterans being mistreated due to staffing shortages at this hospital," said Mark Bailey, president of the Coatesville chapter of the National Association of Government Employees.

"People need to know what is going on inside this hospital — particularly people who have friends and relatives here."

Johnson said three registered nurses, two licensed practical nurses and two nursing assistants were on duty Saturday. The presence of a third registered nurse made the staffing levels "more than the basic standard for nursing coverage," said the hospital's prepared statement.

But a nursing assistant who asked not to be identified said both of the nursing assistants present Saturday had worked until midnight the previous evening, then come back in at 7:30 a.m. to work overtime.

At least 46 employees were cut, mostly through attrition, from the hospital's 1,500-person staff in 1994, Bailey said.

Hospital officials said they could not comment on specific allegations because the administration is in negotiations with the union. They would say only that they were continuing to try to deal with the union's concerns.

Allen is one of two or three nursing assistants charged at any time with caring for 60 patients on Ward 138B, employees said.

About 40 of those patients are classified as requiring "total care," including being dressed, fed, changed and bathed by the nurses, Allen and other ward staff members said.

While the shifts usually include two or three registered nurses, as well as two or three licensed practical nurses, nursing assistants do most of the hands-on care, covering more than 30 rooms, Allen said.

THE HONORABLE MICHAEL BILIRAKIS
COMMITTEE ON VETERANS' AFFAIRS
FEBRUARY 24, 1995

HEARING ON ADMINISTRATION'S FISCAL YEAR 1996 BUDGET

THANK YOU, MR. CHAIRMAN.

I WANT TO COMMEND YOU FOR SCHEDULING THIS TIMELY HEARING ON THE ADMINISTRATION'S FISCAL YEAR 1996 BUDGET REQUEST FOR THE DEPARTMENT OF VETERANS' AFFAIRS. I WOULD ALSO LIKE TO TAKE A MOMENT TO WELCOME SECRETARY BROWN TO THE COMMITTEE.

I AM SCHEDULED TO TESTIFY BEFORE THE RULES COMMITTEE LATER THIS MORNING. CONSEQUENTLY, IT MAY BE NECESSARY FOR ME TO LEAVE BEFORE THE HEARING CONCLUDES. THEREFORE, LET ME APOLOGIZE IN ADVANCE TO OUR WITNESSES. I WILL CERTAINLY REVIEW YOUR WRITTEN TESTIMONY.

THIS YEAR'S BUDGET PROPOSAL IS A MARKED IMPROVEMENT OVER THE ADMINISTRATION'S LAST BUDGET SUBMISSION. THE ADMINISTRATION'S PLAN PROPOSES TO INCREASE THE VA'S BUDGET BY $1.29 BILLION OVER LAST YEAR'S SPENDING. I THINK SECRETARY BROWN PROBABLY DESERVES MUCH OF THE CREDIT FOR THIS INCREASE.

HOWEVER, LIKE CHAIRMAN STUMP, I AM DISAPPOINTED THAT THE ADMINISTRATION DID NOT TAKE THIS OPPORTUNITY TO PROPOSE A STRATEGIC PLAN, PARTICULARLY IN THE AREAS OF HEALTH CARE AND ELIGIBILITY REFORM, THAT WILL ALLOW THE

VA TO KEEP PACE WITH THE FUTURE NEEDS OF OUR VETERANS. INSTEAD, WE HAVE BEEN PRESENTED WITH A PROPOSAL THAT ADOPTS THE USUAL PIECEMEAL APPROACH TO BUDGETING THAT HAS HINDERED THE VA FOR SO LONG.

ALTHOUGH I AM PLEASED TO SEE THAT THE MEDICAL CARE ACCOUNT RECEIVED AN INCREASE OF $747 MILLION, I AM CONCERNED THAT MOST OF THIS INCREASE WILL BE SPENT ON RISING ADMINISTRATIVE AND PERSONNEL COSTS.

SINCE THE VA IS EXPECTING TO CARE FOR 2.8 MILLION VETERANS -- AN INCREASE OF APPROXIMATELY 43,000 ELIGIBLE VETERANS -- OVER THE NEXT YEAR, I AM WORRIED THAT THE VA WILL NOT HAVE ADEQUATE RESOURCES TO MEET THE DEMAND FOR MEDICAL CARE.

I SEE FROM SECRETARY BROWN'S WRITTEN TESTIMONY THAT THE VA "WILL IMPLEMENT EFFORTS TO INCREASE EFFICIENCIES AND GENERATE SAVINGS" IN ORDER TO MEET THE NEEDS OF OUR VETERANS. I AM ANXIOUS TO HEAR MORE DETAILS ON THE OPERATIONS IMPROVEMENTS THE DEPARTMENT IS MAKING. HOPEFULLY, THESE MODIFICATIONS WILL ALLOW THE VA TO FULFILL ITS ANTICIPATED HEALTH CARE OBLIGATIONS.

FOR TOO MANY YEARS, MY HOME STATE OF FLORIDA HAS LACKED THE RESOURCES NEEDED TO ADEQUATELY CARE FOR ITS VETERANS POPULATION. WHILE FLORIDA RANKS SECOND IN TERMS OF THE SIZE OF ITS VETERANS POPULATION, MY STATE IS ONLY SEVENTH IN TERMS OF MEDICAL SERVICES EXPENDITURES.

IN ADDITION, EVERY YEAR, THOUSANDS OF VETERANS TRAVEL SOUTH TO SPEND THE WINTER IN FLORIDA. THESE "SNOWBIRDS" PLACE AN EXTRA BURDEN ON AN ALREADY OVERTAXED SYSTEM. PREVIOUS DEPARTMENT SECRETARIES HAVE NOT ALWAYS RECOGNIZED THE IMPACT SNOWBIRDS HAVE ON THE AVAILABILITY OF VA SERVICES IN FLORIDA.

THEREFORE, I WOULD LIKE TO COMMEND SECRETARY BROWN FOR THE DEPARTMENT'S COMMITMENT TO ENHANCING FLORIDA'S RESOURCES. THE PRESIDENT'S BUDGET REQUEST CONTAINS THREE IMPORTANT CONSTRUCTION PROJECTS IN MY HOME STATE: A NEW MEDICAL CENTER AND NURSING HOME IN BREVARD COUNTY, FLORIDA, A SATELLITE OUTPATIENT CLINIC IN FORT MYERS, FLORIDA, AND AN EXPANSION OF THE NATIONAL CEMETERY AT BUSHNELL, FLORIDA.

I RECOGNIZE THAT THERE ARE MANY NEEDS THROUGHOUT THE VA SYSTEM THAT MUST BE ADDRESSED, AND I AM PLEASED THAT THE DEPARTMENT IS TRYING TO CORRECT FLORIDA'S PROBLEMS. HOWEVER, I AM DISAPPOINTED THAT ANOTHER IMPORTANT CONSTRUCTION PROJECT WAS NOT INCLUDED IN THE ADMINISTRATION'S BUDGET REQUEST.

THE STATE OF FLORIDA HAS ONE OF THE HIGHEST CONCENTRATION OF VETERANS WITH SPINAL CORD INJURIES AND SPINAL CORD DISEASES IN THE COUNTRY. QUITE SIMPLY, THESE VETERANS ARE NOT RECEIVING THE QUALITY CARE THEY ARE ENTITLED TO IN FLORIDA BECAUSE THERE IS A CRITICAL SHORTAGE OF SCI BEDS.

THE SPINAL CORD INJURY UNIT PROPOSED FOR THE JAMES HALEY MEDICAL CENTER IN TAMPA, FLORIDA IS DESIGNED TO REPLACE THE CURRENT OVERBURDENED SCI UNIT AND IMPROVE SERVICES TO MEET THE HIGH DEMAND FOR SPECIALIZED CARE PROVIDED TO SPINAL CORD INJURED VETERANS.

COMPLETION OF THE SCI UNIT IS LONG OVERDUE. I HOPE THE SECRETARY WILL BE ABLE TO GIVE ME SOME ASSURANCES THAT THIS PROJECT IS MOVING FORWARD AND WILL BE INCLUDED IN THE ADMINISTRATION'S NEXT BUDGET SUBMISSION.

THERE ARE OTHER ASPECTS OF THE ADMINISTRATION'S BUDGET REQUEST THAT I ALSO FIND TROUBLESOME, INCLUDING THE VA'S RESEARCH BUDGET AND THE EXTENSION OF PROVISIONS OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993. HOWEVER, I AM ANXIOUS TO HEAR FROM OUR WITNESSES SO I WILL NOT TAKE THE TIME TO ELABORATE ON THESE CONCERNS NOW.

IN CLOSING, THIS YEAR'S BUDGET SUBMISSION REFLECTS A GREATER APPRECIATION FOR VETERANS PROGRAMS ON THE PART OF THE ADMINISTRATION. UNFORTUNATELY, SIGNIFICANT SHORTFALLS STILL REMAIN.

MR. CHAIRMAN, I LOOK FORWARD TO WORKING WITH YOU AND THE OTHER MEMBERS OF THIS COMMITTEE TO ENSURE THAT OUR NATION'S VETERANS RECEIVE THE BENEFITS TO WHICH THEY ARE ENTITLED.

THANK YOU.

JOSEPH P. KENNEDY II
8TH DISTRICT, MASSACHUSETTS

COMMITTEE ON BANKING AND FINANCIAL SERVICES
SUBCOMMITTEES
HOUSING AND COMMUNITY OPPORTUNITY
RANKING MINORITY MEMBER
DOMESTIC AND INTERNATIONAL MONETARY POLICY

COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE
HOSPITALS AND HEALTH CARE
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Congress of the United States
House of Representatives
Washington, DC 20515–2108

Statement of Joseph P. Kennedy II
February 24, 1995

Mr. Chairman, thank you for convening today's hearing on the Fiscal Year 1996 budget for the Department of Veterans Affairs. I would also like to thank Secretary Jesse Brown and representatives from the veterans service organizations for presenting testimony today.

But, yesterday's cuts by the Republican-led Appropriations Committee have turned us back -- with no choice but to revisit the budget for 1995.

Unfortunately, today we are forced to face Republican cuts of over $200 million to the VA medical budget for 1995. As far I'm concerned, we've got all the evidence we need now to understand that the Republicans won't keep their promises to hold veterans programs harmless.

Mr. Chairman, maybe you can explain it to me. Last week, at a hearing of this Committee where we heard testimony from veterans organizations, all of the promises being made from the Republican side of the aisle must have just amounted to a lot of hot air. Republicans must be honest with veterans -- purely paying lip service for their service to our country is not acceptable.

Turning to the Clinton Administration's budget request for FY 1996, I want to commend you Secretary Brown for working hard to advance a budget that will position the VA to better provide services for our veterans. At a time when overall government spending decreased by 0.8%, you managed to secure nearly a 5.5% increase of $1.3 billion in badly needed funds for the VA.

It is my hope that this budget will allow us to reach our goals of: 1) operating the VA hospitals more effectively with more outpatient care for more veterans, 2) reducing the backlog in processing benefits claims, and 3) funding construction improvements at VA hospitals to make them more like the private sector.

I have a couple areas of special interest -- funding for homeless veterans, Persian Gulf research, and eligibility reforms -- that I will address later in my questions.

Again, I would like to commend Secretary Brown for this budget. While many agree that the VA could use even greater funding especially for medical care, this budget moves the Department forward in its commitment to provide the best possible services for our veterans.

THIS STATIONERY PRINTED ON PAPER MADE OF RECYCLED FIBERS

CONGRESSWOMAN CORRINE BROWN
HOUSE COMMITTEE ON VETERANS AFFAIRS
FEBRUARY 24, 1995

Mr. Chairman, members of the Committee, I am happy to be with you today and am hopeful that this year will be a good one for our veterans.

I am pleased with the $1.3 billion increase in the Administration's FY 1996 budget for VA. Also on a positive note -- especially for veterans in Central Florida -- is the VA's reuse of the Orlando Naval Training Center Hospital for an outpatient clinic and 120-bed nursing home care unit. Currently, VA has begun to move its outpatient clinic operations from its presently leased location to the Orlando Naval Training Center site.

However, I remain concerned about the needs of homeless veterans and about adequate access to health care for Florida's great -- and growing -- number of veterans. Therefore, I am hopeful that funding for the new medical center and nursing home in Brevard

County, Florida, which is included in the President's proposed budget, will become a reality.

The plight of homeless veterans must be realistically addressed! These veterans have no home, no address, and no way to be contacted by family or potential employers. Therefore, I would like to work with you and with the Committee to develop a successful, cost-effective program to help these veterans out of homelessness and into jobs.

I look forward to working with you on these issues of concern. Thank you for your assistance and cooperation in the past. Your outstanding leadership is greatly appreciated.

Prepared statement of Congressman Everett

THANK YOU, MR. CHAIRMAN, FOR HAVING THIS HEARING TODAY. THANK YOU ALSO TO SECRETARY BROWN FOR APPEARING BEFORE US.

THIS BUDGET IS A SLIGHT IMPROVEMENT OVER LAST YEARS, HOWEVER, WE MUST KEEP IN MIND THE CONSTITUENCY WE ARE SERVING. REPUBLICANS AND DEMOCRATS ALIKE WILL AGREE THAT WE CAN'T "BALANCE THE BUDGET ON THE BACKS OF VETERANS" - VETERANS MUST NOT BE SINGLED OUT FOR CUTS OR TAXES TO THEIR BENEFITS.

AS CHAIRMAN OF THE COMPENSATION, PENSION, INSURANCE AND MEMORIAL AFFAIRS SUBCOMMITTEE, I KNOW WE WILL HAVE OUR WORK CUT OUT FOR US. I ESPECIALLY LOOK FORWARD TO REVIEWING THE IMPLEMENTATION OF TITLE 1 OF PL 103-446, COMPENSATION TO PERSIAN GULF VETERANS. EVERYONE WOULD LIKE TO KNOW WHAT IS GOING WRONG WITH THESE YOUNG SOLDIERS AND SEE THAT THEY ARE COMPENSATED FOR THEIR ILLNESSES. ADDITIONALLY, WE WILL BE FOCUSING ON CLAIMS PROCESSING IN THE REGIONAL OFFICES AND EXAMINING THE THREE-PHASE COMPUTER MODERNIZATION PLAN VA IS IMPLEMENTING. CLAIMS PROCESSING CURRENTLY RUNS ABOUT 170 DAYS. WILL THIS TECHNOLOGY ALLEVIATE THE BACKLOG AND PROCESSING TIME? THE SUBCOMMITTEE IS LOOKING FORWARD TO AN ACTIVE OVERSIGHT AGENDA ON THESE AND OTHER IMPORTANT ISSUES TO OUR VETERANS.

I LOOK FORWARD TO HEARING YOUR TESTIMONY SECRETARY BROWN, AND TO YOUR RESPONSES TO OUR QUESTIONS.

THANK YOU MR. CHAIRMAN.

STATEMENT OF THE HONORABLE CLIFF STEARNS
COMMITTEE ON VETERANS AFFAIRS
HEARING ON ADMINISTRATION'S FISCAL YEAR 1996 BUDGET
FEBRUARY 24, 1995

I am pleased to be here this morning. I would like thank you Chairman Stump for holding this hearing today. I would also like to welcome Secretary Brown as well as the other distinguished members scheduled to testify and thank them for being here today. I am sure I speak for everyone when I say that we look forward to hearing their insightful testimony.

While I applaud the fact, Mr. Secretary, that you have requested a $747 million increase in funding over the 1995 level for medical care, there are two areas of concern that I would like to bring to your attention.

First, I would like to once again impress upon you the importance of going forward with the 120 bed Psychiatric Building Component of the Ambulatory Care Addition/120 Bed Psychiatric Building project at the Department of Veterans Affairs Medical Center (VA) Gainesville, Florida.

The Department of Veterans' Affairs announced in December of 1994 that it had requested approval to stop further design. The State of Florida has an exploding veterans population. in fact, the influx is estimated to be at the rate of 5,000 veterans per month. Many veterans suffer from post traumatic stress disorders which require special care.

I wish to take this opportunity to request that you reconsider your decision to stop this project. For years the southeast quadrant has looked to this Gainesville Medical Center as the answer to a glaring need for psychiatric care. We must meet all the health care needs of our veterans. We owe them no less.

The second issue of concern is that the veterans population continues to increase in a number of states and many of these same states have seasonal

increases in the number of veterans seeking care. This causes long waiting periods and puts a strain on not only the facility but also the personnel in attendance. We must provide some type of relief for these overburdened facilities. Why should residents that live in these regions be subjected to such delays before receiving treatment?

Mr. Chairman, I know that the primary goal and chief concern that we all share is the need to follow through on the commitment we made to our veterans - I hope that we continue the process.

I look forward to working with all of you and I feel certain that we will not let our veterans down.

STATEMENT FOR VETERANS COMMITTEE BUDGET HEARING

GIVEN BY MR. COOLEY OF OREGON

MR. CHAIRMAN, IT IS A PLEASURE TO BE HERE THIS MORNING TO REVIEW THE PRESIDENT'S BUDGET PROPOSAL.

WITH ALL THE POLITICKING HERE IN CONGRESS LATELY, FROM FOOD STAMPS TO PUBLIC BROADCASTING, IT IS MY SINCERE HOPE THAT AS WE EXAMINE THE BUDGET, THAT WE LEAVE POLITICS AT THE DOOR.

WE ARE NOT DEALING WITH WELFARE, WE ARE NOT DEALING WITH AN OBLIGATION THAT WAS GRUDGINGLY OFFERED.

WE ARE DEALING WITH PAYMENT FOR SERVICES WELL RENDERED. I SAY THIS NOT AS A VETERAN, BUT AS A PUBLIC SERVANT.

LIKE ANY CONTRACT THE GOVERNMENT MAKES, WE MUST DO ALL WITHIN OUR POWER TO LIVE UP TO IT. DOLLARS MAY BE SCARCE, BUT WE MUST MAKE THIS OUR PRIORITY.

ANOTHER POINT THAT I WOULD LIKE TO MAKE IS THAT, SEVERAL HEARINGS AGO, TWO OF OUR COLLEAGUES ON THIS

COMMITTEE EXPRESSED CONCERN THAT REPUBLICANS HAD VOTED TO CUT $206 MILLION FROM VETERANS.

I AM HAPPY TO REPORT THAT I, ALONG WITH NEARLY ALL REPUBLICANS AND THE MAJORITY OUR FRIENDS FROM THE OTHER SIDE OF THE AISLE, SUPPORTED AN AMENDMENT BY OUR CHAIRMAN TO RESTORE THIS FUNDING TO VETERANS.

I AM CONCERNED WHEN EVERYONE KEEPS TALKING ABOUT SACRIFICES TO COME IN ALL AREAS OF THE BUDGET. IN CASE ANYONE IS WONDERING -- YES, WE DO STILL COLLECT NEARLY ONE QUARTER OF ALL MONEY MADE IN THIS COUNTRY.

I WOULD LIKE TO POINT OUT THAT THIS MEANS THAT THERE IS PLENTY OF MONEY COMING IN FOR VETERANS AS LONG AS DON'T GIVE THEIR MONEY AWAY TO WORTHLESS CAUSES, PORK PROJECTS, AND THINGS THE GOVERNMENT SHOULDN'T HAVE ITS HAND IN.

WE HAVE ALWAYS BEEN STRONG SUPPORTERS OF VETERANS - NOT ONLY IN WORD BUT IN DEED. LET US CONTINUE IN THAT VEIN TODAY - PARTNERS AND NOT ADVERSARIES -- SUPPORTERS AND NOT OPPONENTS -- ADVOCATES AND NOT POLITICIANS.

FOR RELEASE ON DELIVERY
Expected at 9:00 A.M. EST
February 24, 1995

STATEMENT OF
HONORABLE FRANK Q. NEBEKER
CHIEF JUDGE, UNITED STATES COURT OF VETERANS APPEALS
FOR PRESENTATION BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
FEBRUARY 24, 1995

MISTER CHAIRMAN AND DISTINGUISHED MEMBERS OF THE COMMITTEE:

On behalf of the Court, I appreciate the opportunity to present for your consideration the fiscal year (FY) 1996 budget for the United States Court of Veterans Appeals. In my testimony, I will briefly address two matters: first, the Court's operating budget request for FY 1996; and, second, the Pro Bono Representation Program (Program), for which the Court is again requesting funding.

First, I would like to focus on the Court's FY 1996 budget request. For FY 1995, the Court had requested $9,523,000, which included a request for $790,000 to continue the pro bono Program. The Court received an appropriation of $9,429,000. This appropriation reflected a decrease in General Services Administration rental payments and included $790,000 to continue the pro bono Program. For FY 1996, the Court requests $9,820,000 to fund its normal personnel and operating requirements, including $678,000 to fund the pro bono Program.

The Court recognizes congressional and executive branch efforts to reduce spending. As is noted in the budget submission before you, the Court plans reductions in a number of spending categories. The Court's voluntary personnel reductions through FY 1995 met executive branch targets for administrative and personnel reductions. The Court's budget estimate for FY 1996 reduces by one full-time equivalent position the Court's staffing from its 1995 authorized level. With this reduction the Court will have reduced staffing by 6% since fiscal year 1993.

There are no new funding requirements in the Court's FY 1996 budget request. The Court's request for FY 1996 reflects a net decrease in funding from FY 1995 funding levels for all budget categories other than pay and benefits. The pay and benefits categories for judicial and non-judicial staff include a 2.2% inflation rate adjustment, following guidance from the Office of Management and Budget. Other categories reflect normal increases in the cost of court security operations, finance and accounting support, rent, the actuarial study of the Judges Retirement Fund, and the Court's contribution to the Judges Retirement Fund.

Second, I wish to highlight a few features of the pro bono Program, included once again in the Court's budget request. In February 1994, the Court transmitted to you the evaluation reports prepared by the Legal Services Corporation covering the first full year of operations of the pro bono Program and the Court's comments on those evaluations. A two-year status report will be provided to Congress in February 1995. The Program's goal of significantly reducing unrepresented appellants was achieved as to appeals filed in FY 1993 and again in FY 1994. The Court's FY 1996 budget submission and the forthcoming report provide more detailed information concerning the Program's operations through FY 1994 and calendar year 1994. I would like to take this opportunity, however, to highlight several accomplishments of the Program.

First, the Program provides legal advice or representation to every eligible pro se appellant who requests assistance and who cannot afford an attorney. As a result, fully two-thirds of eligible appellants who were pro se when filing appeals in the first two years of the Program's operation received some form of legal assistance. Second, during these first two years of the Program's operation, while only 19% of appellants were represented at the time of filing a notice of appeal to the Court, 42% were represented at case termination as a result of the Program's placement of cases with attorneys. Third, recruitment of volunteer attorneys has been highly successful. Through the end of calendar year 1994, 342 volunteer attorneys have been recruited and are participating in the Program. Since the inception of the Program, attorneys from 25 jurisdictions, in addition to the District of

Columbia, have participated. Nearly 300 attorneys have received training in veterans law, either through the Program's formal day-long training sessions (261 attorneys) or through video training tapes (37 individuals or law firms). Of the 159 volunteer attorneys who have completed cases, over 80% have expressed willingness to take another case, and 51 appellants have already received representation by repeat pro bono attorneys. In FY 1994 the Program provided nearly $4.00 worth of volunteer-attorney services for every $1.00 of federal money spent on the Program.

The $678,000 funding request for FY 1996 reflects a one-time decrease of $112,000 from the FY 1995 level. This decrease is based on nonrecurring savings in the Program that could not be maintained in future years without programmatic changes that the Court does not now anticipate would be desirable. In response to congressional concerns, the Court and the Legal Services Corporation are proposing an equal split of the annual budget request for the Program and are coordinating closely on both policy and funding issues in an effort to ensure the effective continuation of the Program. The Court, however, presently requests that the full amount be appropriated as part of the Court's budget request as was done through the prior three appropriations. Only if the Congress responds to the Corporation's request by appropriating half of the necessary funds through the Corporation's budget would the Court then request a commensurate reduction from $678,000.

Finally, I ask that the Court continue to be excluded from section 509 as has been the case with past appropriations legislation. The language incorporated in section 509 of Public Law No. 103-327, the VA, HUD, and Independent Agencies Appropriations Act for FY 1995, precludes agencies from using, for any other object classifications, funds provided for personnel compensation and benefits. The Court notes that the Office of Management and Budget has recommended that section 509 be eliminated from the Administration's proposed appropriations bill for FY 1996. Should this restriction be included in the Appropriations Act for FY 1996, however, the Court requests continuation of the exemption

it has received in all prior fiscal years. Other United States courts have not been made subject to such funding restrictions, and our Court's relatively small staff and budget warrant a continued exemption to ensure that resources are directed most efficiently.

In conclusion, I appreciate this opportunity to present the Court's budget request for fiscal year 1996. On behalf of the judges and staff, I thank you for your past support and request your continued assistance. If you have any questions, the Court's staff and I will be happy to respond.

STATEMENT OF PRESTON M. TAYLOR JR.
ASSISTANT SECRETARY FOR
VETERANS' EMPLOYMENT AND TRAINING
SUBMITTED TO THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

FEBRUARY 24, 1995

Mr. Chairman and Members of the Committee:

It is with great honor and appreciation that I submit for the record the Fiscal Year 1996 Department of Labor budget as it pertains to veterans' employment and training programs.

I would like to preface my remarks by sharing with you my vision for the Veterans' Employment and Training Service, or VETS, followed by a sampling of the agency's FY 1994 accomplishments. I am committed to making all concerned aware of the outstanding work that this agency, in partnership with its State grantees, does on behalf of veterans. A brief listing of VETS' recent successes will support the VETS' FY 1996 budget request, which I will outline today as it pertains to employment, training, and enforcement activities.

First, my vision. I want VETS to be recognized as a "world class" organization ensuring employment, training and enforcement services to our veterans. The agency must keep pace with the demands and rewards of putting our customers -- veterans and prospective employers of veterans -- first, in order to give each veteran a chance for real job security and job opportunity in a changing world. To accomplish this, VETS' main resource is the partnership it maintains with the State Employment Security Agencies or SESAs, who have veteran-dedicated staff -- the Disabled Veterans' Outreach Program specialists or DVOPs, and the Local Veterans' Employment Representatives or LVERs, who deliver most of the direct employment and training services administered by VETS for veterans.

The Disabled Veterans' Outreach Program is authorized by Title 38 of the United States Code as a grants-to-States program administered by VETS. DVOP specialists provide outreach services to help maximize employment and training opportunities, primarily for disabled veterans, and develop job opportunities with employers through State Employment Security Agencies. The DVOP staff also helps those about to leave the military and their spouses by facilitating TAP workshops under the Transition Assistance Program.

The Local Veterans' Employment Representatives are also mandated by Title 38 as a grants-to-State program administered by VETS. LVERs provide job placement and supportive services directly to veterans. They also act as functional supervisors of services provided to veterans by other local Job Service office staff to ensure compliance with the priority of service requirements and performance standards for services to veterans. LVERs also maintain cooperative working relationships with community organizations and employers, and work closely with staff in other agencies, including the Department of Veterans Affairs personnel involved in vocational rehabilitation and counseling services for veterans. Additionally, LVERs promote and monitor listings of job openings by Federal contractors and subsequent referrals of qualified veterans. They also monitor and promote participation of veterans in Federally-funded employment and training programs.

The emphasis, both within the agency and throughout the DVOP/LVER delivery system, continues to be on total quality management, or TQM, and the teamwork principles underlying this philosophy.

During FY 1994, VETS and its grantees' efforts resulted in accomplishments that had significant impact both on the agency's operations and on the veterans we serve.

* 2.5 million veterans registered with the SESAs in the Program Year ending June 30, 1994, and 560,000 veterans were helped into jobs, at a cost of approximately $430 for each job secured by a veteran. The SESAs delivered two million individual service transactions on behalf of registered veterans, encompassing a wide range of employment and training services appropriate to their interests and needs -- such as career assessment, interviewing, testing, vocational guidance, counseling, job search activities, job development, and other services. These services were either delivered directly by the DVOPs, LVERs, and other SESA staff, or obtained through referrals to other supportive specialists or agencies. Through its DVOP and LVER grantees, together with VETS' State Directors and their staff, VETS vigilantly protected veterans' priority in employment services as mandated by law. VETS and the DVOPs and LVERs have concentrated their efforts on those most in need of assistance: the disabled veterans and those veterans with the greatest barriers to employment. This focus on veterans most in need is illustrated by the outstanding effectiveness of the DVOP stationed at the Department of Veterans Affairs' Regional Office in St. Petersburg, Florida, who received an award from the VA for his success in helping to find jobs for veterans.

* 163,000 military men and women and their spouses were trained in 3,686 Transition Assistance Program, or TAP, workshops at 204 military installations in the U.S. in FY 1994, at a cost of approximately $36 per participant. This represented 73 percent of all those separated from the military at these installations in FY 1994, an 18 percent increase over TAP coverage in FY 1993. TAP delivers workshops to military separatees, providing hands-on, practical guidance on how to find employment in the civilian labor force. An independent national evaluation conducted for VETS on the TAP performance in FY 1991 estimated that service members who received TAP orientations, on average, found jobs three weeks earlier than did service members who did not participate in a TAP workshop. Such a reduction in the time in

which a person is unemployed indicates that, in aggregate, there are large savings to be realized by ensuring that as many separating personnel as possible receive TAP orientations. The reduction of personal anxiety and family stress is an immeasurable additional benefit which TAP workshops can provide. The success of TAP is reflected by the people it has touched, such as the Air Force veteran from Delaware who after nine years of service opted for an early discharge. As he later described it, "...in approximately six months, I would have to find a new job. I was frantic, not knowing which way to turn. That was when a co-worker told me about the Transition Assistance Program." After attending a pre-TAP workshop and a full TAP workshop and working diligently in applying the lessons he learned through TAP, this Delaware veteran summed up his TAP experience: "I had been separated from the military only two days when I received what I had been waiting for. That first call for an interview. Whatever becomes of the interview, I know I am successful. Just coming as far as I have has been incredible. I owe a big debt of gratitude to all the people working in the TAP office....they've armed me with all I need to land that career that seemed so elusive only six months ago."

* 9,600 veterans were matched with employers in on-the-job training programs under the Service Members Occupational Conversion and Training Act, known as SMOCTA. Under the SMOCTA program, DVOP and LVER staff identified potential employers, developed jobs, and assisted in developing on-the-job training programs for employers. They also provide individualized case management services for veterans participating in SMOCTA to enhance their retention in training and post-training employment. The SMOCTA program eligibility rules targeted long-term unemployed veterans, disabled veterans, and those whose military occupational specialties do not have a civilian labor market counterpart, such as infantrymen. SMOCTA also included a sharper focus on job development in industries characterized both by stability and growth. The value of SMOCTA is illustrated by two Desert Storm veterans

who after leaving the military were jobless in Buffalo, N.Y.: one becoming homeless and the other receiving welfare assistance. Through DVOP help, each was placed through SMOCTA into Sub-Assembler Trainee positions paying almost $13 per hour plus benefits.

* The combined impact of the TAP and SMOCTA programs, as supported by DVOP and LVER staff, makes each of these activities valuable investments. The attention given to separating servicemembers' transition to civilian employment shows the Nation's commitment -- learning from the mistakes of the Vietnam era -- to never again neglect this critical and well-deserved assistance for our veterans who are returning to the civilian workforce.

* 8,200 homeless veterans were assisted by the VETS Homeless Veterans Reintegration Project, known as HVRP, and its 30 grantees, with more than 4,150 expected to find jobs. This highly effective program provides comprehensive services to homeless veterans through direct services, linkages with other service providers, such as the Departments of Veterans Affairs and Housing and Urban Development, charitable and State organizations, and local non-profit service providers with an emphasis on job placement and retention. Housing and other services are provided to support this mission and to encourage job retention. The HVRP grants were efficient in their use of resources, as demonstrated by their low average cost of placement -- approximately $1,200 per homeless veteran getting a job. The networking which makes HVRP so effective is illustrated by the assistance provided to a homeless 37 year-old Vietnam-era veteran in San Antonio who not only suffered from alcohol and cocaine addictions, but who also was in need of hernia surgery. The combined efforts of HVRP-funded staff, the Audie L. Murphy VA Hospital, the Department of Veterans Affairs' contracted transitional housing facility and the Texas Rehabilitation Commission were successful in helping this homeless veteran progress through rehabilitation for his addictions, hernia surgery and a period of outpatient recovery in VA transitional housing, placement in an auto repair job with subsidies to

purchase necessary tools, and assistance with his first month's rent for a residence of his own. A follow-up contact several months later revealed that he had been promoted to assistant manager of the auto repair shop.

* More than 3,500 service-connected disabled, Vietnam-era or recently separated veterans will have received training under Job Training Partnership Act Title IV-C (JTPA IV-C) grants, with more than 2,500 of these veterans expected to be placed in jobs upon completion of their training, at a cost of approximately $3,500 per placement. Funding for JTPA IV-C grants, totaling $8.9 million in FY 1994, comes from the Employment and Training Administration's Training and Employment Services appropriation - not from the appropriation for the Assistant Secretary for Veterans' Employment and Training. Virtually all JTPA IV-C funds for FY 1994 -- or Program Year 1993, the most recent yearly data available -- were awarded through a competitive process to 14 State entities through the Governor's office in each State. The remaining funds were allocated for innovative pilot, demonstration and research projects with a national impact. During FY 1994, VETS streamlined its JTPA IV-C grants process to eliminate existing regulations and phase in a revamped system. The result was fewer, larger valued grants over multi-year grant periods. The new grants process improved program maintenance and management, reduced both staffing needs and the number of reports required, and increased the resources devoted to direct client services. An example of the effectiveness of JTPA IV-C grants is an unemployed 44 year-old Vietnam-era veteran in West Virginia who gained medical experience while in the service and wanted to secure a job in the medical field. A one-year Licensed Practical Nursing training program funded by JTPA enabled him to pass his State board exams and resulted in permanent employment at a local hospital. He has received a Florence Nightingale Award for his clinical work, and is now enrolled in a Registered Nursing program.

* 2,831 veterans' service providers were trained at the National Veterans' Training Institute, known as NVTI. This was the highest annual participant total in NVTI's history. The low cost per trainee of $1,033 reflects the efficient use of available funding. NVTI was established in 1986 and authorized in 1988 by Public Law 100-323. It has proven to be an extremely effective means for raising morale, increasing productivity and establishing national uniformity of services by DVOP, LVER, and VETS' staff. More importantly, staff training at NVTI has significantly improved both the quality and quantity of services provided to veterans. NVTI has proven to be efficient in meeting new training needs as they arise, such as the development of revised courses to address changes in the program requirements of TAP, SMOCTA, Veterans' Reemployment Rights, grant management and case management services. NVTI's effectiveness is demonstrated by the most recent data available from 244 class evaluation surveys conducted 90 days after NVTI training. Ninety-six percent of NVTI trainees in these classes and 91 percent of those trainees' supervisors report that the training received at NVTI has helped to enhance the quality of service being provided to veterans by their offices. The same evaluation surveys show that 88 percent of NVTI trainees and 79 percent of their supervisors believe that NVTI training has resulted in an increase in the number of veterans helped into jobs by their offices.

* 1,208 new Veterans' Reemployment Rights, or VRR, cases were filed in fiscal year 1994, and the total number of cases carried over as open from FY 1993 into FY 1994 was 206. By year's end, 1,053 cases or 85 percent of both cases newly opened in FY 1994 and cases carried over as open from FY 1993 had been closed within 90 days of filing. The total number of cases closed in FY 1994, including cases carried over as open from the previous year, was 1,236. VETS' operating cost for VRR in FY 1994 was approximately $3,500 per open case handled. Throughout FY 1994, VETS also actively participated in development of the Uniformed Services' Employment and Reemployment Rights Act, known as USERRA, which was

enacted in October 1994. In FY 1995, VETS is involved with the start-up implementation of USERRA. VETS' enforcement of the VRR statute remains a cornerstone of this Nation's military preparedness, through its protection of the civilian employment rights of our "citizen soldiers" -- the majority of whom are now assigned to our Reserve and National Guard components. USERRA provides, for the first time, that practically all non-career uniformed service members receive such assistance from VETS. The expanded pool of individuals now eligible for that assistance is more than 1.9 million people. With Reserve component forces playing an increasingly integral part in our country's defense, the opportunity for tension with their civilian employers increases proportionately with the use of Reservists for active duty military missions, such as the recent Haiti and Bosnia deployments. Implementation of the new USERRA provisions will minimize the disruptions caused by military service for both service members and their employers. Implementation, however, will significantly increase VETS' veterans' reemployment rights workload. Military involvement overseas in such areas as Haiti and Bosnia have been but the latest examples of a trend which is likely to be repeated in the future, and which will mean that VRR caseloads will remain susceptible to fluctuations as Reservists are called upon to play their vital roles in our National defense. USERRA mandates new investigation responsibilities and grants subpoena authority. It also expands the universe of VETS' reemployment rights clientele to cover practically all non-career uniformed servicemembers, including those in the Federal government and U.S. Postal Service. An example of VETS' impact in VRR situations is shown by an Illinois Reservist whose employer had given him a 10 minute ultimatum to decide which he wanted to quit: his job or the Reserves. During these 10 minutes the Reservist called VETS' Chicago Regional Office and was given immediate advice regarding his rights, which he then used to amicably resolve the problem with his employer.

* An important example of VETS' efforts to improve its program administration within available resources was the FY 1994 implementation of a second generation of VETS' Automated Reporting System, known as VARS, to provide essential management information and data.
* In FY 1994, the Secretary of Labor established the legislatively mandated Advisory Committee on Veterans' Employment and Training, or ACVET. The ACVET was created to provide VETS' external constituencies, such as employers, veterans' service organizations, and others with a forum for consulting with the Secretary of Labor and the Assistant Secretary for Veterans' Employment and Training regarding the broad range of issues facing veterans as a group and VETS as an agency. The ACVET's initial meeting was held in the first quarter of FY 1995.
* VETS awarded a grant in FY 1994 to "Leadership Employment for Armed Forces Personnel", known as LEAP, to train veterans, particularly recently separated veterans, to be housing project managers. The training, a part of which was provided in FY 1994, with a session to be given in FY 1995, was and is being provided by the National Center for Housing Management with the assistance of the Departments of Housing and Urban Development, Justice, Health and Human Services, and Education. The Department of Justice contributed financially to this demonstration project with a view to having graduates placed in as many of that Department's "weed and seed program" cities as possible. Graduates chosen for their leadership potential will also serve as role models for inner city youth to reduce substance abuse and crime, and as a role model in terms of job and career pursuits.

For FY 1996, VETS is requesting a total of $187,114,000 to fund 267 Federal positions and 3,146 State positions; that is, 1,441 LVER positions and 1,705 DVOP specialist positions. This total includes $161,275,000 for grants-to-States, $23,017,000 for administration, and $2,822,000 for the National Veterans' Training Institute. The FY 1996 budget represents a one percent increase over the agency's funding for FY 1995.

Services to veterans by the front-line providers in VETS' delivery system, the DVOP and LVER staff in the State Employment Security Agencies, will continue to be the key component of VETS' operations. The critical importance of the DVOP and LVER programs is reflected by the 86 percent share of the agency's budget which is devoted to DVOP and LVER services. DVOP and LVER activity will continue to include all legislatively prescribed services in FY 1996, with priority to be given to special disabled veterans and other categories of disabled veterans. The focus of DVOP and LVER services will be to serve those veterans most in need of employment and training assistance -- those faced with the greatest obstacles to obtaining employment. VETS will target the efforts of the DVOP and LVER specialists to ensure that veterans become job-ready, and to assist veterans in securing employment and training suited to their individual needs.

Evolution of the roles played by DVOP and LVER staff in service delivery to veterans will be a central feature addressed in the Department of Labor's One-Stop Career Center initiatives as these are developed throughout the States by the Department's Employment and Training Administration, or ETA. I am pleased to report that we are working as full partners with ETA in the implementation of the One-Stop Career Center system. We believe that the opportunities for veterans to obtain appropriate and desirable job training, counseling, job placement services, and labor market information can be increased by the operation of One-Stop systems. We also believe that Department of Labor administered employment and training programs must be flexible, to enable States to customize their delivery system to meet the particular needs of local labor markets while still providing maximum opportunity and priority service to veterans.

We believe that the One-Stop initiative is an opportunity to re-think how we deliver service to veterans, how we use our dedicated resources -- the DVOPs and LVERs -- to better serve our veterans. For example, if a veteran can easily access employment information through a One-Stop system and obtain employment without direct interaction with a veterans' representative, then

additional staff time will be available to help more veterans who need intensive services, such as counseling, vocational rehabilitation, testing, career assessment, and other time-consuming activities. To ensure that veterans will benefit from the implementation of One-Stop systems, we have assigned VETS' staff at the National and Regional levels to work with ETA. VETS' staff have also been directed at the State level to work directly with the State One-Stop coordinators.

A budget-neutral feature in the VETS' budget request includes a provision that would allow States to obligate, through the first quarter of the following year, funds obligated by VETS during a fiscal year for the DVOP and LVER programs. This feature will facilitate more certainty in DVOP and LVER program planning by the States and be consistent with other Federal grants provided. Analysis of funds lapsed annually since FY 1990 shows that the States suffer staffing fluctuations resulting from anticipation of funding levels each fiscal year. Avoidance of these fluctuations through application of the "fifth quarter funding" authority requested would enable approximately 56 more DVOP/LVER staff to be utilized nationwide, translating into approximately 6,000 more placements in FY 1996.

A key priority within the $23,017,000 requested for VETS' various administrative activities will be increasing the responsibility of DVOP and LVER staff in presenting Transition Assistance Program workshops. TAP funding of $2,433,000 in FY 1996 will allow TAP workshops to be presented to 178,000 servicemembers -- 82 percent of the anticipated 217,000 military personnel who will be separating from bases in the States. This represents a 35 percent increase in TAP's coverage of separatees when compared with the FY 1995 anticipated coverage. The Department of Defense TAP efforts overseas will continue to be supported by training provided to DOD's TAP facilitators by the National Veterans' Training Institute.

Another area of emphasis within VETS' administration budget for FY 1996 involves the full implementation of the Veterans' Reemployment Rights provisions of the new USERRA law. Approximately 2,000 such cases are expected

to be opened in FY 1996, and on-site investigations should increase by approximately 263 percent from the 380 cases that required on-site investigations in FY 1994 to approximately 1,000 cases requiring on-site investigation in FY 1996. VETS will continue its efforts to close more than 85 percent of active cases within 90 days and maintain the average number of days from opening to closure at less than 50 days.

VETS will reduce its staffing level for FY 1996 to 267 FTE positions, 5 fewer than in FY 1995 and 11 fewer than the FY 1994 actual level. Agency restructuring or streamlining associated with the reduction in FTE will be facilitated by the proposed increase of $315,000 to fund employee Permanent Changes of Station. This would enable the agency to relocate key employees to positions and locations where they can best be utilized. To ameliorate the impact of field and headquarters FTE reductions, the agency will enhance its automated management information systems for Veterans' Reemployment Rights cases, grant management, and quarterly reporting, and will achieve efficiencies through cross-training and expanded utilization of the remaining staff.

VETS' $2,822,000 request for the National Veterans' Training Institute will permit training of approximately 2,560 participants in NVTI courses. Currently in progress at NVTI are projects --

* to develop training in Total Quality Management (TQM) principles to facilitate better utilization of diminishing resources, with delivery of training is scheduled to begin in FY 1995 and extend into FY 1996; and
* to develop training for VETS' staff to enable them to assist employers and protected workers under the provisions of the new Uniformed Services Employment and Reemployment Rights Act of 1994.

The FY 1996 request for the assistance programs for homeless veterans, which is funded through the Employment and Training Administration's budget, is $5,011,000. It is expected that these resources will assist approximately 8,200 homeless veterans reintegrate into society through the provision of

supportive services and employment and training-related services. Housing resources to enhance reentry into the labor market will be arranged through community resources or other agencies. Approximately 4,000, or 49 percent of the veterans enrolled, are expected to be placed in permanent jobs.

I appreciate this opportunity to describe the FY 1996 budget of the Veterans' Employment and Training Service. I look forward to working closely with the Committee on behalf of our nation's veterans.

STATEMENT OF THE HONORABLE JESSE BROWN
SECRETARY FOR VETERANS AFFAIRS

FOR PRESENTATION BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
FEBRUARY 24, 1995

Mr. Chairman, members of the committee, I am honored to be here today to present the President's FY 1996 budget proposal for the Department of Veterans Affairs. In securing $39.5 billion for veterans programs, we were confronted with balancing our commitment to provide quality care and services against the backdrop of tighter fiscal restraints. Nonetheless, the budget proposal before you reflects the President's commitment to provide quality health care and benefits to our nation's veterans and their families.

At VA, we:

1) Provide quality health care.
2) Deliver timely benefits.
3) Bury our veterans with dignity.

This budget will improve our ability to perform these missions.

The 1996 medical care budget request is $17 billion. With this funding level, we plan to improve our managerial and streamlining operations to better meet the changing needs of our veterans. We have witnessed a dramatic shift in the composition of our veteran population. Our veterans are older and require more long-term care. To meet this demand, the medical care budget includes the necessary resources to open three new nursing homes. The $17 billion requested for VA medical programs will also support 201,254 FTE and provide care to 2.9 million unique patients.

In the provision of health care, the challenge before us is clear. We must continue our commitment to provide the best quality of care within current fiscal constraints. In response to this challenge, we have included numerous initiatives aimed at improving how we manage health care. In 1996, we plan a new corporate management structure that will provide the framework to decentralize authority and reduce organizational barriers. This new structure is expected to encourage and promote management innovations. Through our management plan, we will reduce many management layers that do not directly produce value-added services and plan to consolidate redundant medical services. With these efforts, we will not only enhance the efficiency of the VA system but also improve our ability to provide quality care to our veterans. In accordance with our goal to secure state-of-the art health care, we have increased funding for research.

As Secretary, I have visited VA hospitals in over 37 states. I have seen first hand the unacceptable condition of many of our facilities. Patients are being treated in substandard environments. Communal bathrooms and four or more patients in a room are not uncommon. In many areas, these conditions do not exist in the private hospital across the street. Our veterans deserve better.

I am pleased to say VA's total construction budget for FY 1996 will allow us to begin to address these problems. The Major Construction request is 45 percent more than VA received in FY 1995. The Major request funds six projects that will correct patient environmental deficiencies. Funds are also provided to improve veteran access in California and Florida. These funds, along with a Minor Construction budget increase of 50 percent, will enable us to enhance the health care environment to better meet the needs of our patients.

We have a better benefits delivery system now than we had two years ago. We have made some significant strides in decreasing the processing time for adjudicating claims. I can proudly say that we will meet our performance goals by reducing the timeliness for original compensation cases to 140 days in 1996, and we are well on our way to meet the goal of 106 days by 1998. The FY 1996 requested level will allow us to continue our progress toward implementing several reengineering initiatives which will streamline work processes, enhance service delivery and improve the overall quality of service.

I will now briefly summarize the 1996 budget request for VA, highlighting significant budget issues for our major programs:

MEDICAL PROGRAMS

Medical Care

The 1996 medical care budget request of $17 billion represents a $747 million increase over the 1995 enacted level. VA is also requesting 201,254 FTE in 1996 which is 267 FTE above the 1995 level. With these resources VA will care for all eligible veterans expected to seek care in 1996 --2.87 million unique patients-- an increase of approximately 43,000 eligible unique veterans projected over last year. This funding will result in over 1 million inpatient episodes --953,000 acute care and 109,000 long-term care-- and 26.3 million outpatient visits. This funding level will enable VA to enhance the level of care as well as open newly constructed and leased facilities.

In 1996, VA will open a replacement medical center in Detroit, Michigan. Nursing homes will open in Martinez, California; Marlin, Texas and Baltimore,

Maryland, and a spinal cord injury center will be added to the Dallas, Texas medical center. A 240-bed geropsychiatric facility will be opened in Marion, Indiana and VA will also open relocated and expanded outpatient clinics in Mayaguez, Puerto Rico and Redding, California.

To ensure that the veterans that use VA health services continue to receive quality care, we must make reinventing government a reality. We must change the way we currently do business and achieve real savings. To that end, VA will implement efforts to increase efficiencies and generate savings. These efforts include trimming unnecessary management layers, consolidating redundant medical services, and utilizing available community services.

A new management structure, irrespective of budget considerations, is needed to ensure that decisions affecting patients are made by management closer to the patient. This new corporate management structure, the Veterans Integrated Service Networks (VISNs), will provide the framework and line authority to streamline and consolidate services and administrative activities within a network of VA medical centers. Decentralization will promote management innovations to meet the workload targets and resource levels. We seek Congressional support for this reorganization. The Under Secretary of Health is in the final stages of developing a reorganization of VHA, and I intend to submit a plan to Congress for approval in the near future.

Medical and Prosthetic Research

A total of $257 million and 4,110 FTE is requested to support VA's medical and prosthetic research program. The funds available will support high-priority research projects that not only enhance the quality of veterans' health care but that of the entire population. With the resources provided in 1996, VA research will continue to address critical areas such as aging, AIDS, mental illness, heart disease, diabetes, cancer, and the health-related problems of Vietnam-era veterans, Persian Gulf War veterans, former prisoners of war and female veterans.

Medical Administration and Miscellaneous Operating Expenses

We are requesting $72.3 million for Medical Administration and Miscellaneous Operating Expenses. This level of funding will support 790 FTE and continue the effective administration of VA's medical and construction programs. In 1996, the Homeless Assistance staff funded from the General Operating Expenses appropriation, is being transferred to VHA. This staff coordinates VA's homeless program and promotes relationships with Federal, state and local agencies involved in homeless efforts.

Medical Care Cost Recovery

A total of $111.1 million and 2,275 FTE is requested to collect over $648 million from third parties, copayments, and receipts. Collections are estimated to increase by $62 million over the 1995 level.

The Administration has also proposed legislation to extend through 2000 the following provisions which were enacted or extended as part of OBRA '93 and are due to expire in 1998: (1) recover costs from health insurers for treatment of non-service-connected disabilities of service-connected veterans; (2) certain income verification authority, and (3) recover copayments for outpatient medication and nursing home and hospital care. Combined savings through FY 2000 for these three provisions are estimated to equal $798 million.

Health Professional Scholarships

The 1996 budget request of over $10 million for the Health Professional Scholarship program will help support approximately 427 new scholarship awards. This program has proven to be an excellent tool in assisting VA to secure a cadre of highly qualified health care personnel.

Grants for Construction of State Extended Care Facilities

The 1996 Appropriation request of $43.7 million will provide funding for nursing home projects and various other projects.

Major Construction

A funding level of $513.8 million is requested for the Major Construction program. The 1996 Major Construction budget request emphasizes increased access to care for veterans, improvements to patient environment and ambulatory care improvements. $154.7 million is requested to fund the construction of a new medical center and nursing home in Brevard County, Florida. This area has long been identified as an area in need of a greater VA presence due to its veteran population. Construction funding of $188.5 million is requested for a joint venture between VA and the U.S. Air Force to construct a new medical facility at Travis Air Force base in California. The new facility will replace the former Martinez VAMC, which was closed for seismic safety reasons in 1991.

The request places significant emphasis on improving the environment for veteran patients. Patient environmental improvement projects will be undertaken at the following medical centers: Lebanon, Pennsylvania; Marion, Illinois; Marion,

Indiana; Perry Point, Maryland; Reno, Nevada; and Salisbury, North Carolina. Outpatient improvements will be funded at the VAMC in Boston, Massachusetts.

VA is also requesting funding to develop additional gravesites at the Florida National Cemetery, allowing the cemetery to remain open.

Additional funds are included in the request for asbestos removal and hazardous waste abatement. Funding is also provided for VA to reimburse the Judgment Fund for the payment of settled claims.

Minor Construction

A total of $229.1 million is requested for the Minor Construction program. Our request includes $209.1 million for Veterans Health Administration projects hat emphasize outpatient improvements, patient environment and much needed infrastructure improvements. $42.6 million of these funds will be focused on outpatient improvements that will enable VA to continue its commitment to provide primary and preventive care in an ambulatory care setting. Additionally, $42.6 million will be earmarked to improve the patient care environment by providing private and semi-private bedrooms and private bathing facilities. $9.5 million is also included for National Cemetery System projects designed to alter, extend or improve existing national cemeteries.

Non-Recurring Maintenance and Repair

A total of $219 million is requested for the Non-Recurring Maintenance and Repair (NRM) program in the Medical Care appropriation. NRM resources will support replacement of additional building service equipment, minor structural improvements, and non-recurring maintenance and repair to existing structures. In addition to new requirements, funds will be applied to the backlog of routine maintenance projects such as repairing roofs, maintaining heat and ventilation and air conditioning systems, ensuring adherence to fire and safety codes, and making needed electrical and utility system repairs. Non-recurring maintenance funds will also be used to adapt systems and areas to comply with requirements to control the potential spread of tuberculosis.

BENEFIT PROGRAMS

The VA benefits programs continue to reflect this country's commitment to veterans who suffered disabling injuries during their service, the survivors of those who died from service-connected causes, needy wartime veterans who became disabled after service, those who wish to use education benefits to make a successful transition to civilian life, and those who can acquire a home through the VA home loan guaranty program.

The Compensation and Pensions account reflects an appropriation request of $17.6 billion as requested under current law. Reflected in this amount is $170.9 million in cost for the projected impact of the December 12, 1994, United States Supreme Court decision (Gardner v. Brown) which invalidated VA's interpretation of the law authorizing compensation for veterans disabled by VA medical treatment. This budget also reflects an increased cost of $153.3 million in 1995 due to this decision. FY 1995 costs can be funded within available unobligated balances. In 1996, 2.2 million veterans and 303,000 survivors will receive benefits under the Compensation program. The Pension program will provide benefits to nearly 409,000 veterans and 335,000 survivors. Our current claims adjudication backlog has been reduced from a high of 548,000 in FY 1993 to 449,000 cases in FY 1994 for compensation and pension.

Proposed in this budget is a 3.1 percent adjustment (COLA), based on the projected change in the Consumer Price Index, to be paid to compensation beneficiaries including Dependency and Indemnity Compensation (DIC) spouses and children. Proposed legislation extending through FY 2000 (OBRA '93) will allow: (1) spouses under the old DIC program, pay grade E-7 and above, to receive one-half of the increase in the base rate provided to spouses under the reformed DIC program each year through FY 2000, (2) compensation increases to be rounded down to the nearest dollar, (3) the monthly pension benefit for beneficiaries in Medicaid funded nursing homes, and (4) VA to match income records with the IRS and SSA for pension beneficiaries. Combined savings through FY 2000 for these four provisions are estimated to equal $1,674.2 million.

An appropriation of slightly over $1.3 billion is requested for the Readjustment Benefits program to provide education opportunities to veterans and eligible dependents and for various other special assistance programs for disabled veterans. Education benefits will be provided for over 559,000 trainees in 1996.

Legislation will be proposed to extend through FY 2000 the OBRA '93 provisions reducing by half the FY 1995 COLA in Montgomery GI Bill benefit payments. Estimated savings associated with this proposal for five years are over $202 million.

In 1996, VA's Home Loan Guaranty program anticipates approving nearly 325,600 loans totaling $31.3 billion at a loan subsidy value of about $489 million. In FY 1996, losses on defaulted guaranteed loans, acquisition of homes and other costs associated with direct loans obligated and loan guarantees committed prior to 1992 are estimated to be slightly over $1.2 billion. Sufficient funds are available to fully fund these estimated obligations.

The following legislative initiatives are being proposed to improve VA's housing program operations and help reduce program expenses. The Administration has proposed legislation which will extend through 2000 three provisions of OBRA '93 due to expire in 1998: (1) the loan origination fee increase of .75 percent; (2) the 3 percent fee for multiple home loans with less than 5 percent down; and (3) current law on resale losses on loans. The interactive effects of these proposals result in an estimated savings of $371.9 million for FYs 1999 and 2000. Also included in proposed legislation are provisions that would: (1) require a two percent fee and a ten percent down payment on manufactured home loans, and (2) repeal the restriction of collection of Loan Guaranty Debts. The combined five-year total of estimated savings for these two provisions is $89.7 million.

GENERAL OPERATING EXPENSES

A total of $915.6 million is requested for the General Operating Expenses (GOE) appropriation in 1996. This funding level, combined with $131.7 million of administrative costs associated with VA's credit programs (funded in the loan program accounts per Credit Reform provisions), and $12.2 million in reimbursements from the Compensation and Pensions (C&P) account for costs associated with the implementation of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), together with other reimbursable authority, will provide $1.15 billion to support operations funded in the GOE account.

Veterans Benefits Administration

The 1996 budget request for the Veterans Benefits Administration (VBA) is $694.1 million with an average employment level of 13,032. This request, combined with $126 million associated with Credit Reform funding, will result in an increase of $22.2 million in discretionary funding over the 1995 level. Average employment is 188 below the 1995 level primarily as a result of VBA's streamlining plan. This reflects a reduction in workload of 88 reimbursable FTE (primarily cooperative support units), combined with a minus 100 GOE funded FTE, primarily from support staff.

The timely processing of claims remains one of VBA's foremost concerns. While VBA's total 1996 employment is less than the 1995 level, FTE in the Compensation and Pensions (C&P) program will remain constant in 1996. This employment level, along with continued efforts to modernize the workforce and reengineer the way benefits are delivered, will enable VBA to reduce the backlog of claims and improve timeliness. In fact, VBA has already begun to experience improvements in these areas. The average length of time required to complete an original compensation case dropped from 212 days in May 1994 to 168 days in January 1995. Under this budget request, VBA expects to meet its performance goals by reducing the timeliness for original compensation cases to 140 days in 1996 and 106 days in 1998.

In 1996, VA's Vocational Rehabilitation program for service disabled veterans will rehabilitate 5,400 veterans, generating approximately $116 million in earned income. It is estimated that the average rehabilitated veteran achieves a 415 percent increase in salary. VBA will continue to provide service through partnership with external providers. These providers include rehabilitation facilities, education and training institutions, rehabilitation personnel with the state departments of vocational rehabilitation, and independent contractors to provide specific rehabilitation and counseling services. Through these partnerships, a number of research and demonstration projects will be initiated in 1996.

In addition, VBA will continue to implement its modernization program with the award of Stage 3 in 1996. Stage 3 will provide for centralized applications at the National Service Centers and on-line file contingency and direct processing support for Insurance and other VBA applications. VBA's modernization program is a part of a long term benefits delivery redesign called VETSNET. VETSNET will be developed based on a veteran-centered approach and will use today's business practices to remain flexible in serving the many needs of veterans. The first phase of VETSNET, which is the redesign of the C&P delivery system, is expected to be completed in 1996.

National Cemetery System

For FY 1996, the National Cemetery System will operate with a budget of $75.3 million and 1340 FTE. This represents an increase of $2.7 million over the FY 1995 level and supports a stable level of FTE. The additional dollars will support increased pay requirements and inflation. Projections indicate that interments will rise by 2.7 percent; the number of graves to be maintained by 2.6 percent; and acres of grounds to be maintained by 5.4 percent. In addition, 292 acres will be developed within the system in FY 1996.

General Administration

The General Administration 1996 request is $221.5 million and 2,903 FTE. This total reflects an increase of $7.4 million above last year's level and a reduction of 19 FTE. This activity sustains the pay and personnel system and the reporting systems necessary to account for much of VA's resources. Funds in this account also help provide legal services to the offices that service America's veterans and provide appeal opportunities for veterans seeking benefits. It also provides resources to administer the Contracts Disputes Act.

General Counsel

In FY 1996, VA's General Counsel will begin to streamline its field operations by consolidating 52 district counsel offices into approximately 25 regional counsel offices. This effort will result in a smaller, more efficient workforce while continuing to provide competent and timely legal service to all VA field components. In addition, the General Counsel will proceed with its Automated Data Processing modernization effort which began in FY 1995. This initiative is closely coordinated with the field restructuring to avoid duplicative efforts.

Board of Veterans' Appeals

The Board of Veterans Appeals (BVA) continues to address the unacceptable amount of time it takes to process an appeal. In FY 1996, BVA is requesting an additional 28 FTE for a total of 477 FTE. This increase in staff will result in a reduction of 58 days in the average response time to 687 days.

PAY VA

PAY-VA is an initiative to replace VA's 30 year old payroll and personnel reporting system. It will improve the accuracy and integrity of data, reduce error rates and reduce time and staff needed to make future payroll and personnel changes. This budget request includes $5.9 million for this initiative.

CLOSING

Mr. Chairman, the challenges before us are great but they do not exceed our dedication and commitment to ensuring the best possible care and service to our Nation's veterans. We owe our veterans the best we can provide. I look forward to working with you and the members of this subcommittee to meet these challenges. This completes my prepared statement. I will be pleased to answer any questions the committee might have.

STATEMENT OF

JAMES N. MAGILL, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

FY '96 DEPARTMENT OF VETERANS AFFAIRS BUDGET

WASHINGTON, D.C. FEBRUARY 24, 1995

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

The VFW appreciates the opportunity to participate in this morning's hearing on the Department of Veterans Affairs Fiscal Year 1996 budget. The VFW is again proud to be a co-author of the veterans *Independent Budget* (*IB*) and, as in the past, our contribution lies in the construction aspect of this document. Therefore, this statement by the VFW will concentrate on the VA's construction program.

In view of the fact that the VFW is committed to reforming the VA's eligibility criteria for those receiving health care at VA medical facilities, we are particularly concerned that VA has the physical capability of providing care to an expanded veteran population.

The VA construction program was re-organized in FY 1993 as a result of internal and external critiques. Most of the program was assigned to the Veterans Health Administration (VHA) creating an Associate Chief Medical Director for Construction Management (AsCMD for CM) and assigning some functions to the Associate Chief Medical Directors for Operations and Resource Management. This organizational change has resulted in functional CM teams ready to respond to local and facility director needs. A specific team is assigned for VBA and National Cemetery Service requirements. Streamlining will allow VA to reduce authorized full-time equivalent employees from 314 to 249; VA has already accomplished half of the reduction. However, no staff reductions were taken in the functions assigned to Operations and Resource Management.

CM currently supervises $3.6 billion worth of construction projects. It has embarked on a philosophy of customer service. Central to the adaptation of this philosophy is the development of a total quality project concept which emphasizes "partnering", a system DoD and the Corps of Engineers use to work more effectively between field and CM staff. CM is also delegating more of its construction efforts to field managers and staff. The IBVSOs support these changes.

Efforts are underway to develop a seamless time line from design to construction. The IBVSOs applaud such efforts. To the extent VA can reduce the design to move-in time line to five years or less, funds will be saved and veterans better served. The current plan of beginning design with 35-percent of funding, stopping, and waiting for additional funding tends to reduce quality and increase costs. Medical administration executives consider that a facility which requires more than five years from design to move-in is obsolete on activation.

Medical facility personnel have been trained in construction project supervision. The program, however, was only about three hours in length. The *Independent Budget* co-authors believe at least a one week program should be offered to appropriate staff in each designated veterans service area.

CM has delegated authority to medical facility directors to lease up to 10,000 square feet of space, costing up to $300,000 -- the maximum delegated by law -- to meet outpatient clinic needs. The IBVSOs applaud such efforts. Expedited lease acquisition provides facility directors greater flexibility and control in meeting their patients' needs for accessible ambulatory care by accelerating the leasing process. Leasing space at the time of initial site inspection, rather than delaying the process through a formal Solicitation for Offers, grants VA facility directors more flexibility in responding expediently to local market conditions. This is particularly important in states currently implementing health care reforms that may offer veterans cost competitive alternatives to receive care form more accessible community providers. However, Central Office is now having reservations about granting facilities this degree of autonomy and plans to revisit the issue.

The National Institute of Building Sciences (NIBS) performed a review of the CM program at the request of the Department. Several issues in *VA Cost and Standards Study, Phase II*, June 17, 1993, bear emphasis. The IBVSOs believe additional studies should be carried out by VA staff or under the leadership of NIBS:

•Construction Management's re-organization is imperfect. Elements that were delegated to Resources Management in the reorganization should be returned to CM. CM and Resources Management often reach contradictory decisions on projects, equipment, or budget issues. Resources Management sets policies which directly impact construction costs, but only CM is held accountable for cost. Returning some Resources Management functions to CM would allow for better coordination of the two offices' functions and allow further staff reductions by eliminating overlap.

•VA designs to the highest level of architecture and engineering. For example, VA designs require that all rooms be handicap accessible. This standard far exceeds guidelines for the Americans with Disabilities Act (ADA) for general purpose hospitals and long-term care facilities. Only rehabilitation facilities require such a stringent code. VA could realize cost savings by applying the appropriate ADA guidelines to its facilities or by setting a higher standard only when necessitated by the facility's user population.

VA also applies natural hazard mitigation standards differently than the private health sector. The latter designs and builds for protection of life. VA designs for continued operational capability -- a much more costly venture. VA has developed its own seismic standards; whenever a state has higher standards, VA uses those. Planning and application of natural hazard mitigation codes should be better coordinated on a priority basis with the VA National Health Care Plan (VANHCP).

•VA's Hospital Building System (VAHBS) has been criticized as cost-additive for years. NIBS could not reach a definitive answer in its evaluation, but cast some doubt on the process. VAHBS has been most severely reproached for its extensive use of interstitial space which adds to initial cost. Under the leadership of NIBS, an external group should validate the cost effectiveness of VAHBS. The IBVSOs also believe the VAHBS study should arrive at a life-cycle for such facilities as hospitals, nursing homes, clinics, administrative offices (VBA). Establishing life-cycles for major delivery components allows VA to avoid the appearance of building for 100 years.

A study should also further identify those services appropriately "in an envelope" using interstitial space and those services not requiring it. Designs must be flexible to respond to future needs and technological advances. However, services using interstitial space should have reasonable expectations for long-term expansion and be able to clearly validate their need to justify the additional costs.

FY '96 Budget

***Independent Budget* Funding Recommendations for FY 1996**

Major Construction

The *Independent Budget* recommends a $490 million Major Construction appropriation for FY 1996. The majority of the *IB*-recommended appropriation is for leases for outpatient clinics and nursing homes. In these uncertain times, the *Independent Budget* co-authors believe that leasing is preferable to new construction. Leasing offers an affordable, expedient and impermanent solution to the immediate need for VA capacity in the outpatient and nursing home venues. The *IB* funding recommendation accommodates the annual cost of leasing three nursing homes. It also accommodates annual leasing costs for approximately 100 outpatient clinics. Funding for leased clinics complements other *IB* recommendations for grants to enhance ambulatory care. VA must also increase its in-house capacity and offer VA care in remote community settings such as vet centers.

Replacement and modernization costs also comprise a significant portion of the Major Construction budget. The *Independent Budget* co-authors believe that VA should be considering acquisition and conversion projects as an alternative to new construction funded through this account. Facilities available for acquisition offer VA an opportunity to realize substantial savings and activate beds more quickly than a "ground-up" construction project would.

The *Independent Budget* co-authors recommend that some new construction complement leasing and bed conversions as a means of increasing available VA-operated beds for nursing home care. The *IB* Major Construction budget includes funding for **four** new nursing homes. It also recommends funding for **two** new VA domiciliaries. Domiciliaries offer shelter and often some social services for aging, mentally ill, and homeless veterans and those with substance abuse disorders.

Minor Construction

The FY 1996 *Independent Budget* recommends a $269.8 million appropriation for Minor Construction, which funds smaller facility construction projects. The increment requested reflects the IBVSOs' growing concern about VA facilities' urgent need to update and repair facilities. Most VA facilities were constructed during the 1950s and updating and repair needs are increasing rapidly. Earlier appropriations have fallen far short of addressing these needs. Needs for repairs, beautification, installment of amenities (like phone lines), and mission conversions should be system-wide priorities, especially if VA medical centers enter competition with private-sector providers.

VA should use $1.8 million of the Minor Construction fund to convert unused and unneeded hospital beds to nursing home care. The IBVSOs recommend that VA convert the remaining **thirty** beds from its FY 1994 plan, accomplish those it plans for FY 1995, and convert **twenty-five** 120-bed wards in FY 1996.

Parking Garage Revolving Fund

The FY 1996 *Independent Budget* recommends a $1.5 million allocation to this fund, which finances VA facility parking garage construction and operation. Reasonable parking access is essential to patient care. If the VA is to be competitive, veterans will need access to available parking within reasonable distances to the medical facilities. Eventually, parking garage revenues should pay for new projects.

VA should also promote private-sector construction of parking garages through the Enhanced-Use Leasing Program. Enhanced use agreements would allow VA to provide accessible parking to its patients and their families without having to recognize the associated construction investment building such facilities entails. The IBVSOs encourage VA to investigate further utilization of this program to build parking garages where they are needed.

Grants for the Construction of State Extended Care Facilities

The state home program greatly enhances VA's extended care workload capacity. This appropriation provides grants to help states acquire or construct state domiciliary and nursing homes for veterans. It also provides grants to assist in the expansion, remodeling, or alteration of existing facilities, including state home hospital facilities.

The Grants to State Extended Care Facilities are mutually beneficial to the states and VA. States benefit by receiving federal money to add nursing home capacity for state residents with dual eligibility for VA and state programs such as Medicaid. Under these grants, states are responsible for at least 35 percent of nursing home construction costs. States pay at least 50 percent of treatment costs, which are reimbursed on a per diem basis; and VA pays a portion of the per diem cost.

Congress should encourage and fund Grants for the Construction of State Extended Care Facilities wherever states will participate. For FY 1996, the *Independent Budget* recommends a $180 million appropriation for these grants.

Grants for the Construction of State Veterans' Cemeteries

The state program makes grants to states to help them establish or improve state-owned veterans cemeteries. VA anticipates that it will need $6 million to fund program requirements in FY 1996.

Grants to the Republic of the Philippines

Grants to the Republic of the Philippines help to replace and upgrade medical equipment and rehabilitate physical plants and facilities. The Veterans' Memorial Medical Center at Manila provides care to U.S. veterans. The facility is now more than 40 years old, so replacement and rehabilitation are major needs. The IBVSOs recommend a grant of $500,000 for FY 1996.

Investment Fund

If the Veterans Health Administration is to operate in the emerging health care environment, retaining its patient base as well as attracting new patients to the system who will pay for their care through third-party reimbursements, then VA must provide services in accessible, attractive and modern care venues. The *American Health Security Act* proposed an investment fund for VA that would have significantly augmented Minor Construction funding for modernization and infrastructure improvement projects. VA has many old and unattractive facilities. it also lacks amenities commonly found in the private sector, like telephones in each patient room and private or semi-private bathrooms. VA spending priorities for this fund were to specifically focus on redressing these problems.

Not enacting this legislation denied VA the investment fund it desperately needs to correct its infrastructure deficiencies. Correcting these critical deficiencies would have enabled VA to become more competitive with other health care providers in local markets. Consequently, the IBVSOs still support the creation of a $3.3 billion dollar investment fund for infrastructure improvement, believing that such a fund is essential for enabling VA to participate in the new health care environment under state and market-driven health care reform. A one-time appropriation of $3.3 billion is requested for this fund in FY 1996.

Mr. Chairman, this concludes the testimony of the VFW. I will be pleased to answer any questions you may have at this time. Thank you.

HOUSE VETERANS' AFFAIRS COMMITTEE
HEARING ON
DEPARTMENT OF VETERANS AFFAIRS
FISCAL YEAR 1996 BUDGET
February 24, 1995

Highlights of Testimony

Veterans of Foreign Wars, James N. Magill, Director National Legislative Service:

- VFW concentrates on the construction programs, which is their responsibility for the Independent Budget.

- applauds design-build concept for construction funding.
  - says design-build shortens construction timeframe.

- requests a one week program be developed for VSO personnel in construction project supervision.

- recommends cost-savings by having VA follow construction standards for general purpose hospitals and long-term facilities as set by Americans With Disabilities Act rather than a higher standards as is currently the practice.

- recommends a study be undertaken to review VA's Hospital Building System (VAHBS).
  - study would identify cost-savings in VAHBS.

Major Construction Budget
- recommends leasing as preferable to new construction to meet immediate need for VA capacity in outpatient and nursing homes.
  - Independent Budget provides leasing costs for approximately 100 outpatient clinics.
- recommends VA change its Construction budget to highlight acquisition and conversion projects rather than replacement and modernization.
  - acquisition projects offer quicker response to needs than does a "ground-up" construction project.

Minor Construction Budget
- cites growing need to update and repair facilities.
- recommends VA use $1.8 million to convert unused and unneeded hospital beds to nursing home care.

Parking Garage Revolving Fund
- recommends VA promote private-sector construction of parking garages through an Enhanced-Use Leasing Program.

Grants for the Construction of State Extended Care Facilities
- recommends $180 million appropriation versus $43.7 million in VA budget for FY 1996, reduction of $3.4 million from FY 95 level.

Investment Fund (as contained in 1995-Clinton Health Security Act)
- requests a one time $3.3 billion appropriation to enable "VA to participate in the new health care environment under state and market-driven health care reform."



PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF

RUSSELL W. MANK

PARALYZED VETERANS OF AMERICA

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

THE *INDEPENDENT BUDGET* AND THE PRESIDENT'S

BUDGET REQUEST TO CONGRESS FOR FISCAL YEAR 1996

FEBRUARY 24, 1995

Chairman Stump, Ranking Minority Member Montgomery and Members of the Committee, Paralyzed Veterans of America (PVA) is honored to be here today to present our views on the fiscal needs of the Department of Veterans Affairs (VA) programs. For innumerable years PVA presented its views on the resource requirements of VA medical programs. We are proud to be among the *Independent Budget* coauthors, a group that has worked together for the last eight years assessing the needs of all VA programs, with increasing agreement on the most pressing issues facing the veterans' community today. We are aware that this Committee has worked with us as

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agents of VA reform and as veterans' advocates. We have seen some fruits of our labors together, in increased funding for special programs and introduction and enactment of legislation that we have advocated. We thank you for being a steadfast source of support to the veterans' service organizations as we attempt to bring longstanding components of our mutual agenda to fruition.

Notwithstanding our past accomplishments, we of the *Independent Budget* feel that this is a year in which we must change our approach to securing adequate funding for the Department of Veterans Affairs Medical System. This is the year when the Department of Veterans Affairs must break its complete dependence on discretionary appropriations. The *Independent Budget* has proposed a plan to set VA on this course.

Mr. Chairman, in past years, the *Independent Budget* coauthors have viewed the President's budget request as a starting point in our negotiations with Congress for funding. This year we are told that we should view the President's budget as a "high watermark." We are appreciative of Secretary Brown's and the Administration's efforts on behalf of veterans in this budget. Veterans' programs fared well in comparison to many other discretionary programs. PVA sincerely hopes that the members of this Committee will do their best to protect the President's VA budget request from poorly conceived and unwarranted cuts. We acknowledge the fiscal constraints facing this Administration and this Congress, and understand that finding the means of funding veterans' programs is difficult. Still, even the President's request does not reflect critical changes that must occur within VA—changes we are here to address today.

Let us be clear about where we stand. We are behind this Congress' efforts to reduce programs that have outlived their usefulness and are perpetuated solely because of the bureaucracies that now engulf them. We know that most of the members of this Committee join us in believing that the Department of Veterans Affairs medical programs were created, and exist today, to fulfill unique and important roles in our society. These programs are literally a matter of life and death. We are also behind this Congress' efforts to make "big government" programs more efficient, with more opportunities for local management to make meaningful decisions. We understand that the VA is on the verge of undergoing significant reform to gain such local authority and bring management closer to the patient. We plan to work with Congress and the Administration in educating our constituents as to the importance of such changes, but at the same time, the Congress and the Administration must work with us to ensure that the VA can fulfill its obligations to America's veterans even while its resources and management are vastly restructured.

We begin this year's *Independent Budget* medical programs section with a quotation from Oliver Wendell Holmes..."I find the great thing in this world is not so much where we stand, as in what direction we are moving: To reach the port of heaven, we must sail sometimes with the wind and sometimes against it—but we must sail, and not drift, nor lie at anchor." External changes continue to beset our medical care system. For too long now, Mr. Chairman, many in the veterans' community have been content to do things in the same way, resulting in predictable outcomes from year to year. This Congress offers us a chance to begin anew. In such an environment, rife with as much opportunity as challenge, the *Independent Budget* proposes a new approach to attaining the funds the VA needs to fulfill its unique missions for America and for veterans. For years you have

heard the veterans' service organizations plead for more funding. This is an approach that, although warranted, is no longer constructive. Mr. Chairman, we are here today to say that we *can* accept the President's Budget Request *if* together, we can find the way to achieve the rest of our legislative agenda. We can do this *without* increasing the limited discretionary funds Congress allocates for veterans' medical programs. We can do this *as* we *increase* access to veteran patients and selectively allow their dependents to enter the system. But to achieve these goals we need the cooperation and commitment of this Committee. We appreciate this Committee's continued counsel to seek the cooperation of other Committees with jurisdiction over VA's funding, and we plan to do so. The changes we propose are not easy. The *Independent Budget* coauthors readily admit that we do not have all of the answers. But Mr. Chairman, we feel that your Committee, and the Senate Committee on Veterans' Affairs, are the essential link between making our vision for the VA's future a reality. It is only through you that all of us can succeed in turning the VA medical programs toward a bright future.

This year, the *Independent Budget* coauthors significantly revised the approach used in developing the VA medical care budget. To allow for greater comparison with the President and Congress' funding recommendations, we began this year with *your* baseline, the appropriation the last Congress made to the VA medical care account. In years past, we recommended only an appropriation for medical care. This year, we recommend not only an appropriation, but also a recommended budget authority. Recommending a budget authority allows us to marry our fiscal agenda with our legislative agenda: the two have been isolated from one another until this year.

For fiscal year 1996, we propose a four-point plan which requires new legislation for VA to reform access criteria, treat new patient populations, capture new funding streams, and emphasize the provision of specialized services in which the VA has unmatched expertise. This plan *expands access* to services for veterans and their families and *does not require increased federal government spending*.

The *Independent Budget* recommends that Congress authorize a $19.5 billion budget for VA medical care, but only $16.6 billion of this funding must come from Congressional discretionary funds. *With* the new authorities the *Independent Budget* proposes, Congress can appropriate $400 million less than the President has requested from Congress for fiscal year 1996. *Without* all of the proposed new authorities, Congress must appropriate $18.8 billion for VA medical care, fully $1.8 billion more than the President's request for fiscal year 1996, in order to achieve the same *Independent Budget* targets and initiatives. In other words Mr. Chairman, the status quo is more expensive than embracing change.

The savings that can be realized can only be realized as part of the overall package. Part of this reform package is allowing the VA to retain third party payments, including Medicare reimbursement. Currently, the VA has to turn over third party reimbursements collected from insurers to the U.S. Treasury. VA estimates that it has the potential to collect at least $800 million next year. We must see legislation approved by this and other Committees allowing the VA to keep its third party reimbursements. We are going to have to see legislation approved by other Committees in the House and Senate allowing the VA to collect, and to retain, Medicare

reimbursement from current high income, non-category A veterans. Medicare reimbursements that could accrue to the system from current higher income non-category A veterans are estimated to amount to $133 million. Private sector hospital systems can do this, why not allow VA?

Let me go over this again, Mr. Chairman. I want to make certain that you, the members of this Committee, and the people in this hearing room are absolutely clear on this point. We are not advocating a cut in VA spending. Our proposal would reduce the pressure on the VA Congressional appropriation and the deficit while improving the overall VA financial base by allowing VA to seek out and retain third party reimbursements. You cannot just make the cut on the discretionary side, ignore third party reimbursements, and claim the *Independent Budget* told you to do so.

The *Independent Budget* does not say, "Cut the VA appropriation by $2.1 billion from our target recommendation of $18.8 billion and the system will be able to achieve eligibility reform and provide the full continuum of care to all eligible veterans." The *Independent Budget* does say that you can achieve reductions in domestic discretionary appropriations by making the VA more efficient, but only by allowing the system the ability to recoup and offset discretionary dollars lost in the annual appropriation by retaining third party reimbursements.

The following chart shows how we arrive at these figures.

FY 1996 Funding Needed for VA Medical Care

If We Do Nothing:

FY 1996 Current Services (Built on FY 1995 Appropriation)	$17.6 billion
Plus Additional Initiatives/Improvements (equipment/maintenance backlog, programs etc.)	$18.8 billion
Administration's FY 1996 Request	$17.0 billion
FY 1996 Budget Shortfall	**$ 1.8 billion**

If We Enact Eligibility Reform:

Total Savings From Discretionary Appropriations From Efficiencies Shifting Care From Inpatient To More Cost Effective Venues	$ 2.9 billion
Minus Additional Costs From Additional Outpatient/Nursing Home Care Workload	$ .7 billion
Net Savings From Discretionary Appropriations	$2.2 billion

Discretionary Appropriations Needed If We Do Nothing	$18.8 billion
Net Savings From Efficiencies	$ 2.2 billion
Discretionary Appropriations Needed After Savings From Eligibility Reform Efficiencies	**$16.6 billion**

Funding Needed From Third Party Reimbursements
And Alternative Third Party Sources
To Offset Reductions in Discretionary Appropriations

Projected Retention of Third Party Reimbursements **(BUDGET NEUTRAL with offset)**	$ .8 billion
Medicare Reimbursement from Current Users Higher Income, Non Category A Veterans **(BUDGET NEUTRAL)**	$ .1 billion
Total Third Party Reimbursement: Current Users (BUDGET NEUTRAL)	**$ .9 billion**
Third Party Reimbursement from New Users Dependents, New Paying Veterans **(BUDGET NEUTRAL)**	$2.0 billion
Total Third Party Reimbursements Retained (BUDGET NEUTRAL)	**$2.9 billion**

Discretionary Appropriations	$16.6 billion
Plus Reimbursements From Non Discretionary Accounts And Third Parties **(BUDGET NEUTRAL)**	$ 2.9 billion
Total Budget Authority From Appropriated And Non-Appropriated Funds	$19.5 billion

FY 1995 Appropriation	FY 1996 President's Budget Request to Congress	FY 1996 *Independent Budget* Recommended Current Services Level	FY 1996 *Independent Budget* Recommended Appropriation **(Under Current Legislation)**	FY 1996 *Independent Budget* Recommended Budget Authority **(Under New Legislation)**	Required Appropriation Under New Legislation
$16.2 billion	$17 billion	$17.6 billion	$18.8 billion	$19.5 billion	**$16.6 billion**

Congress can only recognize these savings by following the comprehensive strategy outlined in the *Independent Budget.* This strategy includes:

- ELIGIBILITY REFORM: Congress must authorize the VA to give its veteran patients care in the most appropriate setting. Many VA patients are only eligible for inpatient hospital care. Hospital care is more expensive than outpatient or nursing home care, care which would be more appropriate in many circumstances. Numerous studies have found that many VA patients admitted on an inpatient basis would be better served by receiving outpatient care. Eligibility reform would allow VA clinicians to move patients into more appropriate care settings. The *Independent Budget* estimates that given this legislative authority, the VA could save $2 billion, money desperately needed to improve health care services for veterans.

  In the emerging health care environment, accessible ambulatory care is an important

feature of the veterans' health care system. Accessible entry points to the system - locations that are close to veterans' homes - are essential for veterans to receive adequate primary and preventive care. The VA can improve its management of patients' care by better controlling their access. This can be accomplished by creating efficient intake (or triage) systems, providing preventive care at appropriate intervals, and monitoring patient health, particularly high-risk patients through primary care clinics. Congress must enable VA to provide all of its patients outpatient care, thereby allowing VA clinicians to provide effective care management.

Veterans need alternatives for long-term care and the VA must develop them rapidly to meet growing demand. Nursing home care and many other types of long-term care available in the community, such as adult day health care, community residential care, and hospital based home care, is less expensive than hospital inpatient care.

- PERMISSION TO TREAT NEW PATIENTS: Congress should allow the VA to treat dependents and higher income veterans where the local hospital director believes it serves the veterans' best interest. This is *not* a new entitlement. The new patients would be required to pay for their care. The VA would collect and retain these reimbursements. Veterans and their dependents would benefit by having increased access to the health care system. This proposal is budget-neutral. The *Independent Budget* estimates that VA could provide $2 billion of additional services to these new populations with no additional discretionary funds.

- NEW SOURCES OF FUNDING: In addition to the funding brought in from new patients, Congress should enable the VA to retain funding from the patients it already treats *without further burdening* veterans. VA already collects from veterans' insurers for their non-service-related care, but it must give the money to the U.S. Treasury. The VA should be allowed to retain these funds to improve its facilities and create more access for veterans. Congress should also allow the VA to collect Medicare reimbursement for higher-income veterans and their dependents who are eligible for Medicare.

- CONCENTRATION ON VA'S SPECIAL MISSIONS: While the *Independent Budget* proposes strategies to make the VA health care system more efficient and cost effective, VA should never gain efficiencies at the expense of its special missions. VA's new Under Secretary for Health, Kenneth Kizer, MD, recently asked the members of the *Independent Budget* coalition to list programs that needed special attention under a new management structure. The *Independent Budget* coauthors decided that spinal cord dysfunction medicine, blind rehabilitation services, prosthetics and orthotics services, amputee clinic teams and Preservation Amputee Care and Treatment (PACT) Program, and Post Traumatic Stress Disorder Treatment comprised the core of VA health care, because they treat veterans for conditions they experience disproportionately, and for which VA has established unique expertise.

Mr. Chairman, none of these recommendations are new to you or to this Committee. Eligibility reform has been the battle cry of the veterans' service organizations for almost a decade—we have seen you

propose sound legislation responding to this need. In your new position of leadership, please help us find the way to help you get this done. We need this Committee's guidance and support in approaching other Congressional entities. To accomplish our goals, we know that we must acquire new funding streams outside of discretionary funds. In our plan, we ask Congress to allow VA to capture funding from veterans' insurers and, for some veterans, who VA was not explicitly charged with serving, from Medicare. These new sources of funding are critical to VA's reform efforts. Without them we will be another voice in the wilderness clamoring for more of our share of dwindling discretionary funds.

In this fiscal environment, the *Independent Budget* coauthors believe it is imperative to find alternate funding mechanisms for the Department of Veterans Affairs programs. We believe that the *Independent Budget* offers Congress a realistic strategy that does not increase the deficit, nor burden the taxpayer. More importantly, it allows Congress to keep its promises to veterans and other Americans in a time of fiscal austerity.

Thank you for this opportunity to testify. We look forward to continuing to work with you and this Committee in the future.

VA APPROPRIATIONS BY ACCOUNT
(IN THOUSANDS)

	FY 1995 Appropriation	**FY 1996 President's Budget Request**	**FY 1996 *Independent Budget* Current Services Level**	**FY 1996 *Independent Budget* Recommended Appropriation**	**FY 1996 *Independent Budget* Recommended Budget Authority**
General Operating Expenses	$ 994,612	$ 1,024,451	$ 1,323,404	$ 1,381,839	$ 1,381,839
Benefits Programs	$19,572,224	$19,656,086	$19,697,542	$19,697,542	$19,697,542
Medical Programs	$16,546,602	$17,301,135	$17,971,324	$19,154,223	$19,967,007
Construction Programs	$ 576,803	$ 787,640	$ 947,806	$ 947,806	$ 947,806
TOTAL	**$37,690,241**	**$38,769,312**	**$39,940,076**	**$41,181,410**	**$41,994,194**

STATEMENT OF
RICHARD F. SCHULTZ
NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE
FEBRUARY 24, 1995

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than 1.4 million members of the Disabled American Veterans (DAV) and its Women's Auxiliary, I am pleased to present DAV's views on President Clinton's budget. I am also pleased to provide you with the collective views of the American Veterans of World War II, Korea and Vietnam (AMVETS), DAV, Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars (VFW) on the budget for the Department of Veterans Affairs (VA) as set forth in these organizations' *Independent Budget*.

Fiscal Year (FY) 1996 is the ninth consecutive year the Independent Budget Veterans Service Organizations (IBVSOs) have joined together to formulate an alternative, realistic budget recommendation for VA. As in prior *Independent Budgets*, DAV has authored that part dealing with "Benefits Programs" and "General Operating Expenses" (GOE).

The IBVSOs appreciate the recognition our budget has received from you in the past. We hope that our analyses of VA's funding needs will be helpful to you. We believe our budget truly provides a more realistic assessment of the resources necessary to continue an acceptable level of benefits and services to our nation's veterans.

The Administration's FY 1996 budget for VA requests budget authority of approximately $39.5 billion to provide benefits and services for our 26 million veterans and approximately 44 million family members. This request is an increase of $1.3 billion above the FY 1995 budget. Of the $1.3 billion increase, approximately 1 billion represents an increase in discretionary spending, with the remainder representing an increase in mandatory spending.

The Administration's budget includes:

* A $747 million increase for the Veterans' Health Administration (VHA), with a total request for $17 billion and 201,254 FTE, an increase of 267 employees.

* A $22 million increase for the Veterans' Benefits Administration (VBA), with a total of $820 million and FTE of 13,032, a reduction of 188 employees.

* A $2 million increase for the National Cemetery System (NCS) with a total request for $75 million and continuation of last year's authority for 1,340 FTE.

* A $211 million increase for construction programs, with a total request of $788 million.

* An increase of 28 FTE for the Board of Veterans' Appeals (BVA), for a total of 449.

* A 3.1 percent cost-of-living adjustment (COLA) in compensation and Dependency and Indemnity Compensation (DIC).

The Administration's budget proposes several cost-saving measures:

* Round down of cost-of-living adjustments in compensation and DIC benefits for FY 1996 through FY 2000.

* Extension of the sunset provision in current law, from FY 1998 through FY 2000, to allow VA to access Internal Revenue Service and Social Security Administration Records for income verification in those VA benefit programs that are based on income.

* Extension, from FY 1998 through FY 2000, of the sunset provision in current law which limits the rate of pension to $90 a month for certain recipients of Medicaid-covered nursing home care.

* Provision for reduction by one-half the authorized annual increase in Montgomery G.I. Bill educational benefit payments from FY 1995 through FY 2000.

* Extension of the sunset provision in current law, from FY 1998 to FY 2000, that allows inclusion in the "net value" calculation the amount of expected losses on resale of foreclosed properties with VA guaranteed loans.

* Extension of the sunset provision in current law, from FY 1998 through FY 2000, that allows collection of a 3 percent fee for reuse of VA loan guaranty without downpayment on the loan.

* Extension of the sunset provision in current law, from FY 1998 through FY 2000, that requires payment of a 0.75 percent funding fee on loans refinanced to obtain a lower interest rate.

* Increase in the funding fee, from 1 percent to 2 percent, and increase in the required downpayment, from 5 percent to 10 percent, for VA loans on manufactured homes.

* Repeal of the restriction in current law, in cases of non-judicial foreclosure, that prohibits collection of loan guaranty debts from Federal salaries and Federal income tax refunds.

* Extension of the sunset provision in current law, from FY 1998 through FY 2000, to authorize VA to collect a $2.00 pharmacy copayment for certain prescriptions and a $5.00 and $10.00 per diem charge for certain nursing home and hospital care.

* Extension of the sunset provision in current law, from FY 1998 through FY 2000 to authorize income verification, for medical care purposes, through the Internal Revenue Service and the Social Security Administration.

* Extension of the sunset provision in current law, from FY 1998 through FY 2000, to authorize collections from insurance companies for certain health care provided by VA.

On the whole, the Administration's budget is a good one. The DAV commends Secretary Brown for his efforts to bring about a budget that is fair for our veterans. America's veterans sincerely appreciate Secretary Brown's tireless advocacy in their behalf.

The DAV is appreciative of the Administration's proposal to provide a cost-of-living adjustment in compensation and DIC. This COLA would offset against the increase in the

cost-of-living incurred by disabled veterans and DIC recipients whose buying power would otherwise be diminished. However, rounding down the COLA for the next five years will amount to an erosion of the value of compensation as compared to the rise in the cost-of-living. The quality of life for those affected by service-connected disability should not be sacrificed as a trade-off for some less deserving budgetary goal. The DAV opposes the rounding down of COLAs.

The Administration's budget would also institute or extend a number of cost-saving provisions which perhaps, overall, are less injurious in their impact on VA beneficiaries. Savings realized from these measures should be used toward correction of deficiencies in VA's operations and to support changes in law to remove certain currently existing inequities. The integrity of VA's programs can only be maintained if the benefits of cost savings and streamlining are applied to other areas of VA's operations and programs to remedy deficiencies there. Redirecting resources within VA in this manner will improve the efficiency of VA's operations and effectiveness of its programs, where robbing it of resources can only serve to bring about the opposite result.

The President has requested a budget of $17.3 billion to fund the Veterans' Health Administration, representing an increase of $755 million over the FY 1995 funding level.

Broken down, the proposal requests $16.96 billion for medical care, $257 million for research activities, $72.3 million for Medical Administration and Miscellaneous Operating Expenses, and $10.4 million for the Health Professional Scholarship.

As I said, we are grateful for Secretary Brown's personal commitment and efforts to secure a meaningful budget proposal in these fiscally austere times. Having said that, however, it is estimated that this request falls some $600 million short of allowing VA to provide a FY 1995 current services level of treatment.

The budget request does, however, include certain innovative management improvements which should have a positive impact and create significant dollar savings and efficiencies enabling positive program enhancements to occur. Taken together, these proposals will result in program savings of $335 million and 3,429 employees which have been redirected elsewhere in the budget request.

INDEPENDENT BUDGET RECOMMENDATIONS

This year's *Independent Budget*, under the benefits section, includes some of the priority legislative goals of the IBVSOs. It presents some of the arguments against proposals to means test, tax, and eliminate compensation for certain disabilities. In the section on General Operating Expenses (GOE), the authors have again urged that the Congress provide VA with the resources necessary to timely and efficiently deliver benefits and services. However, it is emphasized that resources alone cannot correct the deficiencies that currently exist in the claims adjudication system and appellate process. The IBVSOs have cited data which serve as evidence of underlying deficiencies and have described some specific practices which are counterproductive or inappropriate and which lead to claims processing that is not cost-effective and which has a very detrimental effect upon VA beneficiaries because of consequent protracted delays in claims adjudication. The IBVSOs submit that the solution to VA's lingering ills is a combination of adequate personnel and technology resources along with prompt

and meaningful reform of its claims adjudication and appellate processes.

SUGGESTED BENEFIT IMPROVEMENTS: Even with the very best procedures and substantive provisions, no benefit program can achieve perfection. There will always be the exception where some inequity results from the effect of the law in unusual circumstances. However, laws sometimes themselves have substantive shortcomings which operate to inequitably impact upon classes of potential beneficiaries. The IBVSOs have identified some of the more pressing of these inequities in the benefits section of the *Independent Budget*. Savings from extension of cost-saving provisions suggested in the Administration's budget should be employed for the purpose of correcting these inequities. Legislative remedies are urged as follows:

* Removal of the one-year limitation on payment of accrued benefits.

* Payment of compensation for temporary total disability beginning on the date of hospitalization or treatment.

* Concurrent payment of military retired pay and VA disability compensation.

* Exception to the three-year limitation on filing amendment of tax returns to allow recovery of taxes collected erroneously on disability severance pay outside the three-year period.

* Provision for correction of clear and unmistakable error in a BVA decision.

* Exemption of veterans' entitlements from the "pay-go" provisions of the Budget Enforcement Act.

* Reinstatement of the presumption of permanent and total disability at age 65, if the current requirement of an evidentiary showing of permanent and total disability is determined not to be cost-effective.

We believe these suggested improvements are particularly meritorious. We look forward to discussing them further in the upcoming year. And, we ask for your support.

OPPOSITION TO BENEFIT REDUCTION/ELIMINATION: As stated in the *Independent Budget*, "There is perhaps no area in which the unanimity among the IBVSOs is more evident than their opposition to misrepresentations about deservedness of veterans' benefits and efforts to erode or eliminate them." Secretary of Veterans Affairs, Jesse Brown so poignantly observed, "How we treat our veterans is an indicator of who we are as a people." In addition to the rational and practical arguments against schemes to means test, tax, and eliminate compensation, there are equitable principles that are more compelling and go to the very foundations of our nation's moral obligations to its disabled veterans.

Maybe the arguments in the *Independent Budget* against these proposals are unnecessary because they are so obvious and compelling to you. Nonetheless, these proposals have been included in various deficit reduction recommendations from outside the Congress and inside the Congress. We are confident the proponents of these schemes harbor no malice toward disabled veterans, but rather lack the insight and understanding necessary to reveal to them how their notions offend fundamental principles of fairness.

We are heartened by the emphatic declarations many of you have made against these misguided initiatives. We sincerely appreciate your enduring commitment to fair treatment for disabled veterans.

Maybe disabled veterans' sense of alarm will prove unwarranted. Maybe our reaction will simply serve as an abundance of caution. We hope so. We ask that you continue to speak out in our behalf.

GENERAL OPERATING EXPENSES: The GOE portion of the budget covers the administrative costs associated with the delivery of VA benefits and services and therefore is naturally a more dynamic area of the budget. It is for that reason that the *Independent Budget* is not preoccupied with numbers in its recommendations for GOE but rather focuses at least equally on concepts.

The Veterans Benefits Administration of VA is responsible for non-medical programs. These are compensation, pension, and education; vocational rehabilitation and counseling; insurance; veterans' services; and ancillary support services for these programs. *The Independent Budget* includes recommendations for each of these programs, but our greatest concern is with persisting flaws in the adjudication of claims for benefits, predominantly compensation and pension claims.

"General Administration" is also funded under the GOE appropriation. This activity consists of the Office of the Secretary, six assistant secretaries, and three VA (department-level) staff offices. The *Independent Budget* provides recommendations for two of these staff offices, BVA and the Office of General Counsel (OGC).

CLAIMS PROCESSING AND APPEALS: The *Independent Budget* addresses the claims and appeals processes from the lowest administrative level, VA regional offices, through the first level of judicial review, the Court of Veterans Appeals (COVA) in the belief that the enormity and cumulative effect of the problems can only be appreciated when viewed within the context of the continuum of the entire process.

In the noble words of Abraham Lincoln, "It is as much the duty of government to render prompt justice against itself in favor of citizens, as it is to administer the same between private individuals." Unfortunately, our nation's veterans are not receiving prompt justice. Indeed, with an aging veterans' population, it is not uncommon for a veteran to die before his or her claim is resolved. In these instances, justice delayed is truly justice denied.

We submit that an increase in the quality of VA's decisions will result in a decrease in the quantity. If VA institutes measures to ensure that its decisions are made correctly the first time, VA claimants' cases will not require multiple decisions at the administrative and judicial levels. The number of required decisions will be reduced, as will the burden on the claims adjudication and appellate processes. It follows that quality claims adjudication is cost-effective adjudication, and veterans will have more timely resolutions of their claims.

We note that this Committee's oversight plan includes hearings on VA's claims and appeal processing. We commend this action on your part and look forward to working with the Congress and VA to find solutions to these problems.

BOARD OF VETERANS' APPEALS: Last year, this Committee responded to recommendations for changes in law needed to permit the Board to improve its operations. These changes are being

implemented, and other administrative changes are being employed to improve BVA's productivity.

The *Independent Budget* identifies some of the continuing problems with the Board, however. These contribute to protracted delays in claims decisions. Hopefully, periodic performance reviews of individual Board members, as required by a recent change in law, will assist in the correction of practices that unnecessarily prolong the pendency of appeals. The proposed performance review standards, if closely followed, will bring about much more accountability on the part of Board members. We applaud these efforts.

The *Independent Budget*, among other things, recommends authority for BVA to increase its FTE by 50 in FY 1996. A gradual increase in Board personnel responsible for decisions is essential if the Board is to reduce its processing time to reasonable levels. The Administration's budget falls short of this recommendation by requesting only 28 additional FTE for this purpose. We urge that the FTE be increased by 50.

OFFICE OF GENERAL COUNSEL: Streamlining of the operations under OGC will result in savings, but it also incidentally creates a need for some additional resources. For this reason, and based on other needs of OGC, the *Independent Budget* includes the following recommendations:

* Additional funds in the amount of $150,000 should be appropriated to permit stationing of attorneys with the Under Secretary for Benefits and the Under Secretary for Health.

* Funding in the amount of $4 million should be provided for necessary automated data processing equipment.

* Funding in the amount of $400,000 should be provided for training in preventative law in personnel matters, contracting, and Medical Center Director legal responsibilities.

* Additional funding in the amount of $400,000 should be provided for increased travel needs.

The *Independent Budget* also discusses the role of VA attorneys in contributing to problems in the appellate process and unacceptable delays at the Court. For example, in the past several months, VA attorneys have failed to timely file their briefs in all DAV represented cases. In addition to the thirty days allotted each party under the Court's rules, OGC has requested no less than ninety days in additional extensions in every case we represent. This means, of course, that four months are required for OGC's brief. This is inexcusable. VA's attorneys have also engaged in other practices which have evoked criticism from the Court. The *Independent Budget* recommends that the General Counsel conduct and internal review of the practices and productivity of this group of attorneys. Additionally, we are prepared to include testimony on these problems in the scheduled oversight hearing on BVA and COVA.

Another recommendation for the General Counsel's consideration is the neutrality of its precedent opinions. Several of these opinions that accounted for determinations of ineligibility for benefits sought by VA claimants have been overruled by COVA. The IBVSOs suggest that "the General Counsel should strive to reach conclusions which follow from a neutral analysis of the law and not tailored to serve institutional objectives."

(7)

NATIONAL CEMETERY SYSTEM: The *Independent Budget* included these recommendations for the National Cemetery System (NCS):

* Appropriate $82 million to meet the burial needs of veterans and their families.

* Increase FTE by at least 15 to cover incremental workload increases.

* Provide a minimum of $2 million in additional funds to reduce equipment backlog.

* Study the feasibility of a VA national cemetery to ease the demand for space at Arlington National Cemetery.

* Expand existing national cemeteries.

* Pursue the goal of one open cemetery in every state.

* Seek relief from historic preservation requirements at NCS facilities.

Thus, the Administration's request for $75.3 million in budget authority and 1,340 FTE, the same staffing level as FY 1995, falls short of the resources needed by NCS.

Equipment backlogs continue to be of the major problems facing NCS. Continuing neglect in this area can only worsen the problem and cause it to become more difficult to overcome in the future. We urge your support in providing the essential resources for NCS.

MEDICAL CARE: The *Independent Budget* speaks in detail to a strategy that, when implemented, would cure many of the acknowledged ills plaguing the system. Our plan would expand access for veterans to quality and appropriate health care services, while actually saving the federal government and the American taxpayer money.

The cornerstone of our proposal relates to:

Eligibility reform:	Allowing VA to treat a core group of veterans in the most appropriate and efficient setting.
Funding streams:	Allowing VA to retain funds they already collect for the treatment of nonservice-connected disabilities, and for new patients accessing the system.

We believe the *Independent Budget* sets forth a credible approach that would produce meaningful reform of VA's health care system. Further, it is our firm belief that VA possess every attribute necessary to successfully emerge as a viable system. The task will not be a simple one. Operational as well as cultural changes need to occur and occur quickly. We view with optimism the reorganizational concepts developed by Dr. Kizer and believe them to be indicative of the direction VA needs to proceed in.

While our colleagues and partners in the *Independent Budget* will present specific details regarding concepts and funding requests felt necessary for the VA health care system, we urge, in the strongest possible terms, this Committee to report an adequate budget request for the Veterans' Health Administration.

This concludes the DAV's testimony on the FY 1996 budget. We appreciate the opportunity to present our views on this most important matter, and we thank this Committee for its continuing support of this nation's disabled veterans.

HOUSE VETERANS' AFFAIRS COMMITTEE
HEARING ON
DEPARTMENT OF VETERANS AFFAIRS
FISCAL YEAR 1996 BUDGET
February 24, 1995

Highlights of Testimony

Disabled American Veterans, National Legislative Director Richard Schultz:

- cites membership at 1.4 million members and women's auxiliary.

- DAV commends Secretary Brown for efforts to bring about a budget that is fair for our veterans.

- appreciates 3.1% COLA for compensation and DIC recipients.

- appreciates cost-saving provision, but suggests savings should be used to correct VA's deficiencies in operations.

- estimates that administration's FY 1996 budget is approximately $600 million of "current services" budget.

Independent Budget Recommendations

- cites opposition to "schemes to means test, tax, and eliminate compensation" proposals.
  -suggests that these types of proposals come more from lack of insight and understanding than from malice.

- recommends that VA institute measures to ensure that claims' decisions are made correctly the first time so claimants' cases would not require time consuming work at the administrative and judicial levels.
  -quality claims adjudication is cost-effective adjudication.
  -commends House Committee's oversight plan that includes hearings on VA's claims and appeals processing.

- recommends Board of Veterans Appeals increase FTE by 50 in FY 1996, saying that VA's recommendation of increasing by 28 falls short.

- National Cemetery System should be increased well above administration's plan to meet burial needs, workload increases and reduce equipment backlogs. ($82 million, add 15 FTE, $2 million for equipment backlog)

- Medical Care reform, eligibility reform should be instituted as suggested by Independent Budget.

- VA should be able to keep funds collected for non-service treatment.

- agrees with Dr. Kizer's reorganizational concepts.

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SERVING
WITH
PRIDE



Statement of

Noel C. Woosley
AMVETS National Service Director

before the

Committee on Veterans Affairs

of the

U.S. House of Representatives

on the

Independent Budget for the Department of Veterans Affairs for fiscal year 1996

Friday, February 24, 1995
Cannon House Office Building
Room 334



AMVETS

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Mr. Chairman, AMVETS is grateful to you and the committee for allowing us the opportunity to testify today. We are proud to join with the Disabled American Veterans (DAV), the Paralyzed Veterans of America (PVA) and the Veterans of Foreign Wars (VFW) in presenting the Independent Budget (IB) for the Department of Veterans Affairs (VA) for fiscal year 1996.

For the ninth consecutive year we, the authors of the IB, have worked closely to analyze the needs of America's veterans and to determine the funding necessary for VA to meet those needs. We view it as a true picture of the realistic funding required by VA to adequately carry out the many roles and missions designed to meet the needs of America's veterans. The content of this presentation is consistent with previous editions of the IB. Each VSO has developed and will discuss a major section. DAV is responsible for general operating expenses (GOE) and benefits. PVA develops medical programs within the VA health care system. VFW compiles the VA construction program. AMVETS' testimony primarily addresses the National Cemetery System (NCS).

The continued downsizing of the VA total work force will have a dramatic impact of VA's ability to deliver expected levels of service. We are unable to rationalize the loss of VA employees when it takes over three years to process a claim for VA benefits if an appeal to the Board of Veterans Appeals is involved, and three to six months just to get a VA clinic appointment. At the same time, VA, in its transition away from being a government-funded health care provider, is also being called upon to accomplish a radical shift in culture and operating practices to compete for veterans' health care dollars. In spite of all the good intentions of Congress and VA management, it may be asking too much to enforce personnel downsizing while simultaneously attempting to recast VA in the private sector mold.

AMVETS national resolutions offer solutions to many challenges facing VA. To eliminate unfair competition from other well-deserving agencies, AMVETS calls for separate appropriations committees in both Houses of Congress dedicated solely to VA matters. We further support funding VA medical benefits from mandatory spending accounts. It goes beyond being counterproductive to mandate entitlements and then to use discretionary funds to provide VA personnel to deliver those benefits to veterans.

Improved substance abuse and PTSD treatment, adult day care and Alzheimer's disease programs and continued emphasis on resolving the health mysteries related to Persian Gulf War veterans and their families are also supported by AMVETS national resolutions. We thank the committee for its past achievements and look forward to sharing more successes during this session of Congress on behalf of the men and women of the U. S. armed forces of yesterday, today and tomorrow.

In consonance with the goals outlined above and those contained in the legislative portion of the IB, we fully support fiscal year 1996 VA medical funding at a level several billion dollars above the president's request. As it applies equally to veterans health care, funding mandated Veterans Benefits Administration (VBA) programs from discretionary accounts is neither fair nor practical, and such a philosophy offers VA no hope of improving its delivery of services to veterans and their families. We fully support restoration of burial and plot allowances to their pre-OBRA 90 levels, adjusted to account for inflation. To accomplish these and other legislative goals contained in the IB, AMVETS fully supports $19.7 billion for VBA programs. This is in keeping with the president's VBA budget offering for FY 1996. But we must express our concern that continuing to define veterans' health

care and treatment programs in terms of maintaining and enlarging VA's current inventory of facilities will further inhibit VA's ability to deliver timely, quality services to the nation's veterans. However, among those programs and services veterans count on are those administered by the National Cemetery System, and the need here for additional facilities is more the exception than the rule.

NCS continues to provide high quality service despite continual underfunding. That is not to say that everything is okay. Because the system has not had the full funding support necessary to ensure its viable future, many of the long-term projects aimed at its longevity may have to be abandoned.

The NCS has three major missions. First, it maintains a system of national cemeteries which, by law, are considered national shrines. Second, NCS provides burial benefits for veterans and eligible dependents. And third, it administers the presidential memorial program, the state cemetery grants program, and the headstone and marker program.

NCS currently operates 114 cemeteries, not including 34 additional sites such as Confederate Cemeteries and Soldiers' Lots. This might seem impressive until one realizes that 56 of the 114 cemeteries are closed already, and yet another (Wood, Wisconsin) is scheduled to close in 1995. NCS now owns a total of 10,662 acres of land, 5,355 of which have been developed. Since the system's inception during the Civil War, NCS has conducted a total of 2.3 million interments. To meet future needs, approximately 278,000 gravesites remain available on developed land. Undeveloped areas can accommodate an additional 1.6 million casket sites.

The IB VSOs' major concern regarding the future of NCS is that it continue to expand to meet the needs of America's 27 million veterans. To put that in perspective, NCS statistics show that historically 10 percent of all veterans choose interment in national cemeteries. If the 10 percent figure continues to prove accurate, between 1995 and 2010, nearly 800,000 to 900,000 veterans will request burial in a national cemetery. Clearly, the existing developed acreage will not sustain that total, and Congress must support expansion of existing sites where land is available. That means that NCS faces a deficit of nearly 700,000 interment sites.

Residence and distance also play a significant role in the choice of a burial site. Many veterans' families are reluctant to cross state lines to bury a loved one and 75 miles seems to be the maximum distance most consider a reasonable distance from home. For that reason, it is important that NCS develop and maintain at least one open national cemetery in each state.

Another important challenge to NCS is the impending closure of many of its facilities due to lack of space for first member casket burials. While many of these cemeteries will still accept second family members and cremains, veterans who live in those areas may not find space available for burial. VA estimates that by the year 2000 seven more cemeteries will be declared closed to initial burial. NCS has five new cemeteries in the planning stages: Albany, Chicago, Cleveland, Dallas and Seattle.

NCS faces a shortfall of 278 full-time employee equivalents (FTEE) in 1996, and will need an additional 13 FTEE just to maintain the current level of service. To achieve expected service delivery requirements, NCS will emphasize burial operations in lieu of other functions such as maintenance and repair. The backlog in obsolete equipment for 1996 is $8.2 million, a level that wipes out modest gains made in 1991 and 1992 when Congress voted additional funds to ease the equipment shortage. The FY 1996 budget request for equipment will do nothing but further exasperate the unconscionable backlog.

The implications are clear. Congress and the administration cannot continue to under-fund NCS in its maintenance and repair, equipment and FTEE accounts and still expect a high degree of quality in its delivery of services. Further, under current trends, the overall condition of the cemetery system can only deteriorate. Last year, the IB pointed out NCS' problem in complying with historic preservation requirements. We again recommend relief for the NCS that would allow the system to remove and replace dilapidated buildings that pose a safety hazard and detract from the park-like setting of most cemeteries.

NCS also has missions in addition to those explained above. The matching grant program for state veterans cemeteries will assume a greater importance as national cemeteries close. Last year, VA awarded grants totalling $4,144,527 to seven states. NCS also administers the Presidential Memorial Certificate program which provided 282,552 certificates in 1994. To assist NCS to process applications and to ensure reasonable response rates, the IB VSOs recommend $500,000 to complete the Automated Memorial Application System (AMAS). Also, as part of its burial benefits responsibilities, NCS provides a headstone or flat bronze grave marker to each eligible veteran who requests the service. Last year, VA provided 300,754 headstones and markers.

The following is a summary of FY 1966 IB recommendations for NCS:

- A total appropriation of $82 million
- A minimum FTEE increase of 15 to cover incremental workload increases
- A minimum of $2 million additional funds for equipment backlog reduction
- VA feasibility studies concerning a second national cemetery to ease the demand for space at Arlington National Cemetery. While the IB VSOs understand that it is not possible to duplicate the national appeal of Arlington, properly promoted and placed, a second site with national significance should be pursued.
- VA pursuit of an open cemetery in every state
- VA pursuit of expansion of existing national cemeteries wherever possible
- Continued VA progress toward a policy of an open national cemetery within 75 miles of 75 percent of America's veterans
- VA request for relief from historic preservation requirements at NCS facilities wherever appropriate.

Mr. Chairman, we are cautiously optimistic about the enthusiasm and determination characteristic of the 104th Congress, but we are seriously concerned about how the clamor to balance the national budget and reinvent government will affect our veteran community. Collectively and individually, AMVETS looks forward to working with you and the members of the committee to ensure that America honors the debt we, as a grateful nation, owe our veterans. This concludes my statement.

HOUSE VETERANS' AFFAIRS COMMITTEE
HEARING ON
DEPARTMENT OF VETERANS AFFAIRS
FISCAL YEAR 1996 BUDGET
February 24, 1995

Highlights of Testimony

AMVETS, National Service Director Noel C. Woosley:

- indicates that AMVETS will concentrate its testimony on National Cemetery System...which reflects AMVETS role in developing the Independent Budget.

- comments on establishing VA medical benefits as a mandatory account rather than a discretionary account.

- suggest VA and veterans' issues be separated from appropriations' subcommittee on VA/HUD and Independent Agencies.

- supports emphasis on resolving the mysterious Persian Gulf Illness.

- supports administration's budget of $19.7 billion for VBA programs.

- expresses concern with VHA budget which continues to define veterans' health care and treatment programs in terms of maintaining and enlarging VA's current inventory of facilities.
  -suggests that the budget will further inhibit VA's ability to deliver timely, quality services to nation's veterans.

National Cemetery System

- reviews NCS current status...NCS owns total of 10,662 acres of land, 5,355 is developed.

- states that NCS faces a burial space problem and Congress and administration must support expansion of existing sites to accommodate veterans' burials.

- NCS faces shortfall of 278 FTEE in FY 1996 and will need 13 FTEE just to maintain the current level of service.

- backlog of obsolete equipment for FY 1996 is $8.2 million.

- continued underfunding will lead to faltering delivery of service.

- recommends that Congress provide relief to NCS against "historic preservation" laws so NCS can remove dilapidated buildings that pose safety hazards and detract from setting of most cemeteries.

- outlines a number of other recommendations for improving NCS.

- expresses concern about "clamor to balance the national budget and reinvent government" and affect on veteran community.

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Independent Budget for Department of Veterans Affairs

Fiscal Year 1996

Prologue

For the last nine years, four congressionally chartered veterans' service organizations (VSOs)—AMVETS, Disabled American Veterans, Paralyzed Veterans of America and Veterans of Foreign Wars of the United States—have produced a needs-based budget proposal for the Department of Veterans Affairs (VA) as a counterpoint to that of the Administration. Collectively, the *Independent Budget* coauthors (the IBVSOs) represent more than 5 million veterans. The legislative implosion of the national health care reform effort and the subsequent electoral revolution have created a perplexing environment in which to formulate this year's budget document. The federal budget arena has changed immeasurably. Talk of tax credits, tax incentives, entitlement caps, freeze levels, Medicare cuts, firewalls protecting the defense budget from being used for domestic programs and line-item vetoes renders imponderable any attempt at forecasting next year's federal budget outcome. We can only continue to depend on our own analysis of veterans' issues, confident that Congress will remain firm in its support of veterans' needs.

"Incrementalism" is now the keynote in national health care reform's symphony. We submit that the foremost legislative increment for VA should deal with eligibility reform and adequate funding for VA-delivered health care. These issues head the IBVSOs' lists of recommendations and legislative proposals contained in this year's document.

Past editions of the *Independent Budget* have carried the statement that our publication was predicated on a loss of confidence that the Office of Management and Budget (OMB) had any interest in understanding or responding to a user's perspective of veterans' needs. This year, OMB did invite and receive input from this document's VSO authors on many veterans concerns and recommendations. Although the lack of definitive response at this writing is understandable, OMB's manifest interest is sincerely appreciated.

In previous years, we rejected the Congress's and the Administration's definition of "current services" as that level of appropriation needed to maintain a previous year's VA medical care workload plus coverage for inflation. Instead, to track veterans' true health care requirements, which budget shortfalls suppressed annually, we used the FY 1988 appropriation level as a baseline from which to calculate the

appropriation needed during the coming year to maintain comparability to more stable and realistic earlier budgets. This year, we have pragmatically abandoned that practice, due to the uncertainties attendant upon the congressional promise of a new budget process bill. Yet, we do so mindful of a decade of VA health care revenue loss in constant dollars, despite the ever-increasing need for service.

Because we are veterans' advocates, VA health care and benefits users, and volunteers, the veterans' service organizations have a proprietary interest in the system's well-being. Volunteers, often the staff and members of veterans' service organizations, contributed more than 14 million hours of time and many other resources to the VA system. We believe in the system and have not lost our faith in its ability to overcome problems that funding shortfalls, inflexible bureaucratic management structures and unfunded mandates have engendered. Department of Veterans Affairs programs must prevail in the face of such obstacles, to offer veterans the benefits and services upon which we rely.

As authors of this FY 1996 VA budget proposal, we take pride in the large number of endorsing organizations that support this effort and pleasure in submitting it for consideration by Congress.

Arthur W. Klinger, Jr.
National Commander
American Veterans of World War II, Korea and Vietnam

Donald A. Sioss
National Commander
Disabled American Veterans

Richard Grant
National President
Paralyzed Veterans of America

Allen "Gunner" Kent
Commander-in-Chief
Veterans of Foreign Wars of the United States

Endorsements

Air Force Sergeants Association
Alliance for Aging Research
American Academy of Ophthalmology
American Association of Dental Schools
American Association of Spinal Cord Injury Nurses
American Association of Spinal Cord Injury Psychologists and Social Workers
American Defenders of Bataan & Corregidor
American Ex-Prisoners of War
American Merchant Marine Veterans, Inc.
American Military Retirees Association, Inc.
American Nurses Association
American Optometric Association
American Paraplegia Society
American Physiological Society
American Podiatric Medical Association
American Psychiatric Association
Arthritis Foundation
Association for Academic Surgery
Association for Health Services Research
Association of American Medical Colleges
Association of Professors of Medicine
Association of Schools of Public Health
Association of the United States Army
Association of University Radiologists (AUR)
Blinded Veterans Association
Catholic War Veterans, USA, Inc.
Diabetes Action Research & Education Foundation
Enlisted Association National Guard of the United States

Jewish War Veterans of the U.S.A.
Legion of Valor of the U.S.A., Inc.
Marine Corps League
Marine Corps Reserve Officers Association
The Military Chaplains Association of the U.S.A.
The Military Justice Clinic, Inc.
Military Order of the Purple Heart
National Alliance for the Mentally Ill
National Amputation Foundation
National Association for Uniformed Services
National Association of County Veterans Service Officers
The National Association of State Directors of Veterans Affairs
National Association of VA Chiefs of Staff
National Association of VA Physicians & Dentists (NAVAPD)
National Association of Veterans' Research and Education Foundations
National Council of Senior Citizens
National Multiple Sclerosis Society
National Organization for Rare Disorders (NORD)
Navy League of the United States
Non Commissioned Officers Association of the United States of America
Ohio Veterans Home
Polish Legion of American Veterans, U.S.A.
The Retired Enlisted Association
Society for Neuroscience
Society of Medical College Directors for Continuing Medical Education
Surgical Infection Society
U.S.C.G. Chief Petty Officers Association (CPOA)
U.S. Coast Guard Enlisted Association
U.S. Merchant Marine Veterans of World War II
Veterans Affairs Physician Assistant Association
Veterans of the Vietnam War, Inc.
Vietnam Era Veterans Association/Rhode Island Veterans Action Center
Vietnam Veterans of America, Inc.

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Introduction

The more things change the more they stay the same—an adage applicable to the constancy of veterans' issues.

In light of Congress's consideration of significant national health care reform, last year's *Independent Budget* registered the coauthors' opinion that it was a pivotal year for the Department of Veterans Affairs (VA). Little did we know how ephemeral the reforms we anticipated to affect the veterans' system would prove to be. *H.R. 3600*, the Clinton health care reform bill, proposed renovation of the VA health care system, including major reforms veterans' service organizations had long sought and which the congressional Committees on Veterans Affairs supported. Unfortunately, the proposal for veterans was inextricably enmeshed with the reform of the national health care system's design and funding mechanisms. Obviously, most Americans and their representatives in Congress did not support the majority of the Administration's proposal, which was integral to implementation of the veterans' portion of the bill. When the bill died, the Veterans Health Administration (VHA), the veterans' service organizations (VSOs) and other veteran proponents were "back to square one," facing the chronic VA health care issues we have addressed through a decade of *Independent Budgets*.

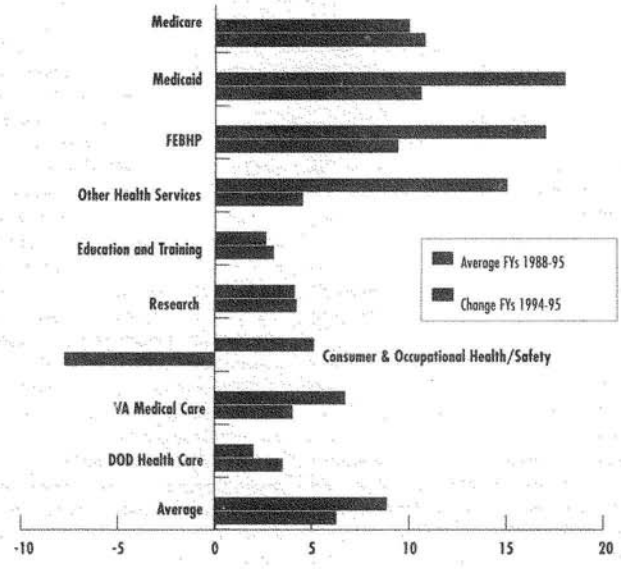
Irrespective of federal action, with the integration of health care systems and managed care driving the nation's competitive medical market through radical organizational and functional changes, reform is well underway. Congress's defaulting on passage of a meaningful health care reform bill ensured that states would hasten pursuit of their own versions of reform. Congressional delay in relieving states of *Employee Retirement and Income Security Act* (*ERISA*) restrictions has somewhat dampened such state initiatives. Waiver is needed to allow states flexibility to design, fund and regulate health insurance programs. However, most of the Congress does not favor *ERISA* reform, and large multi-state industries, who claim to save millions of dollars by self-insuring, are powerful adversaries against it.

Still, state health care reform efforts are active. The Health Care Financing Administration has granted demonstration waivers to several states, providing them authority to redesign their Medicaid programs under capitated funding and managed delivery of benefits. Several other states have waiver requests pending.

Much of this year's *Independent Budget* addresses how VA must respond to this tumultuous private medical sector environment. Reform programs across the country jeopardize VA medical facilities, forcing them into dissimilar, state-based, competitive medical

CHART 1

Federal Health Program Budgets' Average Annual Percentage Change FYs 1988-95



Source: Budget of the U.S. Government

markets while federal law denies them the ability to compete. The proposed *Veterans Health Care Private Program Act of 1994* was designed to solve that problem, but was lost in the congressional health care reform debacle. That legislation would have enabled VA to participate in several selected states' health care reform programs. Compensable service-connected veterans and veterans with incomes below the current means-tested income levels could have received at least the level of health care services their states of residence offered others. Access to VA care would have been available to non-Core veterans, veteran dependents and CHAMPUS beneficiaries, with third-party reimbursement and patient cost sharing. VA could have retained these funds to enhance care for all veterans. VA medical center directors would have received local authority and flexibility for resource allocation, contracting for extramural medical services, personnel recruiting and management, marketing and advertising.

The provisions contained in that lost proposal, and several other legislative initiatives this document describes, are now critical, not only for VA facilities in states where comprehensive health care reform programs are imminent, but across the nation.

With the loss of *H.R. 3600*, ten major veterans' service organizations have united in "The Partnership for Veterans Health Care Reform" and collectively call for fundamental changes consistent with *Independent Budget* promulgations. Their recommendations involve three broad areas. First, the VSOs identify

the critical need for VA financing reform. Chart 1 demonstrates the funding changes in federal health programs over the last ten fiscal years. As shown, VA has lost a considerable share of the federal funding invested in health care—this is at least partially due to the extreme escalation in federal health care entitlement programs, Medicare and Medicaid. The VSOs recommend shifting the VA budget from an annual discretionary appropriation to a mandated funding stream, like Medicaid and Medicare. Congress should also provide VA the authority to collect and retain Medicare payment for higher-income non-Core Group veterans who use VA and extend authority for VA to retain other third-party payments.

VHA cannot successfully operate in a competitive market offering some veterans complete health care services but restricting others' access to fragments of care.

Second, the VSOs recommend administrative decentralization, which would allow VA facilities to operate more efficiently and effectively in local competitive medical markets. Finally, eligibility reforms would ensure that veterans and their adult dependents who use VA can receive a full continuum of care. The Partnership stresses the critical need for cleaning up current Byzantine eligibility rules, because VHA cannot successfully operate in a competitive market while offering some veterans complete health care services but restricting others' access to fragments of care.

This collective action is but an example of the growing convergence of opinion, on the part of veterans' service organizations, the Department of Veterans Affairs and Congress (who together were once known as the "Iron Triangle") regarding VA's future and how to get there. Fortunately, throughout changing times and despite disappointments, encouraging VA program developments and attitudinal changes have kept the VSOs' hope alive. We commend the Department on the perceptive quality of its strategic planning, as documented in such excellent papers as *VA's National Health Plan*, the draft report *VHA Central Office Reorganization* and, most recently, the *Veterans' Health Administration Field Reorganization.*

We agree with VHA's belated realization of such *immediate* needs as a comprehensive reorganization, realignment of its health care delivery facilities and missions, decentralization of management authority, a shift to non-institutional venues and enhancement of primary care. As it realigns its health care facilities, VA must emphasize the continued provision of those specialized services for which VA was originally conceived and in which VA now excels: combat trauma, amputations, prosthetics and orthotics, spinal cord injury medicine, care for the blind, mental health care, treatment of post-traumatic stress disorder, rehabilitation, geriatrics and long-term care. Indeed, including these specialized programs, VHA has many of the required elements to embark upon the extensive structural and functional changes it needs to successfully deliver veterans' medical services in tomorrow's health care environment. Still missing is much of the associated legislative authority only Congress can provide.

Because of the urgency of eligibility reform, we offer the following prefatory comment. The term "entitlement" has acquired such disrepute in Congress that we have long since substituted the word "eligibility" to discuss Congress's legislative authorization for VA to use the most appropriate and economical venues to deliver health care. It is a rather petty exercise in semantics. Neither of the two words, which actually have different meanings, should impede VHA's acquisition of the legislative authority that will enable it to stop the unethical, wasteful and fragmented delivery of medical care and provide instead a full continuum of service to *any beneficiary who has access* to VA health care.

In 1993, the Commission on the Future Structure of Veterans Health Care underscored this recommendation, which is now even more relevant given the current national emphasis on expanding primary care and restricting acute hospital care. In the contemporary medical market environment, most care is provided on an outpatient basis, and patients are assured a full continuum of medical services. The U.S. health care system is changing so rapidly it is a futile effort to statistically or otherwise describe what is occurring.

VA can no longer afford to defer eligibility reform. It must assume a competitive position with states that are reforming their health care delivery and financing. From the provider's perspective, VA must also ensure

that veterans can receive treatment in its system comparable to that available through any other federal or non-federal health care provider or program.

The *Independent Budget* coauthors (IBVSOs) do not waver from our established position that all current Category A (Core Group) veterans who use the VA system should have access to the full continuum of care—from primary through nursing home care—in the most appropriate venue; and all catastrophically disabled veterans should receive immediate Category A access to the full continuum of care.

Funding the full continuum of VA health care is possible with a *net savings to the system* if certain legislative initiatives accompany the reform.

This policy position speaks to the most appropriate, efficient, state-of-the-art delivery of health care. Medicare and Medicaid programs do not suggest that outpatient care be provided only to "obviate the need for hospital care" as current law governing many veterans' eligibility for outpatient care provides. Good medical practice dictates that patients being treated for chronic, stable conditions receive appropriate follow-up care. This same continuity of care must be available to veterans using the VA system.

Congress must address the issue of who receives care in the VA system within the context of VA's being a competitive provider of choice for veterans in states where health care reform is undertaken. In an era when health care is becoming increasingly competitive and veterans have more comparable providers to choose from, it is no longer reasonable for veterans to choose providers that cannot care for their dependents' as well as their own health care needs. With proper assurance that new patients will not displace veterans, Congress should authorize VA to care for dependents, including dependents of active-duty military who use the VA system, on a reimbursement basis.

The request for veterans' eligibility reform carries with it a complexity of related ideas, all focused on the need for adequate funding. For the past ten years—even during the years of plenty—cost was always the reason that Congress did not pursue eligibility reform, except incrementally, of the VA health care system. Under the best of circumstances, determining VA costs is difficult. The data just do not exist to adequately analyze the costs of care delivery. Pursuing an entitlement raises the issue of cost, and the war of numbers begins. In 1988, the Congressional Budget Office (CBO) estimated that extending entitlement to outpatient care to VA users would be "budget neutral" or cost, at most, $40 million. Funding the full continuum of VA health care, however, is possible with a *net savings to the system* if these legislative initiatives accompany the reform.

- Grant VA authority to retain all third-party reimbursements without appropriation offsets.
- Give VA the legislative authority to deliver the full array of care to all veteran users and allow VA to structure the system to most efficiently deliver care using modalities most appropriate to patient needs and avoid unnecessary hospitalizations and prolonged inpatient stays.
- Authorize VA to sell medical services to veterans' dependents and, to bring in outside revenue, offer other community consumers use of VA equipment and technology.
- Authorize identification of VA as a Medicare provider for other than Category A veterans and retain Medicare reimbursements without appropriation offsets.

The most elusive source of non-appropriated VA funding is the often-requested authority for reimbursement from the Health Care Finance Administration (HCFA) to VA medical facilities for health care provided. The term "Medicare reimbursement" has found its way into the glossaries of strategic plans for reforming all the federal health care systems. Arbitrary denial of multiple proposals to legislatively authorize HCFA reimbursement for care provided in VA and DOD facilities to Medicare beneficiaries has become a point of contention in Congress.

Precedent exists, both in law and in practice, to reimburse VA from the Medicare program under certain circumstances. VHA has received Medicare funding under authority provided in *Title 38 U.S.C. Section 8153* for some of the cost of VA care, provided

Medicare-entitled individuals are not eligible for such care under *Chapter 17* of *Title 38*. The Indian Health Service also receives reimbursement from the Medicare trust funds. The IBVSOs will continue to advocate HCFA reimbursement to VA for care delivered to any higher-income patient entitled to Medicare coverage.

Parenthetically, as a matter of principle, VA should *not* collect third-party insurance reimbursement for VA medical care to service-connected disabled veterans for their service-connected conditions. Congressional default should never defer full funding for health care services for those disabled in service to the country to any third-party source of payment. It is difficult to categorize, as some have dared to suggest, the nation's commitment to health care for that group of veterans as a gratuitous concession.

The IBVSOs continue to request—indeed, implore—that Congress definitively address the full calendar of legislative proposals listed on page xxvii. Admittedly, the absence of major health care reform will make more difficult future enactment of legislation mandating such changes for the VA medical care system. Yet nothing less than these imperative reforms will sustain the VA health care system through the turmoil of the nation's health care revolution.

Guiding Principles

The four congressionally chartered veterans' service organizations developed the FY 1996 *Independent Budget* upon the principles we, the IBVSO coauthors, share. We have made few changes to last year's guidelines since they are, for the most part, enduring precepts that reflect a shared, underlying philosophy regarding veterans' programs.

For All VA Programs

- *New appropriations must fund Congressional mandates.* Statutory mandates without adequate appropriations are empty promises. Adequate funding must accompany legislation that creates new service initiatives; otherwise, implementation should be at the Department's discretion. Congress must categorically exempt appropriations for patient care programs from federal budget sequestration.

- *Veterans' service organizations need a formal role in VA strategic planning.* Veterans have a proprietary interest in the VA medical care system. They have a right to help shape decisions about mission changes, construction plans, new program location and implementation, program closing and affiliations. Congress must authorize regional boards to whom each "network" manager would respond. The strongest political advocates of VA medical care programs' continued integrity are veterans' service organizations; their participation in planning is essential to success.

- *VA must have increased flexibility to redirect its scarce resources to the most appropriate and efficient use.* In times of increasing financial austerity for all congressionally funded programs, VA management needs more control of its funding and policies regarding VA spending, to encourage the most effective use of funds. For instance, VA must review the missions for all of its facilities, convert facilities as necessary, and site and staff its facilities in those areas of the country that have the greatest need for veterans' services. Options for contracting both veterans' medical care and some benefits delivery must be investigated. For both health care facilities and regional offices, a geographic reconfiguration is necessary for VA resources to correspond to the veteran population. Realignment may require expansion or modification of existing facilities. Construction funding must ensure the integrity of VA's physical plant. There must be no covert downsizing of system capacity through allowing facilities to deteriorate.

For VA Medical Care

- *Congress must entitle all mandatory veterans to the full range of VA medical services.* Once admitted to the VA health care system, veterans and other care recipients must receive care in the most appropriate setting. VA physicians and facility administrators, in accordance with the patient's and his or her family's wishes, must choose the

appropriate location of patient care—inpatient, outpatient, nursing home or home-based care—according to principles of proper patient management. The establishment of assured access to a full continuum of medical care for entitled veterans, including certain non-service-connected patients, is essential to high-quality care, rational planning and efficient operation. It is also imperative for success in recruiting patients under any competitive enrollment system.

- *Specialized care for veterans must remain the focus of the VA medical care system.* Congress established the Department of Veterans Affairs' medical system to care for the specific needs of our nation's combat-injured veterans. Any strategic planning efforts must highlight this unique contribution VA makes to the national health care system.

- *Veterans must always have the highest priority for VA medical care.* The IBVSOs support the treatment of non-veterans within the VA medical care system when it is in the best interest of the veteran patient and the community to allow it. In exchange, all honorably discharged veterans should have access to the system—VA must open its services to all non-mandatory veterans and their dependents as long as those individuals bring resources with them to cover the cost of their care. The IBVSOs also endorse and favor the enhancement of VA's structured sharing programs with the Department of Defense, academic affiliates and community medical facilities. In all instances, mandatory veterans must be assured an inviolable priority to access their health care system.

- *Congress must ensure adequate financial resources for VA to execute its assigned medical care missions.* VA's financial structure must feature mandatory funding that covers the cost of providing "basic" care to all entitled veterans, retention of third-party reimbursements, and appropriated funding to cover supplemental services, including specialized services, not designated as part of a basic continuum of services available to all entitled veterans or otherwise funded by third-party reimbursement. VA must also receive appropriated funding necessary to execute its special missions of research, teaching and serving as a contingency provider in times of national emergency, as well as to maintain its infrastructure.

- *Congress must provide the tools and support to "reinvent" a VA health care system as a worthy participant in the competitive medical market of tomorrow's health care industry.* These instruments for changing the VA system are discussed at length in the "Medical Care" section. The IBVSOs' prescription for change emphasizes four elements—to decentralize, to regionalize, to specialize and to share. Access to a full range of medically necessary services is also essential to the plan.

- *Women veterans are entitled to the same level and quality of health care services, and the same access to those services, as male veterans.* VA must complete renovation of facilities to meet current privacy standards, to accommodate women veterans' gender-specific needs and to fulfill all other statutory and accreditation criteria. Contract options for the care of women must be enhanced.

- *VA must better prepare to meet the special needs of aging veterans.* VA must promptly convert excess hospital capacity to meet the increasing demand for nursing home care, outpatient clinics, functional rehabilitation and other services for older patients. VA must tailor its affiliations with medical schools to ensure excellent care for the generation of needy World War II veterans. VA must summon the effort and resources to preserve its place in the vanguard of providing geriatric and long-term care.

- *VA's medical school affiliations are essential to high-quality care for veterans.* The two congressionally mandated missions—patient care and education of health professionals—are complementary; enhancements to one program benefit the other. VA must make every effort to improve communication and coordination among its facilities and their affiliates. Affiliates must have an adviso-

ry role in planning for VA medical programs and concomitant responsibility and accountability for the delivery of care to veterans. Veterans' service organizations must have an opportunity to influence deans' committees' decisions that affect veterans' health care.

- *Vigorous research programs are vital to the integrity of the VA health care system.* The academic medical model of integrated clinical care, research and education is universally accepted as the best means of providing the highest quality care. Compromising this model through current limitations of VA's research capability will undermine the quality of care available to veterans.
- *VA's mission to support the military medical system in time of war or national emergency is essential to the nation's security.* VA must maintain its readiness to receive combat casualties and to provide health care resources for people in areas damaged by natural disasters.

For VA Benefits Delivery

- *Entitlement, by definition, implies timely delivery of benefits.* Congress must legislate reasonable timeliness standards for benefit and service delivery. Such legislation must then mandate sufficient funding to meet those timeliness standards.
- *Veterans must not be subject to discriminatory denial or delay of cost of living allowances.* The VSO authors of the *Independent Budget* have repeatedly assured Congress that veterans will support any COLA modification *if it is applied to all federal departments, agencies and accounts.*
- *Veterans should have a national cemetery with available grave space in every state.* Currently, twelve states do not have open burial space.

Summary of Recommendations

Benefits Programs

A. Compensation, Pensions and Burial Benefits

- Repeal the current restriction precluding Dependency and Indemnity Compensation (DIC) reinstatement for remarried surviving spouses or married children who become single.
- Redefine veterans' mandatory and discretionary spending categories so that these categories conform to the intent of enacted authorizing legislation. At a minimum, Congress should authorize additional transfers from existing mandatory budget authority to fund personnel costs of delivering authorized entitlements to veterans.
- Legislate, as an entitlement, reasonable timeliness standards for adjudicating compensation and pension claims.
- Repeal the *Omnibus Budget Reconciliation Act*'s provisions that eliminate the headstone or marker allowance and limit plot allowance eligibility.

B. Readjustment Benefits

- Authorize funding for all vocational rehabilitation benefits and services from the Readjustment Benefits entitlement account.
- Legislate, as an entitlement, reasonable timeliness standards for VA's provision of vocational rehabilitation services to eligible veterans.

C. Veterans Insurance and Indemnities

- Continue these largely self-sufficient programs for veterans.

D. Home Loan Program

- Continue these programs for veterans.

General Operating Expenses

A. General Operating Expenses

1. Claims Processing Backlog

- Establish and meet reasonable timeliness standards for benefits' administration.
- Tailor staffing levels to actual workload and not to a predetermined, arbitrary budget target.
- Fully fund and support completion of ADP modernization.
- Acknowledge, identify and correct systemic deficiencies in claims processing.
- Correct inappropriate practices that contribute to delays and a backlog at the appellate level.

2. Veterans Benefits Administration (VBA)

- Fund personnel costs and equipment and technologies from mandatory spending accounts.
- Give VA authority to replace old data processing equipment on a cycle rather than through large single acquisitions.

- Appropriate $800,000 to maintain current data processing systems while VA phases in new systems.
- Appropriate $4 million to replace obsolete personal computers.
- Employ all available modern training technologies.
- Appropriate $800,000 to provide remote access, through additional access ports, to VA's computer system.

a. Compensation, Pension and Education

- Fund necessary physical reconfigurations of adjudication areas to facilitate a team approach to claims processing.
- Authorize and conduct studies to ascertain if alternatives to renting from GSA, more efficient and competitive procurement and direct contracts for security services would save VA money. Savings should revert to VA accounts for improving claims adjudication.
- Fund centralized training technology, at a starting cost of approximately $2 million, to increase efficiency and long-term savings.
- Authorize and fund a pilot study to determine if reassigning responsibility for VA medical examinations from VHA to VBA would increase savings and efficiency.
- Make separate appropriations for costs to operate the Veterans Claims Adjudication Commission.
- Authorize and fund studies to determine if various VA educational programs could be made more uniform, thereby streamlining their administration.
- Consider whether exempting certain VA programs from the burden of credit reform procedures would be advisable and cost-effective.
- Extend funding due to expire for disposition of the *Service Members Occupational Conversion and Training Act of 1992*, but for which administrative costs continue.
- Intervene if VA's revision of its unemployability ratings regulations do not fairly, realistically and uniformly assess a veteran's employability.
- Institute a new training program to instruct adjudicators on the mandatory nature of case law and its use and applicability. Include a process that accounts for proper and legal adjudications, monitors compliance and quality control, and studies appellate decisions to identify problem areas.
- Renew institutional and individual adjudicator commitment to VA's guiding principles for benefits administration.

b. Veterans Services

- Fund 2,440 full-time employee equivalents (FTEEs), so that Veterans Services may begin to satisfy reasonable service levels.
- Update telephone equipment.

c. Vocational Rehabilitation and Counseling

- Add 600 FTEEs to Vocational Rehabilitation and Counseling.
- Increase the cap on contract counseling funds.
- Sufficiently fund vocational rehabilitation revolving fund loans.
- Authorize non-pay training/work experience in the private sector.

d. Loan Guaranty

- Retain staff in the Loan Guaranty Service and do not reassign them to claims processing.
- Do not increase the loan funding fee.

3. General Administration

a. Board of Veterans' Appeals (BVA)

- Appropriate $200,000 to support BVA's FY 1996 training activities.
- Increase staffing levels by 50 FTEEs.
- Provide sufficient funding to continue ADP automation.

b. General Counsel

- Appropriate additional funds to station attorneys with the Under Secretary for Benefits and the Under Secretary for Health.
- Fund necessary automated data processing equipment.
- Conduct an internal review of the practices and productivity of Professional Staff Group II.
- Fund training programs in preventive law, personnel matters, contracting and medical center director legal responsibilities.
- Appropriate adequate funds for increased travel needs.

- Ensure that precedent opinions of the General Counsel are objective and unbiased.

B. National Cemetery System

- Appropriate $82 million to meet the burial needs of veterans and their families.
- Increase FTEEs by at least 15 to cover incremental workload increases.
- Provide at least $2 million in additional funds to reduce equipment backlog.
- Study the feasibility of creating a second national cemetery to ease the demand for burial space at Arlington National Cemetery.
- Expand existing national cemeteries.
- Recommit to a policy of providing an open national cemetery within 75 miles of 75 percent of America's veterans.
- Pursue the goal of providing one open cemetery in every state.
- Seek relief from historic preservation requirements at National Cemetery System facilities.

Medical Programs

A. Medical Care

1. Hospital Inpatient Care

- With appropriate legislative reform of eligibility rules, divert 150,000 inpatients to outpatient and long-term care venues in FY 1996 and FY 1997.
- Re-examine the types of patients treated in VA intermediate care beds.
- Structure resources to care for intermediate care patients in the most appropriate settings.
- Reform eligibility to remedy some veterans' misplacement in intermediate care beds.

2. Domiciliary Care

- Expand the VA domiciliary program to accommodate an average daily census of 7,600 in VA's own programs and 4,000 in VA-sponsored domiciliary care programs in FY 1996.

3. Outpatient Care

- Increase outpatient workload to achieve the *Independent Budget* target of 27,500,000 million staff visits and 1,880,000 fee-based visits in FY 1996.
- Fund 50 "storefront" clinics in current vet centers and provide resources for 50 nurse practitioners or physician assistants and 50 one-half-time clerical staff members, with additional funding for beneficiary travel to VA medical centers.

a. Prevention

- Offer routine diagnostic work for early disease detection and more effective, less intensive treatments.

b. Outreach and Education

- Mobilize and appropriately fund such programs as VBA's Transitional Assistance Program and the Disabled Transitional Assistance Program to ensure that "new" veterans recognize benefits for which they are eligible or entitled.
- Utilize "storefront" clinics in vet centers to educate veterans about basic health issues and to refer them to VA medical centers for more intensive treatment when necessary.
- Continue to support the effective and important activities of the Patient Health Education program.

c. Case Management

- Expand managed care techniques to other programs, especially those treating veterans with specialized care needs, such as spinal cord injury and psychosocial impairments.

4. Long-Term Care

- Appropriate funds to expand nursing home capacity and implement innovative long-term care programs.

a. Nursing Homes

i. VA Nursing Homes

- Increase the VA nursing home average daily census to 14,750 in FY 1996 (15,080 under new authority to reform access to services) by converting hospital beds, leasing nursing homes and entering into enhanced-use leases.

a. Hospital Bed Conversions

— Convert three 120-bed hospital wards to nursing home use in FY 1996.

b. Nursing Home Construction
- Fund four new 120-bed nursing homes in FY 1996.
- Expedite completion of VA construction projects.

c. Nursing Home Leases
- Lease two 120-bed nursing homes (three homes under new authority to reform access to services), for which VA personnel manage care and equipment, in FY 1996.

d. Enhanced-Use Leases
- Exploit enhanced-use arrangements to add an average daily census of 180 to VA's nursing home census.
- Fund activation costs for leased facilities.

ii. State Nursing Homes
- Increase state nursing home average daily census to 12,420 (12,850 under new authority to reform access to services) for FY 1996.
- Fulfill the obligation to compensate state homes for one-third of the average per diem cost of care for veterans in those homes.
- Allow VA to refer veterans to state veterans homes and contract for nursing home care from them.

iii. Community Nursing Homes
- Increase community-based nursing home census to 9,920 (10,490 under new authority to reform access to services) in FY 1996.

b. Non-Institutional Long-Term Care Alternatives

- Continue to supplement institutional programs with more non-institutional types of care.

i. Hospital-Based Home Care
- Activate hospital-based home care programs in FY 1996 at the 96 hospitals that currently lack them.

ii. Respite Care Programs
- Activate respite programs in FY 1996 at the 35 hospitals that currently lack them.

iii. Hospice Care
- Expand the VA hospice program by creating community-based programs with existing HBHC teams.

iv. Adult Day Health Care
- Increase the number of hospitals with VA or VA-sponsored adult day health care programs from 98 to 123.

v. Community Residential Care
- Establish community residential care programs at the 36 VA medical centers that do not offer such services now.

c. Accommodating Veterans' Long-Term Care Needs

i. Multilevel Long-Term Care Facilities
- Establish four multilevel, long-term care facilities to be associated with nearby VA regional referral centers.

ii. Geriatric Evaluation and Management (GEM) Programs
- Activate GEM programs in FY 1996 at the 38 hospitals that currently lack them.

iii. Geriatric Research, Education and Clinical Centers (GRECCs)
- Establish nine geriatric research, education and clinical centers, including one GRECC dedicated to spinal cord injury treatment and research, in FY 1996.
- Initiate a VA GRECC coordinator to expedite resource and personnel sharing to enhance each center.
- Coordinate the GRECC research agenda with the National Institute on Aging, and develop the program.

5. Bio-Psycho-Social Programs

- Coordinate responses to problems like homelessness, substance abuse, severe psychoses and post-traumatic stress disorder, which often contribute to one another, to best treat the underlying causes of bio-psycho-social disorders in veterans.

a. Homeless Programs

- Expand homeless veterans programs that focus on enhancing veterans' independent living skills, such as the Health Care for Homeless Veterans (HCHV) programs.
- Expand care at new and existing sites through the types of programs shown in Table 13 on page 91.
- Continue to develop drop-in centers in communities with unmet needs and metropolitan areas and establish new Homeless Chronically Mentally Ill and Domiciliary Care for Homeless Veterans programs.

- Continue collaborative projects and partnerships with other federal agencies, state and local governments and nonprofit organizations, including veterans' service organizations, to expand services for homeless veterans.

b. Long-Term Psychiatric Care

- Enhance staffing and resources at VA's long-term psychiatric care facilities.
- Develop innovative psychiatric care programs that treat mentally ill veterans in less restrictive settings and expedite their return to the community.

c. Substance Abuse

- Implement successful new treatment methods within VA programs in a timely manner.
- Enhance program flexibility and deal with substance abusers' special medical needs.
- Maximize opportunities to offer community-based interventions when appropriate.
- Pursue opportunities to join research and treatment projects with other federal programs that fund such projects.

d. Veterans' Industries

- Continue efforts to coordinate Veterans' Industries programs with private, nonprofit organizations and the Department of Housing and Urban Development.
- Establish 75 housing sites for these programs in the community.

e. Post-Traumatic Stress Disorder (PTSD)

- Continue to target eligible veterans and address their specific PTSD treatment needs with the types of programs shown in Table 16 on page 95.
- Establish PTSD clinical treatment teams in 10 additional VA medical centers.
- Enhance treatment resources at existing facilities.

6. Programs for Veterans' Specialized Care Needs

a. Female Veterans' Health Initiatives

- Consider the women veterans' special needs when planning VA's future.
- Publicize women veterans coordinators, who facilitate women veterans' entry to VA facilities through outreach programs.
- Continue implementing the VA Advisory Committee on Women Veterans.
- Give coordinators direct access to facility directors, to assist administrative staff and facilitate their women patients' access to gender-specific VA health care services.
- Accommodate privacy standards for women, with adequate toilet and shower facilities in each VA facility.
- Ensure women veterans' access to specialized care.
- Provide counseling to women veterans who have experienced sexual abuse during active duty.
- Authorize funding for 50 new, dedicated FTEEs for the Women Veterans Coordinators programs.

b. Programs for Gulf War Veterans

- Extend authorization for VA health care coverage for veterans' Persian Gulf illnesses related to their service.
- Continue investigations into Gulf War veterans' unexplained ailments.
- Continue outreach efforts to provide services to Gulf War veterans.

c. Disabled Veterans' Programs

- Expand sharing agreements for these programs when excess capacity exists.
- Share expertise in disabilities, to benefit not only veterans, but the entire disabled community.

i. Prosthetics Users' Services

- Fully implement the Prosthetics Improvement Implementation Plan, particularly elements that expedite purchasing.
- Fund additional FTEEs to staff continuing and additional programs.
- Continue to centrally control and monitor the prosthetics budget.
- Establish new orthotic labs to provide veterans extended access to these services for veterans.

ii. Programs for Veterans with Spinal Cord Dysfunction

- Expand spinal cord injury (SCI) training programs and provide special incentives for SCI-qualified nurses and therapists.
- Continue to organize SCI outpatient facilities under the chiefs of regional SCI referral centers.
- Dedicate a GRECC to the study of spinal cord injury in aging veterans.
- Establish a new SCI clinic.

- Fully fund the Independent Living Fund.

iii. Blinded Veterans' Programs

- Fund outpatient specialists to treat blinded veterans at VA medical centers without dedicated rehabilitation facilities.
- Experiment with funding earmarked from FY 1995 to identify innovative, effective programs for blind rehabilitation.
- Add full-time visual impairment services team (VIST) coordinators at the eight remaining medical centers that lack them.
- Add operating beds to blind rehabilitation programs by creating additional facilities.

7. Education and Training

a. Resident Training Programs

- Provide grants to five more medical centers for the primary care training program (PRIME) in FY 1996.

b. Residents/Fellowships in High-Demand Specialties

- Provide funds to support residents in high-demand specialties.

c. Tuition Reimbursement Program

- Fund nursing tuition reimbursement and expand the program to employees in other health professions.

d. Satellite Television

- Fund expanded satellite television programming, requiring 15 FTEEs.

e. Career Field and Service Chief Development

- Provide 20,000 units of training to service chiefs.

f. AIDS-Related Training

- Fund AIDS-related training.

8. Human Resources Development

a. Nurses

- Continue to monitor the implementation of amendments to the *Nurse Pay Act* and problems in salary compression and pay retention.
- Recruit nurse practitioners to supplement primary and preventive VA providers.

b. Physicians

- Extend tort claim protection to VA contract physicians who are treating VA patients.
- Reprogram staff requirements to emphasize primary and preventive care needs.
- Offer generalist "re-training" to specialists as a recruitment tool.

c. Dentists

- Strengthen VA-dental school affiliations and seek opportunities to share resources and facilities with dental schools.
- Provide 50 dental residency stipends.

d. Physician Assistants (PAs)

- Take corrective steps to ameliorate retention problems and to improve recruitment of physician assistants by implementing more acceptable pay grades.

9. Information Resources Management

- Establish a nonprofit VA information services foundation to facilitate the application of non-appropriated funding to VA information systems development.
- Invest $100 million in the VA information infrastructure in FY 1996.

10. Pharmacy

- Complete improvements in inventory control for controlled substances.
- Complete consolidation of VA mail service pharmacies.

11. Equipment Backlog

- Retire a newly prioritized equipment backlog within the next five fiscal years.

12. Non-Recurring Maintenance and Repair Backlog

- Retire the non-recurring maintenance backlog within the next four fiscal years.

13. Medical Care Cost Recovery

- Authorize retention of all payments collected from veterans' insurers for the treatment of non-service-related disorders.
- Authorize subvention of Medicare funds for higher-income veterans.
- Authorize collection and retention of all funds from all external payers, including Medicare, private insurers and veterans' copayments for treatment of higher-income veterans without appropriation offsets.

- Authorize treatment of veterans' dependents, at the dependent's expense and the local hospital director's discretion, to the extent that veterans' access is enhanced.

B. Medical and Prosthetic Research

- Incrementally fund a $336.6 million appropriation over FYs 1996-98 for medical, rehabilitation and health services research. This amount includes $290 million to meet current services requirements and $20 million more in FY 1996 for special initiatives.
- Establish a new "blue ribbon" research commission.

1. Medical Research

- Appropriate $234 million for biomedical, clinical and prosthetics research.

2. Rehabilitation Research

- Appropriate $34.5 million for rehabilitation research.

3. Health Services Research

- Appropriate $49 million for health services research activities.

4. Areas of Special Concern

- Appropriate $20 million for special initiatives in the priority areas of aging, women's health studies, AIDS and spinal cord injury programs.

C. Medical Administration and Miscellaneous Operating Expenses (MAMOE)

- Appropriate $72.3 million and fund 804 FTEEs in FY 1996.
- Review and implement recent work group recommendations that Deters, Thibault and Farsetta made on MAMOE's appropriate role within VA's management structure.

D. Education Loan Repayment Program

- Authorize the VA Educational Loan Repayment Program to replace the Health Educational Assistance Program.
- Fund this new program at $20 million in FY 1996.

Construction Programs

A. Management Recommendations

- Develop a strategic plan for VA's delivery system that corresponds to state and private-sector health care reforms.

B. Major Construction

- Appropriate $490 million for Major Construction projects, including leases for outpatient clinics and nursing homes.
- Dictate selected replacement and modernization projects that provide natural hazard mitigation and modernize and upgrade the physical plant according to established priorities, based on competition under state and private-sector health care reforms.
- Use new construction to complement leasing and bed conversions as a means of increasing available VA-operated beds for nursing home care.
- Appropriate funding for four new 120-bed nursing homes.
- Appropriate funding for two new VA domiciliaries.
- Construct two new national cemeteries annually until the National Cemetery System meets previously stated goals of one open cemetery in each state.
- Appropriate $16 million to acquire land for national cemeteries in states with no available grave sites.

C. Minor Construction

- Appropriate $269.8 million for Minor Construction projects.
- Convert twelve 30-bed wards to nursing home care in FY 1996.
- Appropriate $18 million for existing National Cemetery System construction projects.

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D. Parking Garage Revolving Fund

- Provide $1.5 million for this fund, which finances VA facility parking garage construction and operation.

E. Grants for the Construction of State Extended Care Facilities

- Provide $180 million for these grants, to fund all pending applications for the state home programs.

F. Grants for the Construction of State Veterans Cemeteries

- Appropriate $6 million to fund VA-anticipated program requirements in FY 1996.

G. Grants to the Republic of the Philippines

- Appropriate the usual grant of $500,000 to meet the Manila facility's repair and renovation needs.

TABLE 1

VA APPROPRIATIONS BY ACCOUNT

(in thousands)

	FY 1995 APPROPRIATION	FY 1996 IB CURRENT SERVICES LEVEL	FY 1996 IB RECOMMENDED APPROPRIATION	FY 1996 IB RECOMMENDED BUDGET AUTHORITY
GENERAL OPERATING EXPENSES (GOE)				
General Operating Expenses	890,193	1,208,813	1,267,248	1,267,248
Office of the Inspector General	31,815	32,591	32,591	32,591
National Cemetery System	72,604	82,000	82,000	82,000
TOTAL GENERAL OPERATING EXPENSES	**$994,612**	**$1,323,404**	**$1,381,839**	**$1,381,839**
BENEFITS PROGRAM				
Compensation, Pension, and Burial Benefits	17,626,892	17,661,972	17,661,972	17,661,972
Readjustment Benefits	1,286,600	1,345,300	1,345,300	1,345,300
Veterans Insurance & Indemnities	24,760	24,800	24,800	24,800
Veterans Job Training Fund	0	0	0	0
Loan Guaranty Program Account	59,371	82,321	82,321	82,321
Guaranty and Indemnity Program Account	572,321	582,207	582,207	582,207
Direct and Other Loan Program Accounts	2,062	487	487	487
Native American Veteran Housing Loan Program Account	218	455	455	455
TOTAL BENEFITS	**$19,572,224**	**$19,697,542**	**$19,697,542**	**$19,697,542**
MEDICAL PROGRAMS				
Medical Care	16,214,684	17,608,398	18,771,297	19,564,081
Medical & Prosthetic Research	251,743	290,583	310,583	310,583
MAMOE	69,789	72,343	72,343	72,343
Health Professionals Assistance Program	10,386	0	0	20,000 *
TOTAL MEDICAL PROGRAMS	**$16,546,602**	**$17,971,324**	**$19,154,223**	**$19,967,007**
CONSTRUCTION PROGRAMS				
Construction, Major Projects	354,294	490,006	490,006	490,006
Construction, Minor Projects	152,934	269,800	269,800	269,800
Parking Garage Revolving Fund	16,300	1,500	1,500	1,500
Grants for Construction of State Veterans Cemeteries	5,378	6,000	6,000	6,000
Grants for Construction of State Extended Care Facilities	47,397	180,000	180,000	180,000
Grants to the Republic of the Philippines	500	500	500	500
TOTAL CONSTRUCTION PROGRAMS	**$576,803**	**$947,806**	**$947,806**	**$947,806**
TOTAL VA PROGRAMS	**$37,690,241**	**$39,940,076**	**$41,189,410**	**$41,994,194**

*The *Independent Budget* recommends authorization of the Education Loan Repayment Program to replace this program.

Legislative Proposals

The VA system exists to offer support to veterans who have borne the cost of battle. Benefits compensate veterans, their dependents and their survivors for service-related disorders that may affect veterans' future wage-earning capability, contribute to loss of functionality and quality of life, and cause irreparable pain and suffering to veterans and their families. Other programs, like vocational rehabilitation, may help veterans reorient themselves to civilian lifestyle after honorable discharge or catastrophic injury or illness incurred in service. The veterans' medical care system exists to serve the special health care needs of veterans—particularly, the health care needs that have arisen due to military service, such as spinal cord injury medicine, prosthetics and sensory aids, care and rehabilitation for the blind, treatment of post-traumatic stress disorder, and other chronic disorders. Strong research and teaching programs, additional medical care missions, enable VA to maintain the integrity of medical care veterans receive. In addition, VA plays a significant role as a contingency medical provider in national emergencies. The proposals below seek to strengthen the VA programs created to implement these missions.

Veterans' Medical Care

Eligibility and Services

- *Reform eligibility for VA health care benefits.* Give VA authority to provide the full continuum of VA health care services, including readily accessible primary care and long-term care, to Core-Group veterans. The Core Group includes the service-connected of all disability ratings, low-income, and all other veterans described in special categories in *Title 38, U.S. Code.*
- *Provide care to catastrophically disabled veterans.* Include veterans who are or who become catastrophically disabled as Core-Group veterans for the purposes of entitlement to VA medical services.
- *Expand eligibility for readjustment services.* Expand eligibility for readjustment counseling and follow-up mental health care, to include veterans of service in theaters of operations of any prior periods of war and veterans of service in areas in which United States personnel were subjected to danger from armed conflict comparable to that of battle with any enemy during a period of war.
- *Provide procreative and pre- and post-natal care services.* Include in the VA definition of "medical services" those services designed to overcome service-connected and non-service-connected disabilities affecting procreation.
- *Provide pre- and post-natal care in VA women's health care programs for Core-Group veterans.* These services ensure female veterans of the same access to a comprehensive continuum of care as men.

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Funding

- *Ensure adequate congressionally appropriated support for Core-entitled veterans' health needs.* Ensure that Congress maintains its commitment to cover the cost of services in VA to entitled veterans by:
  - providing full funding support for a risk-adjusted premium from a mandatory spending account; and
  - ensuring that appropriations adequately support additional services now offered to veterans under *Title 38*.

Depending on the breadth of a basic benefits package, services may vary—for example, if the Clinton proposal had been enacted, such health care items as hearing aids, eyeglasses, custom-fitted prosthetics, spinal cord medicine, home improvements and structural alterations, medical supplies, comprehensive long-term rehabilitation services, aids for the blind, treatment for post-traumatic stress disorder (PTSD), treatment for conditions related to Agent Orange/Ionizing Radiation (AO/IR) exposure, long-term mental health services, domiciliary care, and nursing home care in excess of 100 days would have been considered additional services. Under a less generous plan, more services to which some veterans are entitled would be considered "additional."

- *Provide investment funding to VA medical centers to improve infrastructure, expand access and expand eligibility.* States and the private sector will continue to reform the health care system, regardless of federal activity. VA medical centers must have the ability to recruit new patients and retain current users in the face of competitive alternatives available in the environments in which they operate. To accomplish this, VA facilities must be geographically accessible and "user-friendly." They must be attractive and modern with some basic amenities, such as comfortable waiting rooms and telephones. Most importantly, they must be able to care for the "total" veteran and his or her dependents, to ensure appropriate patient management and enhance patient convenience.
- *Grant carry-over authority for medical care funding.* Ensure that VA carries over to the following year funds not spent by the end of the fiscal year.
- *Allow VA to retain third-party reimbursement.* Allow higher-income veterans and veterans' dependents to use the system when they or a third-party payer can cover the cost of care received at or contracted by VA. Authorize VA to retain third-party payments for treatment of their non-Core-Group veteran beneficiaries. Allow VA to retain Medicare funds and other third-party reimbursement for the treatment of higher-income veterans and veterans' dependents in the Medical Care account without offsetting congressional appropriations.
- *Allow a portion of reimbursements to remain in VA facilities.* Allow individual medical facilities to retain a specific share of reimbursements collected, to encourage initiative and growth.
- *Allow VA medical centers to use funds from all sources for marketing purposes they deem appropriate for local community needs.* Grant VA authority to undertake marketing efforts that allow adequate outreach to current VA users and others who may be allowed to enroll and that enhance the local and national image of VA.
- *Fund compensation and pension examinations from the accounts of appropriate benefits.* Give VA legislative authority to transfer funds from the Compensation and Pensions account to the Medical Care account to cover the costs of examinations of these programs' beneficiaries.
- *Shield VA from the impact of sequestration.* Legislatively provide total exemption from sequestration for VA medical care appropriations.

Employee and Management Issues

- *Eliminate arbitrary restrictions on full-time employee equivalents.* Grant VA medical center directors the discretion to hire necessary staff within funds—including retained third-party funds—available to their centers.

- *Increase pay for VA physician assistants.* Authorize special pay or revise pay categories to offset salary compression and retention and recruitment problems for VA physician assistants.

- *Enact the* "Whistleblower" Protection Act. Repeal *Title 38* exemption from the *"Whistleblower" Protection Act* to protect from retaliation employees who report incidents of agency "wrong-doing."

- *Extend immunity from tort liability to VA-contract physicians.* Extend to VA-contract physicians the same immunity from tort liability in medical malpractice claims that is accorded to regular VA physicians.

Research

- *Codify research merit review boards.* The *Independent Budget* veterans' service organizations were concerned when the VA research merit review boards were dissolved in 1993. The merit review boards, consisting of panels of researchers external to VA, served as the primary peer review mechanism for awarding VA research grants. The *Independent Budget* urges Congress to enact legislation that would re-establish and codify the merit review boards, to ensure the integrity, quality and independence of the VA research peer review process.

Veterans' Benefits

Protection of Entitlement Programs

- *Exempt VA benefits from the "pay-go" provision of the* Budget Enforcement Act. Remove the inequity that often results from this budget provision and allow Congress to base new entitlements on the merits of establishing these benefits, rather than arbitrary budget rules.

- *Oppose the taxation of VA benefits.* Seek legislation expressly exempting VA benefits from any form of taxation.

Benefits Administration

- *Establish mandatory timeliness standards.* Provide resources to meet mandated minimum timeliness standards for processing compensation, pension, and adjudication claims and for initiating vocational and counseling services, or require VA to provide payment for such benefits on an interim basis for claims not decided in a timely (as defined by statute) manner.

- *Repeal the one-year limitation on payment of accrued benefits.* Correct the injustice that occurs when VA delays and errors result in the pendency of a claim for a period in excess of one year and the claimant's death intervenes before the eventual favorable decision and the payment of benefits, by repealing *38 U.S.C. 5121(a)* and authorizing award of all retroactive benefits due and payable to the beneficiaries entitled under *Section 5121 (a)(1)-(4).*

- *Provide for correction of clear and unmistakable error occurring at the Board of Veterans' Appeals.* Seek legislation to allow a claimant to challenge an otherwise final Board decision on the basis of clear and unmistakable error, to require the Board to decide the question and correct the error where found, or to allow a claimant to seek judicial review of the Board's finding that clear and unmistakable error was not committed.

- *Authorize increased compensation on the basis of a temporary total rating for hospitalization or convalescence, to be effective on the date of admission to the hospital or the date of treatment or surgery that necessitates convalescence.* Seek legislation to exempt temporary total ratings from *38 U.S.C. 5111*, so that veterans will no longer be deprived of the compensation needed to offset the total disability during the first month in which temporary total disability occurs and to remedy the inequitable delay in payment and adverse economic effects of current law.

- *Correct the inequity that exists in the requirement that military retired pay be reduced by an amount*

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- *equal to any disability compensation received.* Provide for the receipt of full military retired pay based on longevity along with the concurrent receipt of full VA disability compensation on the principle that these two benefits are in no way duplicative but rather are based on two entirely different entitling factors.

- *Remove the three-year limitation on the time for amending tax returns.* Seek legislation authorizing the filing of amended federal income tax returns for periods preceding the last three years to recover taxes incorrectly withheld from disability severance pay more than three years ago and to claim tax exemptions based on VA disability ratings or correction of military records, which result in awards of disability pay or compensation more than three years retroactively.

Eligibility and Services

- *Reform Dependency and Indemnity Compensation (DIC).* Provide DIC support for widows of those killed in action at the same level as widows of totally disabled veterans.

- *Compensate non-pay training and work experience for vocational rehabilitation in the private sector.* Allow private-sector non-pay work experiences to augment federal, state and local programs as authorized settings for vocational rehabilitation.

Other Benefits

- *Provide assistance for the purchase of automobiles (and adaptive equipment).* Increase the monetary assistance provided veterans for purchase of automobiles from $5,500 to $11,000.

Cemeteries

- *Providing adequate funding for cemeteries.* Authorize funding for VA to build a veterans' cemetery in every state without an open site.

Construction Programs

- *Relieve VA from federal acquisition regulations and VA acquisition regulations to allow for more cost-effective construction projects.* Federal regulations, as well as VA's self-imposed regulations, drive up the costs of VA construction by as much as five percent, according to the National Institute of Building Sciences.

The Role of the Veterans' Service Organizations

- *Establish a mandatory advisory role for VSOs.* Seek legislation requiring that VSOs be included on all commissions, committees or boards involving VA policy and planning efforts anticipated to have a significant effect on VA missions.

Benefits Programs

The Nation which forgets its defenders will be itself forgotten.
Calvin Coolidge

Compensation and Pensions

The Compensation and Pensions appropriation funds compensation, pension and burial benefits and miscellaneous benefits described below.

Compensation

Compensation is paid to veterans for disabilities incurred or aggravated during active military service. The rate of compensation depends upon the degree of disability, with additional payment for dependents of veterans rated at 30 percent or greater.

Dependency and Indemnity Compensation (DIC) is paid to survivors of servicepersons or veterans whose deaths occurred while on active duty or as a result of service-connected disabilities. For survivors of veterans whose deaths occurred prior to December 31, 1992, the rates payable depend on the veterans' military ranks. DIC payments to surviving spouses of veterans who died on or after January 1, 1993, and those who elect to receive payments under *P.L. 102-568* are, effective December 1, 1994, $790 per month; an additional monthly payment of $173 is made to spouses of veterans rated totally disabled for a continuous period of eight years immediately proceeding death. To be eligible for the $173 monthly add-on, surviving spouses must have been married to the veteran during the eight-year period of total disability.

Effective October 1, 1994, survivors receive $200 per month for each dependent child. In addition, service-connected disabled veterans who use prosthetic or orthopedic appliances that tend to wear out clothing receive clothing allowances.

Pensions

Pension benefits are paid to veterans aged 65 or older who were receiving benefits prior to November 1, 1990, to low-income disabled veterans of wartime service, and to their survivors. (There is no disability requirement for survivors.) Amounts payable depend on income and number of dependents. Pensioners who have joined the rolls since January 1, 1979, receive "improved law" pensions. These "improved law" pensions include an automatic annual COLA increase equal to the Social Security COLA and reduce pension amounts dollar-for-dollar for income from other sources; almost all income is considered in determining pension eligibility for "improved law" pensions. More than half of the pensioners and more than $4 of every $5 of pension funds are paid under the improved law program. Older pension programs have major provisions that disregard income, with little or no reduction of pensions for income from other sources and no automatic annual increases.

2 Burial Benefits and Miscellaneous Assistance

The Burial Benefits program provides for:

- the payment of a $300 allowance (plus transportation charges if death occurs under VA care) to reimburse in part burial and funeral expenses of an eligible deceased veteran;
- the payment of $150 for a plot allowance if an eligible veteran is not buried in a national cemetery or other cemetery under the jurisdiction of the United States;
- the payment of a burial allowance of up to $1,500 when a veteran dies as the result of service-connected disability;
- a flag to drape the casket of an entitled deceased veteran;
- headstones or markers for graves of veterans and, in certain cases, graves of eligible dependents; and
- authority to provide graveliners for certain veterans interred in the National Cemetery System.

Miscellaneous Assistance is provided to meet the needs of a select group of servicepersons, veterans and survivors. It provides for the following:

Retired Officers

Emergency officers of World War I and certain other officers who have retired because of service-connected disabilities are entitled to special benefits.

Adjusted Service and Dependence Pay

Claims made pursuant to the provisions of *The World War Adjusted Compensation Act of 1924*, as amended, are paid.

Special Allowance for Dependents

Under certain conditions, dependents of certain veterans who died after December 31, 1956, but who were not fully and currently insured under the Social Security Act, receive a special allowance.

The IBVSOs believe that the *Omnibus Budget Reconciliation Act* provision precluding reinstatement of survivors' benefits for remarried surviving spouses or married children who become single is discriminatory.

Mortgage Insurance

Mortgage protection life insurance (for a maximum of $90,000, effective December 1, 1992) is provided for service-connected disabled veterans who have received grants for specially adapted housing. Effective September 1, 1988, *Public Law 100-322* authorized funding for this program from the Veterans Insurance and Indemnities appropriation.

The Dependency and Indemnity Compensation (DIC)

The IBVSOs believe that the *Omnibus Budget Reconciliation Act* (OBRA) provision precluding reinstatement of survivors' benefits for remarried surviving spouses or married children who become single is discriminatory. Other federal programs—for example, Social Security, Civil Service Retirement System (CSRS), and the CIA Retirement and Disability System (CIARDS)—permit reinstatement of survivors' benefits when a surviving spouse's remarriage is terminated. These programs also permit continuing eligibility if remarriage occurs after the beneficiary reaches a certain age.

We see no reason why the Congressional policy regarding remarriage that applies to Social Security, CSRS and CIARDS should not apply to DIC. At a minimum, DIC eligibility should be restored if a surviving spouse's remarriage ends.

Recommendation

Repeal the current restriction precluding DIC reinstatement for remarried, surviving spouses or married children who become single.

Discretionary vs. Mandatory Spending

OBRA allows entitlement programs, which mandatory spending accounts fund, to grow with the inflation rate. So-called discretionary spending programs, however, are not accorded this status. In fact, *OBRA of 1993* caps discretionary spending through FY 1998 at the FY 1994 level. This "cap" does not allow for inflation.

With respect to veterans' benefits programs, however, the distinction between mandatory and discretionary spending makes little sense. For example, the costs of administering compensation and pensions programs are considered discretionary, even though compensation and pension benefits are mandatory. The IBVSOs hold that a benefit entitlement cannot logically be separated from its accurate adjudication and timely delivery. If no employees are available to adjudicate benefit claims, an authorized entitlement is rendered meaningless. Why, then, are the means needed to adjudicate claims considered discretionary rather than mandatory?

With respect to veterans' benefits programs, the distinction between mandatory and discretionary spending makes little sense.

The consequence, of course, is that entitlement-delivery resources are thrown into the discretionary spending pot, where they are subject to the politics and pressures of such competing but unrelated interests as the space station and housing programs. The results include underfunding of the Veterans Benefits Administration (VBA) and, by any standard, adjudicative inaccuracy and tardiness.

The point, of course, is that budgetary categories should conform to reality. If authorizing legislation mandates a benefit or service, mandatory spending accounts should fund delivery of the benefit or service. Simply conforming the budget process to this reality would rectify much of the harm that the budget process has inflicted on veterans for decades.

Congress has recognized the logic of paying for VBA employees from mandatory spending accounts. Prime examples of these mandatory spending accounts are credit reform and *OBRA* activities. Unfortunately, however, *OBRA*-related activities are primarily geared toward eliminating entitlements. A recent example of paying for VBA employees from mandatory spending accounts is the new DIC formula, effective January 1, 1993. We applaud the Veterans Affairs committees for their foresight and urge them to authorize funding for all personnel costs for entitlement delivery from mandatory spending accounts.

Additionally, acceptable quality and timeliness standards must be integral to entitlement programs' funding if the programs are to have any meaning or substance. This does not diminish the need for efficient, innovative VA management or Office of Management and Budget (OMB) and Congressional scrutiny of VA's administrative activities. To the contrary, mandating quality and timeliness standards as entitlements provides a benchmark for achieving goals and measuring VA's administrative effectiveness, without penalizing veterans' programs beneficiaries.

Recommendations

With these considerations in mind, the IBVSOs urge Congress to:

- Redefine veterans' mandatory and discretionary spending categories to conform to the intent of enacted authorizing legislation (at a minimum, Congress should authorize additional transfers from existing mandatory budget authority to fund personnel costs of delivering authorized entitlements to veterans); and
- Legislate as an entitlement reasonable timeliness standards for adjudicating compensation and pension claims.

Burial Benefits

Burial benefits have historically represented America's gratitude to the families of deceased veterans. In many cases, these are the only benefits paid for honorable wartime military service.

VA predicts an increased demand for headstones, markers and burial flags. The mandatory use of graveliners in VA national cemeteries will likewise increase.

Recommendation

Congress should repeal *OBRA's* provisions that eliminate the headstone or marker allowance and limit plot allowance eligibility.

4 Readjustment Benefits

Fiscal year 1995 appropriations must fund the following Readjustment Benefits programs for veterans and certain eligible dependents and servicepersons:

All Volunteer Force Educational Assistance (veterans) (Chapter 30, Title 38, U.S.C.)

This program, known as the *Montgomery G.I. Bill (MGIB) Active Duty*, provides educational assistance benefits to veterans whose initial entry to active duty took place after June 30, 1985. The program's purposes are to help Armed Forces members readjust to civilian life after separation from military service, to promote and assist the All-Volunteer Force program, and to aid the retention of Armed Forces personnel. Participants must agree to a $100-per-month reduction of their military pay for the first 12 months of active duty. VA pays basic benefits and DOD pays supplemental benefits. Servicepersons who involuntarily separated from service after February 3, 1991, and who were not enrolled in *MGIB* may elect (prior to separation from active duty) to contribute $1,200 and receive assistance under the *MGIB* specialized assistance program.

All Volunteer Force Educational Assistance (reservists) (Chapter 106, Title 10, U.S.C.)

This program provides educational assistance to persons who enlist, re-enlist or extend an enlistment in the Selected Reserve for not fewer than six years after June 30, 1985. The program's purpose is to encourage selected reserve membership. DOD and the Department of Transportation pay for the program, while VA administers it.

Educational Assistance (dependents) (Chapter 35, Title 38, U.S.C.)

This program provides educational assistance benefits to children and spouses of veterans whose service-connected disability is rated permanent and total and to eligible survivors of individuals who die from a service-connected disability or whose service-connected disability was rated permanent and total at time of death. The program also provides benefits to dependents of servicepersons who are missing in action or whom a hostile government has interned for more than 90 days.

Special Assistance to Disabled Veterans (vocational rehabilitation) (Chapter 31, Title 38, U.S.C.)

This program provides benefits to disabled veterans enrolled in vocational rehabilitation programs. Disabled veterans also receive payments for tuition, books, handling charges, supplies, equipment, and beneficiary travel. The program also provides extended evaluation and independent living services for disabled veterans.

Special Assistance to Disabled Veterans (housing grants) (Chapter 21, Title 38, U.S.C.)

This program provides grants of up to $38,000 to help certain permanent and totally disabled veterans acquire specially adapted housing units with fixtures or movable facilities that their service-connected disabilities make necessary. Veterans with service-connected blindness or loss of (or loss of use of) both upper extremities may receive individual grants of up to $6,500.

Special Assistance to Disabled Veterans (automobile grants and adaptive equipment) (Chapter 39, Title 38, U.S.C.)

This program provides for a one-time grant of up to $5,500 for the purchase of an automobile or other conveyance for certain severely disabled veterans and servicepersons. It also provides for adaptive equipment necessary for safe operation of the vehicle. Veterans suffering from service-connected ankylosis of one or both knees or hips are eligible for only the adaptive equipment. This program also authorizes replacement or repair of adaptive equipment.

Work-Study

A student pursuing rehabilitation, education, or training under *Chapters 30, 31, 32 and 35 of Title 38 U.S.C.* and *Chapter 106 of Title 10 U.S.C.* has potential eligibility for a work-study allowance. Students enrolled in full-time programs may agree to perform

VA-related services and receive a work-study allowance. Veterans who have service-connected disabilities rated 30 percent or more receive preference.

A student who agrees to participate in the work-study program may work up to 250 hours per semester. Effective May 1, 1990, a student pursuing at least a three-quarter-time program (one-half-time for *Chapter 31* veterans) who agrees to work up to 25 hours per week for the enrollment period receives the greater of the federal or state minimum wage. A student who agrees to work fewer hours gets a proportionally lesser amount. Students receive 40 percent of the amount of the work-study agreement in advance.

State Approving Agencies

This program reimburses state approving agencies for the cost of inspecting, approving and supervising education and training programs that educational institutions and training establishments offer and in which veterans, dependents or reservists enroll. The IBVSOs would like to note here that, beginning in FY 1994, a provision of the *Dependency and Indemnity Compensation Reform Act of 1992, Public Law 102-568*, links indexing of future increases in *MGIB* with the Consumer Price Index (CPI). The *Omnibus Budget Reconciliation Act of 1993, Public Law 103-66*, however, eliminated the *MGIB* COLA for FY 1994 and reduced the FY 1995 COLA by one-half.

Veterans Insurance and Indemnities

VA administers or supervises eight life insurance programs that provide more than $507 billion of insurance protection to 6.1 million veterans and members of the uniformed services. The amount of coverage VA-sponsored programs provide would make VA the fourth largest life insurer in the country if it were a commercial insurance company. Four of the VA-administered life insurance programs are self-supporting; VA has also invested sufficient revenues in U.S. Treasury securities to meet these programs' liabilities without any appropriated funds.

The Veterans Insurance and Indemnities (VI&I) fund is the only veterans' insurance fund that requires an annual appropriation. The appropriation subsidizes:

- service-disabled veterans' insurance protection at standard premium rates; and
- disability payments when the disability is traceable to the extra hazards of military service. By law, the government bears these premium subsidies and extra hazard insurance costs. Payments made from this fund include transfers to three government life insurance funds and direct payments to insurers and beneficiaries.

The largest category of obligations is the subsidy provided to the Service Disabled Veterans Insurance (SDVI) fund. This fund requires a subsidy because it provides life insurance protection at standard premium rates to veterans with service-connected disabilities and is, therefore, not self-supporting.

Transfers are also made to the National Service Life Insurance (NSLI) and United States Government Life Insurance (USGLIF) funds to pay claims traceable to the extra hazards of military service.

The VI&I fund also includes the obligations and collections of a small NSLI program under which VA issued policies to veterans with service-connected disabilities between 1946 and 1949. The VI&I appropriation also provides disability payments to certain World War I veterans. These payments are total permanent disability awards that originated under the War Risk Insurance programs, which ended in 1926.

Also included under the VI&I appropriation is the Veterans Mortgage Life Insurance (VMLI) program. *Public Law 100-322*, enacted on May 20, 1988, transferred the VMLI program's administration from a commercial insurance company to VA, effective September 1, 1988. In addition, this legislation transferred VMLI expenses funding from the Compensation and Pensions appropriations to the Veterans Life Insurance and Indemnities appropriation. Effective December 1, 1992, this program provides $90,000 in mortgage protection life insurance to individuals who have received grants for specially adapted housing. VA issues policies at standard premium rates to individuals who are considered health risks. This increased coverage was granted to the 2,000 policyholders who had mortgages exceeding $40,000; only 196 declined the additional coverage. As a result of this new increase, VA issued an additional $54 million in coverage.

6 Except for VI&I payments, veterans' insurance benefits programs are self-supporting. VA administers seven life insurance programs and supervises the administration of an eighth, Servicemen's Group Life Insurance (SGLI). Under contract with VA, the Prudential Insurance Company administers SGLI through its Office of Servicemen's Group Life Insurance (OSGLI). OSGLI disburses funds to the General Operating Expenses (GOE) appropriations to pay VA's supervisory expenses.

VA's consolidated insurance funds finance the following insurance programs:

- United States Government Life Insurance (USGLI).
- National Service Life Insurance (NSLI).
- Service-Disabled Veterans Insurance (SDVI).
- Supplemental Service-Disabled Veterans Insurance (SSDVI).
- Veterans Reopened Insurance (VRI).
- Veterans Special Life Insurance (VSLI).

Standing legislation makes budget authority available to USGLI and NSLI funds automatically each year; therefore, Congress need not act. Budget authority consists of net cash income in the form of premium payments, interest on securities, and VI&I payments, which in FY 1995 amounted to just over $1.4 billion.

As of September 30, 1994, approximately 2.9 million USGLI, NSLI, VSLI and SDVI policies were in effect. Since the inception of these insurance programs, VA has issued more than 24 million policies. As of FY 1994, VA collected approximately $2.4 billion in income from these policies, disbursed $2.2 billion to policyholders or beneficiaries, and held $15.1 billion in reserve to cover future liabilities to these funds.

In 1992, VA paid annual cash dividends for NSLI, VSLI, VRI and USGLI before their normal anniversary dates. VA's primary purpose in accelerating payment of $408 million in dividends was to provide an economic stimulus. Legislation authorized a one-year open season, covering September 1, 1991, through August 31, 1992, during which NSLI, VSLI and VRI policyholders could use their dividend credits to purchase paid-up additional insurance. During this open season, approximately 101,000 policyholders increased their insurance by an estimated $505 million.

Public Law 102-568, the Dependency and Indemnity Compensation Reform Act of 1992, among other things, modified VA insurance programs. Its modifications, which became effective December 1, 1992, include:

- increasing the amount of Servicemen's Group Life Insurance (SGLI) and Veterans Group Life Insurance (VGLI), from a maximum of $100,000 to $200,000;
- changing VGLI to a five-year renewal term policy;
- permitting service-connected veterans insured under SDVI who quality for a waiver of premium to purchase an additional amount of SSDVI, not to exceed $20,000; and
- increasing the maximum amount of VMLI from $40,000 to $90,000.

At the end of 1992, VA introduced a new dividend option, called net premium billing, which allows policyholders to use their annual dividends to pay premiums. This option allows veterans to automatically apply the dividend to the premiums. If the dividend amount is less than the annual premium, the policyholder is billed for the balance. If the dividend amount is greater, the excess amount is refunded, or used to buy additional insurance or to reduce an outstanding loan balance. Approximately 38 percent of the eligible policyholders have elected to use the net premium billing option.

Home Loan Programs

Congress created the Home Loan Guaranty Program (HLGP) in 1944 to assist veterans returning from wartime service who could not maintain suitable credit ratings or save for down payments on homes. Originally, the legislation called for a sunset provision of five years; because of the program's popularity and success, Congress permanently codified it in *Title 38* in 1970. The Loan Guaranty Revolving Fund (LGRF)

financed the program's operation. Since its inception, VA has guaranteed 14.5 million loans, and approximately 3.4 million loans are outstanding.

For years, however, the LGRF required substantial appropriations to maintain its solvency. High foreclosure rates contributed to LGRF deficits; as prior *Independent Budgets* described, however, misguided OMB policies, ineffective management and insufficient employees to administer the program added significantly to these deficits.

Congress addressed these problems in *The Veterans Benefits Amendments of 1989*. This comprehensive legislation established the Guaranty and Indemnity Fund (GIF). GIF finances loan guaranty program operations for loans made on or after January 1, 1990. A major feature of the legislation is indemnification of veterans who default on their home loans against liability to VA.

In the event of an insoluble default, VA stands ready, through its contract of guarantee, to make good any loss the loanholder sustains up to the guarantee amount. To offset expenses, Congress raised the basic loan guarantee fee from 1.00 percent to 1.25 percent (compensable-rated, service-connected disabled veterans and surviving spouses of veterans whose deaths are service-connected are exempt from the fee). For loans with 5- or 10-percent down payments, VA reduced the loan fee to 0.75 percent and 0.50 percent, respectively. For loans made between November 1, 1990, and September 30, 1991, the *Omnibus Budget Reconciliation Act (OBRA) of 1990* increased each of these fees by 0.625 percent. Thus, during this period the basic fee was 1.875 percent and the fees for 5- and 10-percent down payment loans were 1.375 percent and 1.175 percent, respectively. The *OBRA* loan fee increase "sunset" on September 30, 1991, and effective October 1, 1991, the pre-*OBRA* loan fees again took effect. Under *OBRA of 1993, P.L. 103-66*, the fees borrowers pay to VA for a VA-guaranteed home loan increased by 0.75 percent of the loan amount (compensable-rated, service-connected veterans and surviving spouses of veterans whose deaths are service-connected are also exempt from this fee). The increased fee applies to loans closed between October 1, 1993, and September 30, 1998.

Another provision of *P.L. 103-66* establishes a fee of three percent of the loan amount for veterans who previously obtained VA-guaranteed home loans. The increased fee does not apply to veterans who make down payments of at least five percent of the purchase price. This increased fee applies in the case of second and subsequent loans closed between October 1, 1993, and September 30, 1998.

Two recently enacted laws have changed the Loan Guaranty program.

- *P.L. 103-353*, signed on October 13, 1994, increased the maximum guaranty from $46,000 to $50,750. Since lenders typically will only lend up to four times the amount of a veteran's entitlement, this has the practical effect of increasing the maximum VA loan for the purchase or construction of a home from $184,000 to $203,000.

- *P.L. 103-446*, signed on November 2, 1994, makes several changes to the Loan Guaranty program:

  - It extends home loan eligibility to service-connected disabled reservists and surviving spouses of reservists who died from service-connected causes.

  - It allows a *one-time only* restoration of entitlement when the VA loan is paid off and the veteran still owns the property.

  - It expands the exceptions to the minimum 24-month-active duty requirement for veterans whose service began after September 7, 1980. The new exceptions are the same as those that apply to the Chapter 30 education benefit.

  - It revises the Interest Rate Reduction Refinancing Loan (IRRRL) program to allow refinancing from an adjustable rate mortgage (ARM) to a fixed-rate mortgage, even if the fixed rate is higher than the current rate on the ARM. It also allows a veteran to add the cost (up to $6,000) of energy-efficient improvements to an IRRRL.

  - It allows VA to accept proposed construction properties with individual water and sewage disposal systems without certification regarding the economic feasibility of installing public or community systems.

- It amends the Manufactured Home program to make any unit that displays a certificate of conformity with federal construction standards eligible for VA financing. It also eliminates the requirements to inspect manufacturing plants or to do onsite inspections of homes sold to veterans. It also enhances VA's authority to debar manufacturers.
- It allows VA to accept conveyance of a foreclosed property, even if the loan holder overbids at the foreclosure sale.

Credit Reform

The Federal Credit Reform Act of 1990, P.L. 101-508, changed federal credit program accounting to make it consistent with and comparable to accounting for noncredit transactions. The essence of credit reform is to separate the subsidy costs from the nonsubsidized cash flows of credit transactions and to focus base budgeting and analysis on subsidy costs.

To accomplish the preceding objective, credit reform separated federal direct and guaranteed loan programs into the following accounts:

- Liquidating accounts—These accounts record all cash flows to and from the government resulting from direct loans obligated, and loan guarantees committed, prior to 1992. These accounts are shown on a cash basis. All new activity in these funds in 1992 or later is recorded in the direct loan financing account.
- Program accounts—These accounts record the subsidy costs for direct loans obligated, and loan guarantees committed, in 1992 or later, and administrative expenses for housing programs. The subsidy amounts are estimated on a net present value basis; the administrative expenses are estimated on a cash basis.
- Direct loan financing account—This nonbudgetary account records all financial transactions to and from the government resulting from direct loans obligated in 1992 or later. The amounts in these accounts provide a means of financing and are not included in the budget totals.
- Guaranteed loan financing accounts—These accounts record all financial transactions to and from the government, resulting from loan guarantees committed during or after 1992.

TABLE 2

FY 1996 Independent Budget Recommended Current Services and Budget Authority for Benefits Programs

Compensation, Pension, and Burial Benefits	17,661,972
Readjustment Benefits	1,345,300
Veterans Insurance and Indemnities	24,800
Veterans' Job Training Fund	0
Loan Guaranty Program Accounts	82,321
Guaranty and Indemnity Program Accounts	582,207
Direct and Other Loan Program Accounts	487
Native American Veteran Housing Loan Program Account	455
Total Benefits	**$19,697,542**

Suggested Benefit Improvements

Because of inequities that result from current laws the IBVSOs seek improvements in the laws discussed below. The *Independent Budget* recommendations for benefits programs shown in Table 2 do not incorporate suggested legislative improvements. We also suggest a study to determine whether removal of the presumption of permanent and total disability at age 65 is cost-effective.

1. *The One-Year Limitation On Payment Of Accrued Benefits Should Be Removed.*

Periodic monetary benefits to which an individual was entitled, but which had not been paid at the time of death, are payable to certain survivors. These benefits which "accrued" to a veteran but had not been paid before the veteran's death may be paid to the surviving spouse or children.

Section 5121 of *Title 38 U.S.C.* limits this payment to the benefits that accrued in the one-year period preceding the ending date of the deceased's entitlement. Therefore, if at the time of death a veteran had just prevailed in an appeal and was entitled to retroactive benefits for the period during which the claim was pending, all but the last

year would be lost. The surviving spouse or children, who also suffered economic deprivation for an extended period because of an erroneous VA decision, would be barred from receipt of a substantial portion of the benefits the veteran would have received but for death.

With the time period for processing claims and appeals often being a matter of years, this limitation is inequitable. Both delays and variations in timeliness result in inequities. For example, if one VA regional office, due to greater staffing or a smaller backlog, adjudicated a veteran's claim within a year of its filing, but another VA regional office took two years to adjudicate the identical claim, the latter veteran would lose a full year of benefits because the regional office was slower. Administrative variances should not affect entitlement in this manner.

With the aging veteran population and the long delays in claims processing, more and more veterans are dying before their claims are finalized. Accordingly, the IBVSOs urge Congress to remove this one-year limitation.

2. *Congress Should Amend the Law to Authorize Increased Compensation on the Basis of a Temporary Total Rating for Hospitalization or Convalescence to Be Effective, for Payment Purposes, on the Date of Admission to the Hospital or the Date of Treatment, Surgery or Other Circumstances Necessitating Convalescence.*

When a service-connected disability requires hospitalization in excess of 21 days, a temporary total disability rating is in order. This rating is effective the first day of hospitalization and continues to the last day of the month of hospital discharge. Similarly, where surgery for a service-connected disability necessitates at least one month's convalescence or causes complications, or where immobilization of a major joint by cast is necessary, a temporary total rating is awarded effective the date of hospital admission or outpatient visit.

While the effective date of the temporary total disability rating corresponds to the beginning date of hospitalization or treatment, the effective date for the beginning of monetary entitlement is delayed, under *38 U.S.C. 5111*, until the first day of the month following the effective date of the increased rating. 9

This provision deprives veterans of any increase in compensation to offset the total disability during the first month in which temporary total disability occurs. This deprival and consequent delay in the payment of increased compensation for total disability often jeopardizes disabled veterans' financial security and unfairly causes them hardships.

Therefore, the IBVSOs urge Congress to enact legislation exempting these temporary total ratings under *38 C.F.R. 4.29, 4.30* from the provisions of *38 U.S.C. 5111*.

3. *Congress Should Repeal the Inequitable Requirement that a Veteran's Military Retired Pay Based on Longevity Be Offset by an Amount Equal to His or Her Disability Compensation.*

Former servicemembers who are retired from the military service on the basis of length of service must waive their retired pay in order to receive disability compensation from the Department of Veterans Affairs. This is inequitable because military retired pay is earned by virtue of the veteran's long service on behalf of the country. Such veterans should not be penalized for choosing the military service as their career rather than a civilian career with perhaps fewer sacrifices and greater rewards.

That is exactly what occurs when a veteran must forfeit his or her retired pay to receive compensation for a disability that continues after service, probably throughout the remainder of the veteran's life. Just as with the disabled veteran who chooses a civilian career, the miliary retiree should be able to receive full military retired pay and full disability compensation. The IBVSOs urge Congress to correct this serious inequity.

4. *There Should Be an Exception to the Three-Year Limitation on Amendment of Tax Returns in the Case of Erroneous Taxation of Disability Severance Pay or in the Case of Retroactive Exemption of More Than Three Years.*

10

Section 104(4) of *Title 26 U.S.C.* exempts from taxable income "allowance for personal injuries or sickness resulting from active service in the armed forces." Similarly, *38 U.S.C. 5301(a)* provides that benefits due or to become due under any law administered by VA "shall be exempt from taxation." In *St. Clair v. United States*, 778 F. Supp. 894 (E.D. Va. 1991), the District Court affirmed that the law excludes disability severance pay from taxable income.

Nonetheless, the Internal Revenue Service (IRS) has taxed disability severance pay as regular income. It has now acquiesced in the District Court's ruling, and veterans may amend their tax returns to recover amounts illegally taxed. However, the three-year statute of limitations on amending tax returns prevents veterans whose illegal taxation occurred more than three years before the court's decision or their learning of this unlawful taxation from recovering amounts the IRS unlawfully withheld.

Additionally, where entitlement to disability compensation is established retroactively but not paid because the veteran received military retired pay during the period, that portion of the taxable retired pay that VA would have paid as nontaxable disability compensation but for the delayed award becomes nontaxable. The veteran may file an amended return to recover the excess taxes paid. Again, the three-year limitation would bar recovery of taxes for periods beyond that time.

Therefore, because of government error, disability severance pay was erroneously taxed, and this may have occurred more than three years previously. Additionally, retroactive compensation entitlement for more than three years would occur only in the case of awards delayed because of error reversed on appeal. In both instances, circumstances beyond the veteran's control may prevent timely amendment of tax returns. An exception to the three-year limitation is fully justified to correct this inequity.

The IBVSOs ask that Congress enact legislation to remedy this problem.

5. *Congress Should Enact Legislation to Require Correction of a Board of Veterans' Appeals Decision Involving Clear and Unmistakable Error.*

A decision of VA becomes final if it is not appealed within one year or if appealed and affirmed by BVA. As an exception to the rule of finality, a VA decision may be corrected at any time if it involves clear and unmistakable error.

Clear and unmistakable errors are those that are undebatable. They are distinguishable from questionable judgements and differences of opinion. They are errors that have deprived and continue to deprive VA claimants of benefits for which their entitlement is simply unquestionable. It would be unconscionable to discover such error and not correct it, to continue depriving a claimant of benefits to which he or she is fully entitled.

Clear and unmistakable error is fundamentally different from disputes in which neither side of the issue is conclusively supported and over which debate could go on indefinitely, or in which a claimant is unwilling to accept an adverse yet conclusively supported decision. Those situations require a rule that, at some point, ends the dispute, whether to the satisfaction of both sides or not. Clear and unmistakable error, as an exception, does no violence to the rule of finality, however. It allows justice to prevail in cases where it has unquestionably been denied previously. It does not provide an avenue for unending debate. When the allegation is made or the question is raised, it must stand fully on its own merits based on the law and evidence of record at the time the challenged decision was made, albeit VA sometimes will not concede the obvious and inevitable and therefore BVA or the Court must declare the error on appeal. Beyond that, however, debate is put to an end. This narrow exception to finality results in a very small percentage of the cases VA decides.

A recent decision by the U.S. Court of Appeals for the Federal Circuit limited a claimant's ability to seek remedy for clearland unmistakable error. This decision held that the veteran could not obtain correction of a clear and unmistakable error through a VA regional office if

BVA had upheld the regional office's decision. While the Board may reconsider its decision on an appellant's motion, such reconsideration is discretionary.

Therefore, where a clear and unmistakable error occurred because VA overlooked some dispositive law or fact and the Board did the same, there is no course a claimant can take if the Board is not inclined to correct its error. Unfortunately, as discussed under "General Operating Expenses" below, the Board is averse to this issue. As a result, an outright and undebatable error lingers uncorrected, and the frustrated claimant lacks recourse.

A House-passed bill in the 103d Congress included provisions to correct this inequity but they were not included in the legislation eventually enacted. The IBVSOs submit that such remedial legislation should be a priority for the 104th Congress.

> How we treat our veterans is an indicator of who we are as a people
>
> *Jesse Brown*
> *Secretary of Veterans Affairs*

6. *Congress Should Exempt Veterans' Entitlements from the "Pay-Go" Provisions of the* Budget Enforcement Act.

The so-called "pay-go" provisions of the *Budget Enforcement Act* require that the costs of any new federal benefits or services be paid out of existing benefits or programs. Recently, this required one group of disabled veterans to forfeit part of their cost-of-living adjustment in compensation to allow Persian Gulf War veterans to receive compensation for undiagnosed illnesses.

Veterans' benefits are a cost of war and maintaining military services. The benefits of one group of veterans should not be reduced in order to pay benefits due another group. If new conflicts were to occur, more and more veterans would share a fixed amount of funds, thereby diminishing each group's benefits.

Therefore, the IBVSOs support legislation to exempt VA benefits and services from the "pay-go" provisions of the *Budget Enforcement Act.*

7. *VA Should Conduct a Study to Determine if the Removal of the Presumption of Permanent and Total Disability for Pension Purposes at Age 65 Resulted in Savings or Whether Costs of VA Examinations and Record Development Outweigh Potential Savings.*

Public Law 101-508 removed the age 65 presumption of permanent and total disability and required development of evidence of permanent and total disability. It is suspected that this provision, designed to result in savings, may in fact cost the government more by reason of the added administrative costs and that entitlement to pension is nonetheless shown in most of these cases notwithstanding removal of the presumption.

VA should therefore conduct a study and make appropriate recommendations to Congress in the event the current provisions are found to be counterproductive.

Opposition to Benefit Reduction/Elimination

There is perhaps no area in which the unanimity among the IBVSOs is more evident than their opposition to misrepresentations about the deservedness of veterans' benefits and efforts to erode or eliminate them. Such initiatives run counter to rational, equitable and practical considerations.

For disabled veterans, the saying that something "costs an arm and a leg" becomes literal when quantifying the personal costs of war. Veterans disabled during service to their country quite often show physically the destruction to parts of their bodies by the instruments of war. These physical deformities no doubt serve to spur the conscience of most in this grateful nation. These disabilities, which veterans suffer for the remainder of their lives, have profound effects, not only in terms of economic loss from decreased work efficiency and limitations on career advancement, but also in the overall quality of life.

A veteran who is blind can never again sense and appreciate life in the same way the rest of us do. Daily life is full of inconveniences and aggravations that

would frustrate most of us. A veteran who uses a wheelchair confronts obstacles in nearly every activity of daily life, such as stairs in relatives' homes, restaurants and public places. The inability to ambulate not only has a severe industrial impact, it precludes many of the social activities the non-disabled take for granted. The physical, mental and social devastation of disabilities is limitless and frequently affects the disabled person in such subtle and hidden ways that the non-disabled never sense it.

Means-testing restricts disabled veterans' potential to rise above a governmentally mandated economic status and station in life.

Yet, there are some who would penalize the service-connected disabled who, by the grace of opportunity and the success of unusual determination, overcome or lessen the economic loss associated with disability. There are some who advocate penalizing the disabled veteran because of income or assets that result from good fortune totally unrelated to the government or any ability to overcome the service-connected disability. Based on income or perhaps the size of a veteran's estate, these people would offset or eliminate the veteran's disability compensation through a process known as "means testing."

It has always been the sense of the American people and the policy of our government that disabled veterans not have their ambitions and opportunities defeated or constrained by arbitrary rules that penalize efforts to overcome their disabilities and thereby condemn them to lives devoid of any chance of personal advancement or enrichment. For example, since its first version, VA's Schedule for Rating Disabilities has always been founded on the principle that disability ratings are based on the average impairment in earning capacity and not individual success in overcoming it.

Many disabled veterans have, despite their disabilities, made invaluable contributions to society through work in the government and private sector. It is inconceivable that the Secretary of Veterans Affairs, for example, would be deprived of the compensation he is due for service-connected disabilities, merely because he has excelled and now receives a salary for his service to veterans as the head of VA.

It is completely unfair that a totally or partially disabled veteran would lose his or her compensation because of monetary gain from some collateral source such as an inheritance. Similarly, it is unfair that a veteran would lose his or her compensation, independence and perhaps dignity because he or she has a successful spouse who earns enough to require forfeiture of the compensation. Means testing restricts disabled veterans' potential to rise above a governmentally mandated economic status and station in life. Means testing simply offends fundamental principles of fairness.

A group that ironically calls itself the "Concord Coalition" (after a "heroic battle" in which the people "answered the call to arms and courageously stood together") advocates means testing of those whose annual income, including compensation, exceeds $40,000. In its publication, The Zero Deficit Plan, the Concord Coalition states: "When the nation promised these benefits and services, it underestimated how much they would cost. Now, we must face the unpleasant truth that we can no longer afford to keep those promises fully."

It is indeed shocking that our government would seriously entertain such a suggestion. This says that our government places no value on promises—that it would readily disregard moral obligations. The government, as a role model, would communicate to our nation's youth that it is perfectly acceptable to break promises when it is inconvenient to keep them. Are our leaders so incapable of finding solutions that they would abandon this nation's disabled veterans, that they would renege on this nation's responsibility to its defenders who have sacrificed and will continue to suffer the lasting effects of disability the remainder of their lives?

Compensation, specifically, and veterans' programs, overall, are comprising less of the federal budget year after year. The suggestion that the nation impair its covenant with veterans, that it disavow its obligation, that it disregard the vested nature of this benefit, fails to take into account the purpose of this benefit, fails to recognize that it is a trust established by this nation for its disabled veterans, and fails to appreciate the principle that this is something the value of which lies in its inviolable status and its exemption

from aberrant trends or capricious governmental actions. The suggestion that disabled veterans be penalized in this manner ignores the fact that compensation for veterans disabled in service is not the cause of the budget problem. This suggestion also fails to consider the effect of necessary annual income verification for all service-connected veterans upon a struggling VA claims system that cannot process the caseload it now has in a timely fashion.

The Concord Coalition also makes the similarly unprincipled suggestion that the government simply terminate compensation payments to service-connected veterans with less than 30 percent disability. This would mean that all veterans with moderately severe muscle injuries from gunshot or shell fragment wounds for which the rating schedule provides 20 percent would lose their compensation. It would mean that veterans with paralysis rated severe for some peripheral nerves and rated moderate for others would no longer be compensated. Such rash proposals reveal their proponents' lack of understanding.

The suggestion of taxing disability compensation is equally misguided. Benefits paid for disability have traditionally been exempt from taxation. To tax people's disabilities is an extreme that offends notions of fairness. Society simply does not consider it necessary to place this added burden on persons already disadvantaged by disability. It becomes all the more inappropriate when directed toward veterans disabled in the service of their country. This prompts the question, have we become a society that has no regard for the predicament of the disabled? Is our desperation so great that we would abandon our values and tax what is intended as some measure of relief from misfortune?

It is certainly reasonable to assume that, because compensation rates for total disability are below median incomes, the rates already reflect an adjustment for taxes. It might well be that the historical lack of taxation of compensation reveals a common sense approach that recognizes it is not cost-effective to pay higher rates of compensation only to incur the administrative expense of recouping a portion of those benefits as taxes. In any event, taxation of the relatively modest compensation of disabled veterans, who but for their disabilities might have pursued much more economically rewarding careers, is unwarranted. 13

The rational, practical and equitable arguments against measures to reduce, eliminate, tax or "means test" disability compensation are numerous, and it is beyond the scope of this publication to deal with them more comprehensively here. But, the IBVSOs hope the fact that these plans would all constitute an unconscionable abandonment of this nation's moral obligations should alone be enough to steer lawmakers to other considerations. The IBVSOs intend to refute the convenient, misleading arguments that disabled veterans are either to blame for the nation's budgetary difficulties or are undeserving of compensation for their service-connected disabilities. Through budget reconciliation, veterans have already lost billions of dollars in entitlements. They have willingly shouldered their share of the burden, as they did earlier in the service of their country.

The IBVSOs do not believe that the sons, daughters, spouses, other relatives, friends and neighbors of veterans support or desire governmental actions that are detrimental to veterans' well-being. Nor do we believe that the citizens of this country, who have a special reverence for veterans, are ready to abandon the nation's moral obligation to those disabled in the service of the Country. We do not believe, as the Concord Coalition would have it, that the moral fabric of this nation has so unraveled that its citizens no longer honor and appreciate the solemnity of its promises.

General Operating Expenses

It is as much the duty of government to render prompt justice against itself in favor of citizens, as it is to administer the same between private individuals.

Abraham Lincoln

Introduction

Fiscal year 1996 represents the eighth consecutive year the IBVSOs have presented an *Independent Budget* for General Operating Expenses (GOE). As we have previously stressed, benefits and their timely delivery are inseparable. This principle is the cornerstone of the IBVSOs' funding recommendations. However, we do not maintain here that claims backlogs and delays result solely from inadequate resources. On the contrary, we believe that flaws in the processes themselves act in concert with inadequate staffing and resources to cause this problem. We therefore suggest reform of the claims processing system along with adequate funding to correct this problem.

There can be no question that lack of timeliness in claims adjudication is one of the most serious problems facing VA. In its September 1994 report "Veterans' Benefits: Lack of Timeliness, Poor Communication Cause Customer Dissatisfaction" (GAO/HEHS-94-179), the General Accounting Office stated: "The time it takes VA to process claims was by far the greatest source of applicants' dissatisfaction, according to our survey." Although excessive delay causes a loss of public confidence in an agency, it would be a mistake to view this lack of timeliness as having no consequences other than claimant dissatisfaction. With an aging veterans' population, there is a very real danger that veterans may die before their claims are decided.

Claimants for VA benefits often must endure economic hardships for long periods of time while they await benefit determinations, all the while living with uncertainty about the future. Many of these claimants suffer serious disability. Delays cause further financial loss and physical and mental suffering. VA benefits are intended to be a source of relief from worry, disability and economic hardship, not a source of added distress. In these instances, justice delayed is truly justice denied.

And it is in this context that we address the ills and needs of the Veterans Benefits Administration. The problems with claims backlogs and consequent delays are not solely attributable to VA regional offices, however. Deficiencies at the administrative and judicial appellate levels combine with those originating at the regional office level to complicate and compound the problem. For that reason, the IBVSOs have taken a somewhat different approach this year by juxtaposing and integrating our analysis of the appellate process with regional office claims processing.

16 General Operating Expenses

Claims Processing Backlogs

As of the end of November 1994, VA had 468,620 compensation and pension cases pending. Original disability claims were taking an average of 168 days to complete. Reopened claims were taking an average of 135 days to complete. Response time for BVA, the time it will take to issue a decision for a new appeal entering the system, is an average 850 days.

A VA survey shows that VA claimants think nine weeks is a reasonable time in which to process an initial disability compensation claim, seven weeks for a reopened compensation or pension claim, six weeks for a dependency and indemnity compensation claim, and seven weeks for an initial disability pension claim.

In its report, the General Accounting Office recommended that the Secretary of Veterans Affairs should direct the Under Secretary for Benefits to "set long-term goals to meet customer expectations for processing times, and prepare a plan describing the incremental steps necessary to meet them." (GAO/HEHS-94-179 at 20.)

There can be no question that lack of timeliness in claims adjudication is one of the most serious problems facing VA.

Analysis and Suggested Corrective Measures

The VA should establish and meet reasonable timeliness standards for the administration of benefits. This can only be accomplished if Congress provides VA with the resources necessary to accomplish the goal and VA identifies deficiencies within the system that do not result from underfunding and that are within VA's control and ability to correct.

Obviously, reasonable timeliness is a subjective concept. Nonetheless, there is general agreement that current processing times are not reasonable. The timeliness standards must of course include actual time it takes, based on work measurement data, to accomplish the processes involved in the adjudication itself. Average record development time, reflecting response time for records sources, must be added along with the amount of time required for transfer between functions. (Although delays in connection with obtaining records from non-VA sources and VA are sometimes unavoidable, VA should make every effort to establish procedures that minimize the time required to obtain records.)

The amount of time the claim is idle because of backlogs should be much less than currently seen. Given the inevitable fluctuation in workloads and the necessity to avoid workers being idle, a zero backlog is neither realistic nor desirable. Some reasonable, manageable reserve of pending caseload is perhaps a necessity, at least until VA can complete its program to cross-train employees to perform alternative functions as necessary. Realistically, there is probably little danger of VA having no backlog.

Without the necessary resources, VA's best efforts cannot succeed. Congress must provide for adequate staffing and needed automated data processing systems.

Staffing levels must be determined by actual workload and not be tailored to a predetermined arbitrary budget target. Mandatory spending accounts should fund appropriations for administering veterans' benefits. Adequate funding will allow the Veterans Benefits Administration to recruit and retain a sufficient number of well-trained employees to ensure timely claims adjudication by creating a rational system of measures that establishes a workforce mindful of and in concert with established workloads. In short, VA should realistically assess its employment needs based on reasonable timeliness standards, and Congress should authorize the required staffing levels.

Such measures would alleviate the need for costly overtime, which is only a stop-gap, short-term fix. Such "band-aid" approaches treat the symptoms and not the chronic disease, thereby permitting the same problem to recur again and again. Except during isolated, episodic system overloads, overtime simply is not a cost-effective method for claims processing. Beyond the increased cost in wages, diminishing returns from employee burn-out and resulting decreased productivity lead to a double-barreled effect in declining efficiency.

With VA's massive workload, there is no acceptable substitute for adequate tools to accomplish the job: there is no acceptable alternative to modern automated data processing (ADP) systems. The work cannot be performed promptly and efficiently without the aid of such systems.

Much has already been done toward ADP modernization, and VA continues to phase in more systems, but there must be a commitment by Congress to fully fund and support completion of the program.

The modernization plan involves three stages of technology acquisition, beginning with Stage I hardware and software to implement 19 transitional applications, followed by Stage II acquisition of document imaging hardware, and finally Stage III integrated and centralized systems. (The modernization program, its applications and benefits are discussed in more detail below.)

Any debate that this modernization is not essential to the future of the claims processing functions is easily refuted by merely considering where VA would be today without benefit of the added efficiency and increased productivity these systems have brought. There was once a time when large operations functioned without photocopying equipment, facsimile machines and modern communications systems, but those tools are now essential to the efficient operation of businesses and government. The same is true for modern data processing systems, an area in which VA was previously far behind.

Staffing and data processing resources are not the total answer to bringing VA's pending caseload under control. First, VA must acknowledge that there are systemic deficiencies in its claims processing. Second, it must identify the specific deficiencies. Third, it must make a dedicated effort to correct those deficiencies.

Underlying deficiencies are readily revealed in such factors as the large proportion of cases that must be remanded by the Board of Veterans' Appeals (BVA or Board) to have regional offices correct inadequate records. Local problems may be revealed where decisions of a particular regional office are overturned by BVA in large numbers.

It is startling that the Board of Veterans' Appeals' remand rates were running at 55 percent for the first half of fiscal year 1994 and 48.3 percent at the end of fiscal year 1994. The percentage of cases that were remanded more than once grew from 2 percent in fiscal year 1991 to 10 percent in fiscal year 1994. In addition to these remands, 18 regional offices had more than 20 percent of their cases overturned by the Board. Nationally, 17.5 percent of the cases BVA received in fiscal year 1994 were reversed. The reversed and remanded cases together comprise 65 percent of the Board's total dispositions. Thus, nearly two-thirds of the cases appealed to the Board during fiscal year 1994 were defective, requiring either reversal or remand.

Trends in appealed cases may also reveal more subtle indications of specific deficiencies. The share of appeals involving service-connected disability compensation grew from 76.2 percent in 1978 to 83.4 percent in 1994.

These VA claimants, many of whom are ultimately shown to be deserving of the benefits denied, must wait for unacceptably long periods of time just to get their appeal before the Board. For example, fiscal year 1994 statistics show an average of 376 days elapsed time between the filing of a notice of disagreement and the date the appeal is received by the Board.

Total appellate processing time is even more shocking. This timeliness indicator measures elapsed processing time between the filing of an appeal with VA and the final BVA decision on that appeal. During fiscal year 1994, the average total appellate processing time for appeals involving no remands was 678 days; appeals involving one remand, 1,016 days; and more than one remand, 1,350 days. These times do not include the processing time for the claim at the regional office, and, of course, do not include the time required for review by the Court of Veterans Appeals, if necessary. Waiting times for VA claimants are measured in terms of years rather than days or months.

There are troubling indicators that BVA unnecessarily lengthens the process by inappropriately remanding cases that it should not and need not remand. The most revealing indication of invalid remand practices of the Board is the discovery that Board attorneys were removing evidence from veterans' claims folders to justify further record development and remand to the regional office for that

18 purpose. Remands involve less effort than decisions on the merits. Prior to this revelation, allegations that such underhanded practices actually go on within VA would have been dismissed as radical and exaggerated. Unfortunately, less drastic, yet inappropriate, remand practices continue.

One of the more regularly seen justifications for remand is a "stale examination." This is a situation where an examination was conducted for adjudication purposes when the claim was decided at the regional office, but the Board notes that, due to the extended pendency of the appeal, that examination is now a year or more old and remands for a more current examination. Of course, under that theory and practice, the Board would never reach a point when it could decide the case, assuming that there continue to be backlogs that result in long delays in the case being referred to the Board. On each occasion, and indefinitely, the Board could again remand because the examination had grown stale. Moreover, this practice disregards fundamental concepts underlying appellate review functions and circumvents the law.

In the typical "stale examination" case, the examination was current when the regional office made its decision. The veteran obviously did not appeal because of a stale examination. Rather, he disagreed with the determination that the examination did not establish entitlement to a higher disability rating. The question before the regional office rating board and the question to be reviewed on appeal is the degree of disability at the time of the regional office decision, based on the then-current examination. The fact that the disability may improve—one, two or ten years later—is not a basis for holding the decision in suspense indefinitely, awaiting some possible future change in circumstances.

When such a case is before the Board, the question is the degree of disability based on the evidence already in the record. The case is ripe for review. If the Board determines that the regional office erred and the veteran is entitled to the higher rating sought, entitlement to the higher rating is effective back to the time it would have, but for the error, been established based on the evidence before the rating board.

For disabilities that have not stabilized and are susceptible to future improvement, VA schedules routine reviews. Where warranted, this is the procedure to determine if there has been a subsequent improvement in a previously established level of disability.

In those cases in which the evidence before the rating board shows a higher level of disability than the rating board granted, the only appropriate action for BVA is to grant an increased rating. Where BVA does not grant that increase and remands for a new examination, expecting a possible improvement in the disability, it circumvents the law. If the new examination on remand does indeed show that, on that date, the disability is improved and the Board then uses that evidence to deny the increased rating, the Board has unlawfully deprived the veteran of the higher rating for the period of time the disability was shown to be worse.

Under the law in that instance, the disability rating should have been increased based on the evidence showing a higher level of disability and later reduced based on the subsequent examination showing improvement. Because it is not the Board's function to conduct routine reviews of disability ratings in conjunction with its appellate reviews, it has no legitimate reason to seek more current examinations or otherwise seek to supplement adequately developed records with the thought of possibly finding something that will allow it to deny a claim in which the current record requires allowance.

The Board's jurisdiction is appellate, but its scope of review is *de novo*. It has the authority to expand the scope of the factual or legal issues to include subsidiary, ancillary or collateral questions where doing so will allow it to render a favorable decision for the appellant. Like appellate courts, it has plenary jurisdiction to decide questions of law. Unlike appellate courts, however, the Board's broader scope of review allows it to decide all material issues of fact and law without necessity to remand for new decisions by the agency of original jurisdiction. Remand by the Board only becomes necessary where there is a real need to seek additional evidence.

Nonetheless, the Board sometimes remands to allow the regional office to entertain purely legal questions. A good example is where a representative at the Board argued that the prior decision was clearly and unmistakably erroneous. Because a clear and unmis-

takable error is one that is undebatable and must be established solely on the evidence of record at the time of the challenged decision, there is no element of rating judgement and no reason to supplement the record. The Board possesses the same discretionary powers and authority to decide an issue as the regional office. Thus, the Board is, in all respects, in as good a position to decide a question of clear and unmistakable error as a regional office.

Yet, as noted, the Board has been known to remand cases merely to afford the regional office the opportunity to consider the question of clear and unmistakable error. Some adjudicators appear to disfavor grants of benefits based on a finding of clear and unmistakable error, and, quite often, the case will eventually be returned to the Board for a decision on the issue it attempted to avoid. Under such circumstances, the veteran is deprived of benefits to which he or she is entitled while the case is shuffled between the regional office and BVA.

With some regularity, an appeal will involve more than one benefit. Where the Board finds it must remand on one issue, it often makes no decision on the other issue or issues even though there is no interdependence. This unnecessarily delays the decision on the issue or issues that could be decided and ensures that the case must be returned to the Board a second time. The Board sometimes then determines it needs to remand the case on the second issue and makes no determination on the first issue for which it initially remanded. Hence, some cases undergo multiple successive remands.

The quality of the Board's decisions continues to suffer and thereby contributes to the number of cases appealed to the Court, immediately extends the delay the claimant must suffer, and eventually contributes to the claims backlog.

The Board ignores the precedent holdings of the Court in many cases. The BVA Select Panel on Productivity Improvement cited an analysis by the VA General Counsel that showed 86 percent of the cases remanded to the Board by the Court resulted from errors contrary to well-established Court precedent. Other statistics show these remanded cases languish in the Board for long periods. In March 1994 when the statistics were compiled, 26.6 percent of all the cases remanded by the Court in fiscal year 1990 were still undecided. For cases remanded in fiscal year 1991, 53.3 percent remained undecided. This percentage has grown each year, to 90 percent of the remanded cases still undecided for fiscal year 1994. Out of the total 2,238 cases remanded by the Court between fiscal year 1989 and fiscal year 1994, 73.5 percent were undecided.

Prior to judicial review, the Board operated on internal policies that had no basis in law. For example, the Board considered appeals from reductions in disability evaluations as claims for increase rather than challenged reductions. The burdens of proof and standards for change in disability evaluation are different in claims for increase and reductions. By considering the appealed reductions as claims for increase, the Board could ignore the regulatory protections against unwarranted reductions and the burdens upon the government to establish material improvement.

In several decisions, the Court was critical of this practice. For example, in *Dofflemyer v. Derwinski*, 2 Vet.App. 277 (1992), the Court said, "The BVA incorrectly phrased the issue in terms of whether appellant was entitled to an increased rating; in fact and in law, the issue presented to the BVA, and to this Court, is not whether the veteran was entitled to an increase but whether the reduction of appellant's rating from 100 percent to 10 percent was proper."

We have been made aware of an unwritten Board policy that a veteran's disability evaluation should not be increased more than one step. For example, a veteran rated 30 percent might only be increased to the next highest available rating for that disability, which is 50 percent, although the evidence strongly supported a 70 percent, or even a 100 percent, rating. The IBVSOs hope that judicial review will eventually put an end to this policy.

With respect to the question of entitlement to a total disability rating based on unemployability of the individual, the Board's decisions have revealed an unusually strong trend toward denial. The Court has often cited arbitrariness in these decisions and was prompted to remind VA in one decision that the claimant need not be "a total basket case" before there is inability to engage in substantial gainful activity.

The BVA is, as are VA rating boards, particularly averse to conceding clear and unmistakable error

20 (CUE) in a prior decision, because that results in an award of benefits to the veteran retroactive to the date they would have been paid if the error had not been made. In some cases, the Board simply unlawfully refuses to address the issue of clear and unmistakable error. In *Johnson v. Brown* 4 Vet.App. 508 (1993), the Court noted that the veteran had repeatedly raised the issue of clear and unmistakable error, but that BVA inexplicably did not address it. Frustrated with the Board and the conduct of VA's attorney before the Court, the Court said, "Because of the Board's having twice failed to adjudicate the veteran's CUE claim explicitly raised to it and the dilatory and unresponsive conduct of counsel for the Secretary, the Board is ordered to issue a decision on remand, not later than 90 days after the date of this decision...."

None of these practices are based on a rule of law. The fact that these practices prevailed demonstrates that the destruction of records by a Board attorney is not the only irregularity in the Board's handling of veterans' claims. The fact that such practices existed, at least one of which a Board Chairman's written policy sanctioned, demonstrates the depth of the problem.

Reading various decisions of the Court of Veterans Appeals reveals that this mindset remains. And, in some instances where the Court remands to the Board, the Board's actions seem to be directed more toward reinforcing its prior erroneous decision than toward fairly deciding the claim. This has forced appellants to take their cases back to the Court to get enforcement of the Court's first decision.

In fact, the Board on occasion has acted in outright defiance of the Court. In *Browder v. Derwinski*, 1 Vet.App. 204 (1991) (*Browder I*), the Court held that the veteran's disability worsened during his military service, and remanded for the Board to provide reasons or bases for its decision that the veteran was not entitled to service connection by reason of aggravation of the disability. On remand, the Board essentially overruled the Court and held that the disability did not worsen. This required a second appeal to the Court. In its second decision, *Browder v. Brown*, 5 Vet.App. 268 (1993) (*Browder II*), the Court instructed the Board on the well-known rule that the Court's holding is the "law of the case," which is binding on the Board. On the second remand, the Board did precisely the same thing as on the first remand, notwithstanding the Court's emphatic instruction that such action is unlawful. This required a third appeal to the Court. Had not the VA General Counsel settled this case, a third decision by the Court would have been necessary.

In *Willis v. Derwinski*, 1 Vet.App. 63 (1990) (*Willis I*), the Court remanded for reasons or bases. On remand, the Board merely devised a convoluted and specious rationale to uphold its prior decision. This required a second appeal to the Court by the veteran. In its second decision, *Willis v. Derwinski*, 1 Vet.App. 66 (1991) (*Willis II*), the Court observed that, "in its attempt to buttress its original decision, the Board has ranged far beyond the boundaries of the record in this case and has entered the world of presumptions and speculation." The Court proceeded to expose the Board's selective reading of the record and the many contradictions in its decision.

In *Hayes v. Derwinski*, 1 Vet.App. 186 (1991) (*Hayes I*), the Court remanded for the Board to readjudicate the issue in light of the Court's decision and provide an adequate statement of the reasons or bases for the Board's decision. On remand, the Board went beyond the scope of the remand and utilized a new theory to arrive at the same conclusion as in its first decision. This required the appellant to bring a second appeal to the Court. In its second decision, *Hayes v. Brown*, 4 Vet.App. 353 (1993) (*Hayes II*), the Court observed that the Board went beyond the scope of the remand and, in addition, relied upon misinterpretations of the law to arrive at a denial. The Board finally, in its third decision on this case, found that the appellant was entitled to the benefits sought.

There are other cases where the Board's behavior is similar. Some of these cases are being appealed to the Court for a second time. Of the cases appealed to the Court, 35 percent involve error requiring reversal or remand.

Asked why the Board, in its remands, did not more specifically articulate the errors of VA regional offices, in a fashion similar to that of the Court in its remands to the Board, the Chairman responded to the effect that criticism or specific holdings of error or deficiencies would disturb the fraternity between the Board and regional offices. There is much in the policies and actions of the Board that contributes to inefficiency and

impedes beneficial reform of the system. The Board is producing less and taking longer, but a substantial portion of its decisions do not conform to the minimum requirements of law, as dispositions of the Court reveal.

Although the Court has, on occasion, criticized VA's unresponsiveness and intransigence, some of the Court's practices allow and encourage this situation to continue. The most grievous of these practices is the Court's willingness to let VA dictate the terms under which a case will be decided.

> "If this nation's veterans are truly to have the benefit of independent judicial review as envisioned by the Veterans' *Judicial Review Act*,...it must be real judicial review, not just the appearance thereof."

In one of its earliest decisions, *Gilbert v. Derwinski*, 1 Vet.App. 49 (1990), the Court held that the law requires the Board to state in its decision the reasons or bases for its conclusions. In a concurring opinion, Judge Kramer stated some warnings that proved to be portentous. He warned that no amount of reasons or bases, no matter how articulately made, can justify that which is not justifiable. He also cautioned against the Court's adoption of a stance that is too deferential to the BVA because that would be contrary to Congress' intent in establishing the Court to serve as the final arbiter. He said, "If this nation's veterans are truly to have the benefit of independent judicial review as envisioned by the Veterans' *Judicial Review Act*....it must be real judicial review, not just the appearance thereof."

An early effort by VA attorneys also foretold what the future would hold for appellants seeking independent reviews of their cases in the Court. In six cases, which were later consolidated for review by the Court, appellants filed briefs specifying errors of the Board of Veterans' Appeals. In an attempt to prevent review of these cases by the Court, the Chairman of the Board of Veterans' Appeals ordered Board reconsideration and vacated the Board decisions. The VA's attorneys then moved the Court to dismiss these cases, arguing that the Court lacked jurisdiction to review them because of the lack of a final BVA decision from which appeal could be taken to the Court.

These six appellants, in *Cerullo v. Derwinski*, 1 Vet.App. 195 (1991), prevailed in their arguments that, once a notice of appeal was filed with the Court, jurisdiction transferred to the Court, and the Board had no retained or concurrent jurisdiction to order reconsideration or vacate its decision. The Court rejected VA's argument that the Board Chairman may, on his own motion, order reconsideration and thereby negate the finality of the BVA decision and strip the Court of its jurisdiction over the cases. The Court observed that VA's position would "give the Department of Veterans Affairs (VA) the power to defeat meaningful judicial review and thereby subvert the intention of Congress in enacting the *Veterans' Judicial Review Act*." The Court further observed:

> *The Secretary's assertion of an unrestricted ability on the part of the BVA Chairman to order reconsideration at any time without a stated reason would also give the Secretary power to delay the progression of a particular claimant's case if it were advantageous to the agency. Appellants correctly contend that reconsideration could conceivably be ordered in order to "afford the Board an opportunity to reinforce its denial in order to withstand judicial review."*

The Court referred to a similar situation in social security cases where the Secretary of Health and Human Services had the power to call cases on judicial review back to the agency. Because of criticism that this authority was exercised to bolster decisions so that they would be more likely to withstand judicial review, Congress amended this provision. It was also suggested that the previous practice could lead to laxity in administrative review, since the agency had a second opportunity to strengthen its case prior to judicial review.

Unfortunately, VA was undeterred, and the Court now acquiesces in a slightly different approach by VA that allows it to accomplish those same things the Court precluded in *Cerullo*. Indeed, the stage was set for this practice in *Cerullo* where the Court held that

22 the VA may file a motion for remand based on confession of BVA error. Like many devices originally intended to have a beneficial use, confession of error is susceptible to misuse, as in this situation where it can be used to deprive the veteran of an independent review by the Court.

Solicitor General Frederick Lehmann, confessing government error, explained, "The United States wins its point whenever justice is done to its citizens in the courts." The Supreme Court similarly said in *Young v. United States*, 315 U.S. 257 (1942), "The public trust reposed in the law enforcement officers of the Government requires that they be quick to confess error when, in their opinion, a miscarriage of justice may result from their remaining silent." Chief Justice Rehnquist has stated, however, that the Court should not respond in "Pavlovian fashion" to a confession of error but rather rule independently on the case.

Now, more than four years after the Court's decision in *Gilbert* that BVA must provide adequate reasons or bases for its decisions, VA attorneys continue to use the lack or purported lack of reasons or bases in the Board's decisions as a means to get the case away from the Court and back before the Board, using confession of error or simply a motion for remand. The Court complained about the Board's failure to improve its decisions in *Simon v. Derwinski* 2 Vet.App. 621 (1992). The Court stated its hope that the Board Chairman would take steps whereby the "Board will be persuaded to part from its old ways." The Court expressed its displeasure that, after it issued numerous decisions that the Board is required to provide reasons or bases, the Board failed to do so, but the Court's practices encourage Board recalcitrance.

The Court has shown a great willingness to grant VA's motions for remand, without addressing errors in law or fact argued by appellants, and despite appellants' strenuous objections. The practice thus allows VA to essentially defeat a veteran's right to independent judicial review through confession of error, that is, by arguing that the Board failed to provide adequate reasons or bases.

Appellants before the Court have pointed out that, under well-established rules of appellate practice, only appellants have a right to assign errors in decisions appealed, that appellees may challenge decisions below only if they have filed cross-appeals, and that this is impossible in VA's case because the law precludes VA from appealing to the Court. In effect, this practice allows VA to appeal its own decision, on its own terms. It allows VA to limit the issues on appeal to the ones it substitutes for the veterans' issues. The unfair effect is more egregious with VA as appellee than it would be when private parties are involved because VA was the decision maker in the case appealed and will again be the decision maker when the Court remands the case.

Under these circumstances, VA is able to confess error on lesser issues to avoid having its decision reviewed on the issues the appellant raised. Most often, VA, in a conclusory fashion, contends that it made none of the errors the appellant identifies but admits that the Board's decision does not contain adequate reasons or bases and, therefore, moves that the Court remand the case to the Board.

Even though the appellant specifically points out that the reasons or bases are completely adequate to understand the Board's decision and are simply wrong, or that the appellant is not prejudiced by any purported deficiency in reasons or bases because the case turns solely on error in law which the Court may decide *de novo*, the Court may simply grant VA's motion and remand for the purposes in that motion. Appellant's objections to remand are often to no avail.

Although the Court has repeatedly stated that it must have adequate reasons or bases to review the propriety of the Board's decision, the Court does not retain jurisdiction when it remands for the reasons or bases. It seems a contradiction for the Court to cite, as its reason for remand, reasons or basis inadequate to permit judicial review, and yet not retain jurisdiction. After the BVA provides reasons or bases in its decision on remand, the appellant must bring a new appeal to the Court. Therefore, a veteran must appeal twice to the Court to have his or her case decided, the first time to get reasons or bases and the second time to get a decision on the merits.

Appellants have argued that the Court has no jurisdiction to dispose of an appeal based on errors alleged by VA. The Court has responded by attempting to distinguish them as confessions of error rather than assignments of error. The Court maintains that it is completely

free to entertain the VA's confessions of error to the detriment of appellants and over their objections.

Whether they are termed confessions of error or assignments of error, the effect is the same, and the effect is that which is generally precluded, except where there is a valid cross appeal:

> *a party who does not appeal from a final decree...cannot be heard in opposition thereto when the case is brought here by the appeal of the adverse party. In other words, the appellee may not attack the decree with a view either to enlarging his own rights there-under or of lessening the rights of his adversary, whether what he seeks is to correct an error or to supplement the decree with respect to a matter not dealt with below. But it is likewise settled that the appellee may, without taking a cross-appeal, urge in support of a decree any matter appearing in the record, although his argument may involve an attack upon the reasoning of the lower court or an insistence upon matter overlooked or ignored by it.*
>
> *United States v. American Ry. Express Co.*, 265 U.S. 425, 435 (1924).

This rule is "inveterate and certain." *Morley Const. Co. v. Maryland Casualty Co.*, 300 U.S. 185, 191, *reh'g denied*, 300 U.S. 687 (1937).

The Court does not seem concerned that, if the VA's argument of inadequate reasons or bases is true, it is also an open admission that VA apparently never intends to comply with *Gilbert*, given that its decisions still do not conform to the Court's instructions after four years. The Court seemingly rewards VA for its intransigence. And, with the knowledge that it can continue to obtain remands to avoid judicial review, VA has no incentive to conform its practices to the law.

Under these circumstances, all the time and resources the appellant has invested in the appeal to the Court are lost, and VA, which had complete control over the case and its outcome before, has regained complete control to do with the case what it wishes.

Often, the Board's actions on remand make it appear that it is going on a "fishing expedition" in the hope, we believe, that some new examination or medical opinion will provide it with evidence adverse to the appellant. The Board on remand will engage in readjudication of factual issues that were previously not in dispute to arrive at the same result via a different theory. The Board solicits medical opinions from its own physicians who often take a position contrary to that of private and VA physicians who have examined or treated the veteran.

The Court has been critical of this practice. In *Austin v. Brown*, 6 Vet.App. 547 (1994), regarding use of a Board physician's opinion, the Court held that "there was no process at work to ensure impartiality, and [this] creates the impression that the Board was not securing evidence to determine the correct outcome, but rather to support a predetermined outcome."

The Board Chairman insists that he has the authority to generate evidence within the Board despite *38 U.S.C. 7109* and its legislative history, which make it clear that advisory medical opinions, other than those routinely obtained from VA medical facilities, are to come "from one or more independent medical experts who are not employees of the Department."

Even when the Court remands by an opinion that addresses the merits, it often gives VA the desired "fishing license" with inappropriately broad directions, quoting its decision in *Fletcher v. Derwinski*, 1 Vet.App. 394 (1991) where the Court stated that it expects BVA to reexamine the evidence of record and, "seek any other evidence the Board feels is necessary..."

Certainly, in cases in which the Board's error was a decision based on an inadequate record, the instruction may be appropriate, but in many other cases it is not. This broadens the issues on appeal rather than narrowing them at each successive stage as it should be, and this results in added litigation when BVA seeks to use the remand as an occasion to reinforce its prior decision.

Motions for remand by VA sometimes also request that the Board be allowed to obtain additional evidence, even though the appellant has not asserted any record inadequacy. In granting these motions, the Court allows VA to do what it prohibits veterans from doing. Responding to the appellant's motion to remand for clarifying evidence in *Hatlestad v. Derwinski*, 3 Vet.App. 213 (1992) (*Hatlestad II*), the Court said:

The Court agrees with the Secretary that the appellant's motion is inappropriate as an attempt to piggyback into the Court's proceedings evidence that is precluded from the Court's consideration because it was not part of the 'record of proceedings before the Secretary and the Board'." Again, this practice, which unduly favors the government, only paves the way for added litigation arising out of VA's "fishing expeditions."

The Court also acquiesces in another practice that adds to appeal time. Although the Court's rules require good cause for extensions of time, and although the Court has held that VA's argument of a heavy caseload is not good cause, the Court routinely grants VA's motions for extensions of time on such grounds as VA's stated heavy caseload. The Court does not enforce its own ruling. Motions for extension of time by VA are the rule rather than the exception. One of the IBVSOs once surveyed its substantial caseload and could find no case without a VA motion for extension of time. In some cases, VA has moved for and received up to three 30-day extensions of time in which to file its brief. With the original 30 days allotted under the rule, this allows VA 120 days to file a brief.

Objections to these extensions by appellants' counsel have generally proven fruitless. In one recent case, VA's motion for a 60-day extension of time in which to file a brief because of counsel's vacation was granted without question. We know of no other Federal Appellate Court that is so lenient with the government.

The Court also condones other evasive and delaying tactics by VA attorneys with the General Counsel's Office. For example, these attorneys frequently respond to appellant's briefs with inappropriate motions for summary affirmance, the premise of which is that the appeal is totally without merit. Several of these cases were reversed outright in favor of the appellants. Numerous others were held to involve prejudicial errors requiring remand. Therefore, it was clear in these cases that a motion for summary affirmance misrepresented the record and merits of the case. The Court has treated this conduct on the part of VA attorneys rather lightly, occasionally complaining in an order or opinion.

The conduct of VA attorneys in the Court has been less than admirable in these instances. It has not furthered the ends of justice and has often delayed proceedings. With these delays and evasive actions, VA has departed from the principle that justice for a citizen is justice for the government. And, while the Court's desire to exercise restraint is understandable, its long-term tolerance of these practices could create the appearance of a pro-VA bias. Here, the Court risks creating the same dissatisfaction and frustration that brought it into being.

In summary, looking at the entire process shows that large numbers of poor decisions at VA regional offices result in large numbers of appeals to BVA, where cases are received at a rate exceeding the Board's capacity to decide them. This is where the case backlog cycle begins or is made even worse. This also accounts for the long delays veterans experience in receiving decisions from the Board.

The adverse effects do not end at the Board, however. As noted above, because of improper record development, or improper remands, around half of all cases received by the Board in FY 1994 were returned to regional offices without a decision by the Board. This extends an already unreasonable claims processing time. Ten percent of the cases are remanded more than once by the Board.

Add to this the Court's remands, sometimes multiple, and it is easy to see why the process takes years. It means a veteran's case must go through multiple administrative decisions and levels of review before it is eventually properly decided. It would be entirely understandable if, to the VA claimant who must negotiate this course, it appeared to be a maze with obstacles and diversions designed to delay and evade and stand between the claimant and justice.

Those who have influence on the direction of VA must be vigilant to prevent anyone who might seek to maintain the *status quo*, or who might be well-intentioned but misguided, from instituting policies that would make the process more onerous for VA claimants. Generally, it is not the law and regulations that can be faulted for these systemic deficiencies, but the failure to abide by them in the processing of claims.

Obviously, these deficiencies are not without added costs to the government. They require added

administrative and litigation costs, which could be spent on veterans' programs. Errors in VA decisions also cost the government under fee-shifting provisions in the *Equal Access to Justice Act (EAJA)*. Attorney's fees may be awarded to the appellant where the position of VA was not "substantially justified." As of December 1, 1994, *EAJA* fees had been awarded in 132 cases appealed to the Court of Veterans Appeals. These fees totaled $491,240. Better decisions by the Board would prevent some of these costs.

Regrettably, this is a system that sometimes seeks first to serve itself. Congress should take a hard look at the system and demand and enact measures to bring about meaningful reform, yet be skeptical of suggested measures that will make the process easier for VA at the expense of claimants. Fairness and efficiency are not mutually exclusive. VA claimants should not be put in the position of sacrificing one for the other. The system can and should be made to produce both.

Recommendations

- VA should establish and meet reasonable timeliness standards for the administration of benefits.
- Staffing levels should correspond to actual workload and not be tailored to a predetermined arbitrary budget target.
- Congress should fully fund and support completion of ADP modernization.
- VA must acknowledge that there are systemic deficiencies in its claims processing; it must identify the specific deficiencies and their causes; and it must correct those deficiencies.
- Inappropriate practices at the appellate level that contribute to delays and the backlog should be corrected.

Veterans Benefits Administration

The Veterans Benefits Administration (VBA) administers most of VA's non-medical benefits and services to veterans and their dependents. It does so through 58 regional offices (some of which are medical/regional office centers) and through a nationwide toll-free telephone line. The benefits VBA administers include compensation for service-connected disabilities; pensions for low-income, aged or disabled veterans; vocational rehabilitation; education and training support; home loan guarantees; and life insurance.

Prior *Independent Budgets* recommended that Congress expand entitlement account transfers to fund VBA functions essential to the timely and accurate delivery of authorized benefits and services. Earlier discussion of particular benefit programs explain the logic and utility of doing this.

We again wish to point out that we seek simply to have the discretionary-mandatory spending dichotomy conform to reality. "Discretionary" means "regulated by one's own judgment or choice." "Mandatory" means "authoritatively commanded or required; obligatory." For example, we note that VA cannot refuse to take and adjudicate benefit claims or arbitrarily deny vocational rehabilitation services to eligible disabled veterans. Personnel costs for delivering these entitlements are therefore unquestionably mandatory.

The IBVSOs continue to believe that the resources needed to purchase the equipment and technologies that support employees' performance should come from mandatory spending because these resources are indispensable to benefit delivery. Purely from a functional standpoint, VBA's personnel costs for the veterans services; compensation, pension, and education; vocational rehabilitation and counseling; loan guaranty; and insurance functions are mandatory because they are dedicated exclusively to delivering authorized entitlement programs.

Transfers from mandatory spending accounts already fund all loan guaranty administrative costs. We recommend that transfers from mandatory spending entitlement accounts also fund personnel costs for veterans services; compensation, pension and education; and vocational rehabilitation and counseling.

This stable funding mechanism is necessary to ensure that VBA has enough employees to:

1. meet minimum standards for claims adjudication and vocational rehabilitation services; and
2. restore good service generally.

26 If our recommendations were implemented, we would not expect VBA's funding needs to rise dramatically. In fact, once systems are fully modernized, we expect personnel and administrative costs in general to stabilize or actually decrease, after an allowance is made for inflation. The goal is to deliver good service as cost-effectively as possible. VA cannot maximize cost-effectiveness, however, without a well-equipped and well-trained workforce. This is particularly true when new technologies and work processes are replacing outmoded ones.

VBA's modernization plan calls for an expenditure of $94.9 million over four fiscal years to purchase its new computer systems. This equipment will double the access of adjudicators and their support staff to the benefits delivery system. VBA will implement this system to reduce its claims backlog.

As noted above, VBA's modernization program is to be accomplished in three stages. Stage I is the purchase of hardware and software; Stage II is the acquisition of imaging technology; and Stage III is the creation of a national data center that incorporates and enhances all of the previously instituted applications. This system will interface with central file locations and other agencies.

There are nineteen Stage I transitional applications, described below.

ADVISOR: Performance Enhancement Training System. Provides training lessons in the various benefit areas for the Regional Office Veterans Benefits Counselors.

AMIE: Automated Medical Information Exchange. Dramatically improves AMIE access and response time through use of Stage I local area networks and other communications facilities. AMIE provides regional offices direct access to medical center data on admissions, discharges, and compensation and pension examinations.

ARMS: Automated Reference Materials System. Automated text retrieval system that supports all VBA programs by including reference materials, such as Court of Veterans Appeals decisions, VBA policies and procedures, and VBA program directives, manuals, and circulars. The data will be stored on both CD-ROM and hard disk (magnetic) devices.

COVERS: Control of Veterans Records. Barcodes veterans' folders. Tracks folder location within the Regional Office. Folders will be barcoded and scanned each time a record changes within the Regional Office.

COWC: Committee on Waivers and Compromises. Provides the benefits of Stage I (enhanced access and improved user interfaces) to the tracking of requests for waivers of debt.

CPS: Claims Processing System. Provides automated support for gathering of evidence and documents required for processing original disability compensation claims. Includes a special feature to generate a claim application in situations where clients are interviewed.

C&V: Construction and Valuation. Tracking system that manages and controls construction monitoring and property valuation activities at a regional office.

EMPLOYEE PROPERTY CHECKLIST: Employee Property Checklist. Employee entry on duty records. Needs such as badges, key-cards, equipment issued, and issuance information are entered into the system.

EVR: Eligibility Verification Report. Modifies processing of EVR responses to permit client identification data to be entered by wanding of barcodes rather than by key entry.

HOLAR: Hearing Officer Letters and Reports System. Provides the benefits of Stage I (enhanced access and improved user interfaces) to maintaining Hearing Officer schedules and data and to generating Hearing Officer letters.

LOCAL TRAINING SYSTEM: Local Training System. Tracks all training received, required, planned and scheduled. Prepares, provides and distributes required forms for student training needs.

PCGL: Personal Computer Generated Letters. Provides enhanced facilities for generating custom letters to compensation and pension claimants. Includes automatic access/use of benefits delivery network data, simplified menus for letter/paragraph selection and automatic generation of required enclosures and forms.

QSR: Quarterly Statistical Report. Uses Stage I technologies to improve efficiency and user interfaces in the collection of statistical data for education benefit programs.

RBA: Rating Board Application. Provides rating specialists the ability to create quality rating board documents in a timely manner through access to stored formats and text. Workstation point-and-click technologies will minimize keyboard input.

RIMS: Records Inventory Management System. Provides the benefits of Stage I (enhanced access and improved user interfaces) to the tracking and disposition of large record holdings.

SLS: Single Log-on System. The Single Log-on System will allow users to log-on to host systems such as the BDN and Wang without re-entering previously supplied USER IDs and passwords. The security information required by individual applications will be automatically transmitted with no user intervention required.

SUPERVISORY PERSONNEL SUPPORT: Supervisory Personnel Support. Provides commonly needed information, such as position description, performance plans, performance evaluations, recruitment and status on outstanding personnel items.

TRAVEL AUTHORITY: Travel Authority/Voucher Preparation. Automates production of forms, relates authority to voucher, generates maximum information. Provides automated routing and concurrences.

VRAMS: Vocational Rehabilitation Automated Management System. Wang VS-based application provides an automated means to track veterans' cases. The veterans' case is tracked from initial contact through final case closure. Through VRAMS case letters, forms, agendas and reports are automatically generated.

These transitional applications are either complete and in use or in various stages of development. The eight applications in use are ADVISOR, AMIE, EVR, ARMS, PCGL, C&V, RBA and VRAMS. The remaining 11 applications are under development and will begin deployment later in FY 1995. The priority of modernization is for use in compensation and pension claims, with a goal of total completion in the year 1996.

Stage II is in planning and development. How long it will take to phase in this technology is unknown. All of its possible applications have yet to be determined. Stage III is scheduled to be in place by August 1996. However, obligation authority has been delayed until September 1, 1995.

Due to concerns of the General Services Administration, the Center for Naval Analysis (CNA) will conduct a review of VA's overall modernization effort, scheduled for completion in early 1995. This study is expected to cost $1 million and will be taken from money budgeted for hardware. The delay associated with this study may prevent VA from meeting some of the previously set deadlines.

To save money, VA is undertaking as much of the modernization program in-house as it can. This also increases accountability. It is suggested that VA be given authority for routine acquisitions for the future to replace old equipment on a cycle rather than singular large acquisitions. The current system must be maintained even as it is phased out with concurrent phasing in of new technology. An additional $800,000 is needed for this maintenance. There is no commitment of future discretionary dollars for these purposes.

Obsolete personal computers cannot run the new programs. These units need replacing, with an estimated cost of $4 million, which has not been budgeted. VA must also create more access ports if it is to open these systems to VSOs. Minimally sufficient ports for remote access will cost an additional estimated $800,000.

The viability of this program depends on a full commitment to continue its funding. Future budget cuts to meet ceilings imposed by OMB cannot be allowed to interfere with the realization of this much-needed modernization. The IBVSOs urge full sup-

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TABLE 3

General Operating Expenses

Independent Budget Funding Recommendations

	FY 1996 *Independent Budget* Recommended Current Services Level	FY 1996 *Independent Budget* Recommended Appropriation
Veterans Benefits Administration (VBA)		
Executive Direction	33,870,000	33,870,000
Veterans Services	82,773,000	97,463,290
Compensation, Pension and Education	196,331,000	200,311,000
Loan Guaranty	86,261,000	86,261,000
Insurance	14,977,000	14,977,000
Vocational Rehabilitation and Counseling	38,631,000	64,785,820
Information Technology	112,288,000	112,288,000
Support Services	213,711,000	213,711,000
Reimbursements	152,574,000	152,574,000
Subtotal VBA	$931,416,000	$976,241,110
Independent Budget Initiatives for VBA		
ADP Maintenance		800,000
IRM Equipment Replacement		4,000,000
Additional Access Ports		800,000
Total VBA	**$931,416,000**	**$981,841,110**
General Administration (GA)		
Board of Veterans Appeals	29,676,000	32,636,050
General Counsel	37,000,000	42,050,000
Assistant Secretary for Finance and IRM	79,812,000	79,812,000
Assistant Secretary for Human Resources and Admin.	51,473,000	51,473,000
Consolidated Staff Offices	21,372,000	21,372,000
Reimbursement	58,064,000	58,064,000
Total GA	**$277,397,000**	**$285,407,050**
General Operating Expenses (GOE)	**$1,208,813,000**	**$1,267,248,160**
National Cemetery System (NCS)	**$82,000,000**	**$82,000,000**
Office of Inspector General	**$32,591,000**	**$32,591,000**
TOTAL GENERAL OPERATING EXPENSES (GOE)	**$1,323,404,000**	**$1,381,839,160**

port and funding for this essential element of VBA's future needs (as shown in Table 3).

Training in the various services is also essential to VBA's ability to meet its future challenges. The IBVSOs encourage VBA to continue to expand its training activities. All employees should receive centralized, focused training shortly after hiring or promotion. All employees should receive refresher training to enhance work skills, at least once a year. We also encourage the use of training technologies, such as videotaping, videoconferencing and computer-assisted training and testing, to conduct ongoing on-site training.

As noted in prior *Independent Budgets*, training is an investment that pays large returns in workforce competence, innovation and productivity. Systemized training also reduces on-the-job training costs. The IBVSOs believe that VBA should continue to have a budget line item for training. A small staff should develop and coordinate VBA-wide training activities.

Recommendations

- Mandatory spending accounts should be established to pay personnel costs and for purchase of equipment and technologies.

- VA should be given authority to replace old data processing equipment on a cycle rather than singular large acquisitions.
- To maintain current data processing systems as is necessary while new systems are phased in, an additional $800,000 should be budgeted.
- An additional $4 million dollars should be appropriated for replacement of obsolete personal computers.
- To create more access ports and provide remote access to VA's computer systems, an additional $800,000 should be appropriated.
- VA should employ all available modern training technologies.

> A man who is good enough to shed his blood for his country is good enough to be given a square deal afterwards.
> *Theodore Roosevelt*

Compensation, Pension, and Education

This service includes the adjudication and administration of compensation and pension benefits, the adjudication of basic education and vocational rehabilitation eligibility, and administration of education allowances. Compensation and pension also includes benefits for certain survivors and dependents, paid in the form of dependency and indemnity compensation and death pension. There are also burial benefits and special benefits, such as clothing allowance, automobiles and adaptive equipment, and specially adapted housing for eligible service-connected veterans.

General operating expenses comprise the resources necessary to perform all of the claims development and adjudication functions required to gather evidence, determine entitlement, make awards, complete certain follow-up reviews, and monitor for continuing eligibility. Initial stages of appeals are completed by regional offices as well, including hearings before hearing officers and due process matters, such as statements outlining the law, facts and rationale in claims denied and being appealed. Thus, the costs are for the administration of benefits rather than for the benefits themselves.

Adjudication of claims for service connection of disabilities also serves to determine basic eligibility for vocational rehabilitation. Similarly, the adjudication division must determine eligibility for educational benefits under several different programs and must monitor a variety of factors that determine continuing eligibility and rates of entitlement. 29

Recent reports reveal that timeliness has improved somewhat in claims processing. However, some of this improvement is due to overtime and other temporary measures. Other factors, such as a slowing of military downsizing, may provide some relief in this area. Reductions in the numbers of claimants who must submit annual eligibility verification reports will lighten the workload in that area. Work in the data matches with other agencies, as required under the *Omnibus Budget Reconciliation Act*, is declining.

To improve efficiency, VA is implementing suggestions of the Blue Ribbon Panel on Claims Processing. The centerpiece of this effort is the organization of adjudication teams to handle the full range of responsibilities associated with rating issues. This will create a rating activity responsible for control, development, rating and authorization of rating issues. This reorganization will not be uniform, but will allow each station to tailor its reorganization to local demands and resources. Local stations will have a selection of models to choose from and may modify the plan chosen to meet local needs.

The organizational models and the consolidated rating activity structures will be developed and implemented within existing funds and staffing, both in VA Central Office and in the field stations. Implementation is scheduled to begin in early 1995.

Responsibility for control, development and award action will be consolidated and assigned to a single "rating technician" position. Rating technicians will be empowered to perform all control and development functions that must be completed prior to a decision by the rating specialist. At the discretion of the station, the technician might also have the authority to make simple rating decisions, such as follow-up due process notification decisions. It is intended that the skills

gained in this position will expedite the transition from claims examiner to productive rating specialist, while providing valuable service and improving overall timeliness. This will also be accomplished with existing funds and staffing. Planned implementation is mid-1995.

In C&P Service, there are currently some 43 initiatives to implement Blue Ribbon Panel suggestions. Some of these are:

- preparation of a centralized training program for developing claims;
- evaluation of single-signature rating authority being tested in the field;
- development of formal rating training programs with certification;
- development of personal computer word processing capability for the rating staff, including standardized formats and glossaries;
- use of specialization selectively to concentrate on certain categories of complex rating cases;
- expansion and expedition of centrally coordinated training for rating staff;
- reallocation of employee resources to rating activity and authorization;
- targeting the use of rating help teams to reduce the backlogs when needed;
- deployment of development checklists for all aspects of adjudication;
- expansion of the current service medical records (SMR) agreement with the Army to all branches;
- assignment of VA personnel to Department of Defense (DOD) records centers to assist and perform liaison;
- change of VBA procedures to provide for immediate forwarding of claims from separation regional office to home regional office;
- expansion of the current VBA-VHA memorandum of understanding to include examination quality measures;
- establishment of examining physicians' coordinators at VA Central Office, medical centers and regional offices;
- establishment of a reporting scheme to monitor quality locally and nationally;
- establishment of a joint VBA-VHA education and training effort on compensation and pension examinations;
- initiation of national VA/DOD dialogue on separation examinations to ensure they meet VA requirements;
- education of DOD medical staff on use of VA's Physician's Guide;
- establishment of guidelines to permit information to be provided to VA by telephone, facsimile and E-mail to supplement written communications;
- development of centralized training that utilizes videos, video- and teleconferencing, satellite and interactive PC-based programs;
- transfer of responsibility and resources for compensation and pension examinations from VHA to VBA.

The team approach will merge Veterans Services Division personnel with adjudication personnel. Cross-training, consolidating functions, and use of rating help teams are all designed for flexibility and maximum efficiency in utilization of personnel resources. Staffing levels must match actual demand, however. Many of these efforts will be diminished or defeated without full resources for modernization and adequate staffing.

With the team approach, VA offices must be reconfigured with a modular arrangement to accommodate the physical layout and provide the necessary working environment. Funding must be provided for this purpose. Concerning offices, there is a belief within VBA that VA is surcharged by the General Services Administration (GSA) for capital investments but never receives any benefit from the monies charged under the Standard Level Users Charge. Additionally, rents do not seem to go down with the market, and where there is rent reduction, the savings do not benefit VA,

because appropriations are reduced. These issues should be studied to determine if there are ways to bring about savings that could be passed on to VA for needed office improvements.

Similarly, consideration should be given to reform in contract and procurement authority to permit more competitive procurement than that available through GSA. Consideration should also be given to authorizing VA to contract directly for security guard services. It should be determined whether this would be more cost-effective and result in more accountability. Again, savings should be used for other needs of VA.

A process of accountability should be instituted to enforce higher standards of quality and legality in the adjudicators' decisions.

If the Blue Ribbon Panel's suggestions are to be fully implemented, the purchase of additional software beyond that included under State III will be needed.

Centralized training by satellite will increase efficiency in the training process and result in long-term savings and, of course, savings in travel costs. It is projected that the start-up cost of this program will be approximately $2 million dollars.

VBA believes it can more effectively manage the compensation and pension examination process with the authority to do so and with shifting of the associated resources from VHA to VBA to allow the use of fee-basis examiners. Congress should fund a pilot study to determine if increased savings and efficiency can be realized in this manner.

Public Law 103-446 established a nine-member Veterans Claims Adjudication Commission to study VA's system for the disposition of claims, both at regional offices and BVA. The $400,000 slated for the expenses of this commission may well prove insufficient. VBA should not be required to absorb any additional costs, and funding should be provided.

The C&P service now administers several educational programs that have substantial differences in format and eligibility criteria. To improve efficiency, there is a move toward regionalization of education claims processing. However, many purely administrative provisions, quality controls and discretionary policies could perhaps be revised for uniformity and simplicity and to remove any outmoded provisions. With the goals of cost-effectiveness, a more user-friendly system, and overall efficiency, a study should be conducted to determine if reform in the administration of these benefits is advisable.

VA officials advise that credit reform procedures, as they apply to education loans and transitional housing grants, cost as much or more than the principal of the outstanding loans and the sum of the grants. Consideration should be given to necessary changes in this area to remove those burdensome, costly and perhaps counterproductive requirements.

Administration of the *Service Members Occupational Conversion and Training Act of 1992* is provided by this service. It is projected that funding for this program will run out in early 1995. Without funding, the continuing administrative costs of this program will be wasteful. Remedial measures are needed here, whatever the disposition of this program.

One of the areas in benefits adjudication where the Court of Veterans Appeals has been very critical of VA's regulations and its decision making is total disability ratings on the basis of individual unemployability. The Court has characterized VA's regulations governing these ratings as a "confusing tapestry" and, in several decisions, urged their overhaul. The Court has found the adjudications on this issue to be very arbitrary, prompting it, as noted above, to admonish VA that a veteran does not have to be a "total basket case" to be unemployable. The Court has reversed the Board in several of these cases.

VA has responded by undertaking a review and revision of these regulations. It is hoped that the new product will be reflective of a new era in VA benefits administration, that the VA will have profited from and will seek not to repeat the errors of the past. The IB-VSOs hope that these new regulations will provide for a realistic assessment of a veteran's ability to be gainfully employed, will be constructed to ensure fairness and uniformity, and will be clear in their meaning and applicability. If not, the Congress should stand ready to intervene legislatively to bring these qualities into the law governing this most important area of veterans' benefits.

In response to criticism that VA adjudicators are ignoring precedent cases of the Court of Veterans

Appeals, the Secretary of Veterans Affairs has established a committee to investigate these allegations and make appropriate recommendations. As discussed above, it is believed that systemic deficiencies in claims processing contribute to the claims backlog by necessitating multiple decisions and long waits. The IBVSOs therefore suggest an aggressive new approach to this problem.

This approach should establish training to familiarize adjudicators with this developing area of legal authority, its applicability and its implications. This training should be designed to ensure that adjudicators fully understand that judicial precedent is as much the law as statutes and regulations. Instructors should be chosen based on their ability to communicate a new enthusiasm and a renewed appreciation for the supremacy of the law over any ingrained attitudes or notions that may run counter to the law. There should be a follow-up phase and continuing legal education as necessary.

A process of accountability should be instituted to enforce higher standards of quality and legality in the adjudicators' decisions. VA should conduct thorough studies of BVA allowances and remands to identify trends and problem areas. Regional office management should be accountable to the Director of Compensation and Pension Service for the quality of work performed by adjudication divisions. And, of course, accountability should continue up the chain of command to the Secretary, with appropriate Congressional oversight.

Thus, while Compensation and Pension Service is undertaking many new approaches and processes to improve its service and customer satisfaction, there are mixed signals relating to the quality of its product, and there are some areas where its efforts are lacking. Customer satisfaction requires courtesy, promptness and many of those intangible qualities of service that shape a customer's perception of VA's performance. However, just as a physician with a wonderful bedside manner will ultimately disappoint a patient if the medical care given lacks reasonable competence and skill, customer satisfaction for VA cannot be attained by good interpersonal interaction with claimants by itself. A measure of customer satisfaction also derives from the accuracy and fairness in VA's decisions and in its dealings with VA customers.

Veterans know when the outcomes of their cases do not square with the facts. Veterans know that, with rare exception, the law properly applied will not bring about a result that offends equity, and they are able to sense when decisions involve overly strict or narrow applications of the law to support denial.

VA should undertake a plan to revive its commitment to the fundamental principles of compassionate and fair service to veterans. Management should institute a system of accountability that ensures the agency is resolving reasonable doubt in favor of the veteran and endeavoring to award veterans all benefits to which they are entitled under the law.

There should be an effort to increase adjudicator recognition and appreciation of the fact that their decisions affect the quality of veterans' lives, for example, the devastating effect of an improper denial of total rating due to unemployability. The great degree of responsibility that goes with the job of rating specialist should be emphasized.

Finally, reasonable timeliness standards must be established and met as discussed above.

Recommendations

- Funds should be appropriated to cover necessary physical reconfigurations of adjudication areas to make them conducive to the team approach to claims processing. VA estimates this cost at $1,980,000.
- Studies should be authorized and conducted to ascertain if VA could realize savings from alternatives to renting from GSA, more efficient and competitive procurement, and direct contracts for security services. Any savings should revert to VA accounts for use in improving claims adjudication.
- Congress should fund centralized training technology to increase efficiency and result in long-term savings. VA estimates a starting cost of $2 million.
- Congress should authorize and fund a pilot study to determine if increased savings and efficiency can be attained through reassignment of responsibility for VA medical examinations to VBA from VHA.
- Appropriations should be made for the costs associated with the operation of the Veterans Claims Adjudication Commission.

- Studies should be authorized and funded to determine if the various VA educational programs can be made more uniform for simplicity in their administration.

- Consideration should be given to whether exempting certain VA programs from the burden of credit reform procedures would be advisable and cost-effective.

- Action should be taken toward a disposition of the *Service Members Occupational Conversion and Training Act of 1992* for which funding is due to run out but for which administrative costs continue.

- Congress should stand ready to intervene in the event VA's regulations governing unemployability ratings are not revised in a manner that will provide for fair, realistic and uniform assessments of a veteran's ability or inability to be gainfully employed.

- VA should promptly institute an aggressive new training program to instruct adjudicators on the mandatory nature of case law and in its use and applicability. This training should be complemented by a process incorporating a chain of accountability for proper and legal adjudications, with monitoring for compliance and quality control, along with studies of appellate decisions to identify problem areas. Management should take necessary measures to bring about a renewed institutional and individual adjudicator commitment to VA's fundamental guiding principles for the administration of benefits, such as broad and liberal application of the law, resolution of reasonable doubt, and award of all benefits to which entitlement may be established.

Veterans Services

In the last three *Independent Budgets*, we noted that:

> Veterans Services' (VS) basic problem has been that it is funded at a level that constricts demand. When hundreds of thousands of veterans' inquiries go unanswered because there are not enough veterans benefits counselors (VBCs) to answer telephone calls, much less conduct mandated outreach programs, demand for VA benefits and services obviously will be constricted. This budgetary shortfall translates into large unmet veterans' needs that VA cannot begin to address with current staffing.
>
> Limiting demand for veterans' benefits and services directly counters VS's congressionally mandated mission. Recent legislation significantly increased demand for VA services. We speak of the Transition Assistance Program (TAP) and the Disabled Transition Assistance Program (DTAP), which *Public Law 101-237* instituted, and the *Defense Authorization Act for FY 1991*, which contains provisions for a program to furnish counseling and assistance to members of the Armed Forces who are within 180 days of separation. These very worthwhile programs, however, simply increase the already large number of mandated outreach functions for which VS has the responsibility but not the staff to provide. *The time is long overdue to stop the charade of authorizing programs without providing a stable funding source to implement and administer them properly.*

Congress continues to authorize programs without providing a stable funding source to implement and administer these programs properly.

Four years have passed since the above paragraphs were first written; however, the situation has not changed. Congress continues to authorize programs without providing a stable funding source to implement and administer these programs properly. It continues to ask Veterans' Services to do more with less. In 1992, under *Public Law 102-590*, VS was required to assist with the homeless veteran program. Congress authorized no additional funds for this program, and counselors had to be taken from their normal duties to handle this new duty.

Similarly, VS finds itself in the same situation with respect to *Public Law 103-446*. Veterans' Services must provide counseling and outreach services to Persian Gulf veterans. Again, it must provide these

34 expanded services without any additional, congressionally authorized resources. Additionally, this law mandates a toll-free phone number by February 2, 1995, so that Persian Gulf veterans can contact VA for assistance or with questions. The start-up costs for this will be $990,000 in Fiscal Year 1995, and it will subsequently cost $1 million annually. The IBVSOs strongly support the provisions of this new law; however, we are concerned that no additional funding was authorized.

If Congress believes that TAP, DTAP, the homeless veteran program and outreach to Persian Gulf veterans are important—and the IBVSOs certainly do—Congress should authorize adequate resources to enable Veterans' Services to provide appropriate support. Otherwise, these new programs are meaningless. Last year, inadequate staffing levels adversely affected the timeliness of responses. VS can only spread its staffing so thin before the quality of the services they provide deteriorates to such a state that the service becomes of no benefit to those who need it.

To assess VS's employee and equipment needs, it is important to note the scope of the activities credited to this critically important information link between VA and America's veteran population. In fiscal year 1994, Veterans Services responded to more than 9.1 million telephone calls and conducted more than 1.8 million face-to-face interviews. In addition, Veterans Services also conducts educational institution enrollment verification and compliance surveys, processes work-study applications, and conducts personal hearings and field examinations to appoint and audit fiduciaries for incompetent veterans. Veterans Services' outreach activities assist homeless veterans, women veterans, former POWs and incarcerated veterans and provide "front-line" contact with persons soon to be discharged from the military.

Veterans Services' Transition Assistance Program (TAP) activities have dramatically expanded. In 1990, VS conducted a TAP pilot program at approximately 22 military facilities. By the end of 1994, the program was available at 250 military installations.

Veterans Services significantly expanded its military services program in late 1991. A military service coordinator (MSC) was designated at each veteran service division (VSD), with some coordinators stationed at locations strategic to large military populations. MSCs and other veterans benefits counselors (VBCs) also provide benefit briefings at regular pre-separation and retirement programs and are involved in outreach to members of the Reserve and National Guard.

In fiscal year 1994, Veterans Services responded to more than 9.1 million telephone calls and conducted more than 1.8 million face-to-face interviews.

In addition to VS's successes in outreach to service members, VS attempts to improve outreach to the homeless population. VBA provides staff support to comprehensive homeless centers (CHC) in Dallas, Brooklyn, West Los Angeles and Pittsburgh. *Public Law 102-590* appropriations are currently being directed from VHA to VBA to support the four CHC positions and six other collaborative homeless projects with local VAMCs and community resources. In all instances, VHA provides funding, without employee ceiling relief, to support the regional offices' full-time commitment to these special programs. During 1994, VS accomplished more than 4,700 shelter visits and 9,000 contacts with community agencies. Additionally, more than 24,000 homeless veterans received personal assistance at regional offices during this same period.

Approximately 130 VBCs are assigned on a full- or part-time basis to VA medical centers, representing the VBA. These counselors assist patients and their families to understand VA benefit programs, complete claims and applications, and interpret VA programs, policies and decisions. Additional responsibilities include liaison functions with educational program services, military medical facilities, physical evaluation boards, casualty assistance offices and family and personal service activities at military installations within their immediate jurisdiction.

The increase in use of Chapter 30 education benefits, which began in 1990, will increase demand for information and assistance through 1995. Veterans Services will also continue its involvement with VHA in homeless service efforts. (VHA provides some funding for VS counselors in this regard; however, this funding does not compensate VS for the loss of use of the counselors' time on other programs.)

Table 4 presents workload VS accomplished during fiscal years 1993 and 1994.

TABLE 4

	FY 1993	FY 1994
Briefing Sessions	6,995	7,415
Attendance at Sessions	311,628	307,441
Personal Interviews	114,913	114,771

Examining VS's telephone services probably best illustrates its abi'ity to meet demand for its services. A 1993 US Sprint study for 800-service lines at 57 stations and local telephone company studies for 23 stations reveal the large demand VS does not satisfy. These studies show that blocked calls (those that receive busy signals) represent 25.1 percent of local line calls and 62 percent of 800-service line calls.

In 1992, a similar study of 55 stations for 800-service lines and 22 stations from local telephone companies revealed blocked-call rates of 20.7 percent for local lines and 26.1 percent for 800 lines. Current VS estimates of blocked telephone calls project no relief.

The abandoned-call rate (representing those times when the caller gets through but, after waiting and not getting service, abandons the call) continues to increase. Of the 9.1 million calls received, approximately 1.3 million callers, or 13 percent, hung up before talking to a counselor. Abandoned calls result from insufficient telephone circuits or employees to respond to veterans' calls. Additionally, VA has established a new standard for answering phone calls; phone calls will now be answered within 180 seconds. No statistics are yet available on this new standard, and VA no longer keeps statistics on waiting time.

Inadequate staffing in fiscal year 1995 will increase blocked and abandoned calls due to inadequate telephone coverage. In fiscal year 1996, the blocked call rate alone will be almost 70 percent. Installing additional telephone circuits, with enhanced routing features for overflow traffic during peak calling times, and adding additional employees to answer veterans' calls or using interactive voice response technology would solve the blocked- and abandoned-call problem. Automation and new telecommunications technology are essential to enable VS to meet its increasing workload.

Inadequate staffing in fiscal year 1995 will increase blocked and abandoned calls due to inadequate telephone coverage.

VA cannot do more than it currently does without additional employees or automated systems. The Veterans Automated Assistance Telephone System (VAATS) is an initiative to improve claimants' access to information and services through computer-telephone integration technologies. Through a voice message system, claimants can obtain general information about benefits and services. VAATS' long-range goal is to enable claimants to access their individual account information (Compensation, Pension, Education, Insurance, Loan Guaranty and Vocational Rehabilitation). VS's VAATS initiative should reduce the national blocked-call rate from the anticipated 70 percent to about 40 percent in fiscal year 1996.

If Congress intends that VA meet the information and outreach needs of veterans and individuals soon to be veterans, it must provide VA with the resources to do so. We cannot overstate the importance of providing VS with sufficient resources to adequately handle all the programs under its control. In last year's *Independent Budget*, we recommended funding to staff 2,440 employees. The administration's proposed fiscal year 1995 budget request was for 2,123 employees, 33 fewer than in fiscal year 1994, and more than 300 fewer than what the IBVSOs considered necessary for VS to run its programs. Currently, the VS employee level is 2,103, but the actual figure of on-board employees is approximately 100 fewer. These figures are further complicated by the fact that some new VBA initiatives around the country use VS counselors in adjudication units, such as the self-directed case management concept in place in the New York City regional office.

As we state throughout the *Independent Budget*, the VSOs believe that the cost of delivering benefits should come from mandatory spending accounts. If Congress authorized funding for all VS personnel costs by transfer from mandatory spending accounts, VA could staff VS adequately to perform its mandated functions. In addition, the VSOs note that reimbursements from mandatory spending accounts

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TABLE 5

Independent Budget
Recommended Full-Time Employee Equivalents
General Operating Expenses

	FY 1996 Independent Budget Recommendation	FY 1995 Enacted	Additional Staff Recommended by Independent Budget
Veterans Benefits Administration (VBA)			
Executive Direction	345	345	0
Veterans Services	2,440	2,103	337
Compensation, Pension and Education	4,253	4,253	0
Loan Guaranty	1,942	1,942	0
Insurance	435	435	0
Vocational Rehabilitation and Counseling	1,285	685	600
Information Technology	952	952	0
Support Services	2,545	2,545	0
Total VBA	14,197	13,260	937
General Administration (GA)			
Board of Veterans Appeals	499	449	50
General Counsel	637	635	2
Assistant Secretary for Finance and IRM	1,201	1,201	0
Assistant Secretary for Human Resources and Administration	368	368	0
Consolidated Staff Offices	254	254	0
Total GA	2,959	2,907	52
General Operating Expenses (GOE)	17,156	16,167	989
National Cemetery System (NCS)	1,330	1,315	15
Office of Inspector General	413	413	0
Office of Acquisition and Material Management Supply Fund	702	702	0
TOTAL GENERAL OPERATING EXPENSES(GOE)	19,601	18,597	1,004

would offer considerably more flexibility to allocate VA resources where they are needed most.

Recommendations

- The VSOs recommend 2,440 FTEEs, so that VS may begin to satisfy reasonable service levels (additional staff requirements for VS and other GOE programs are shown in Table 5).
- We also recommend that VS update its telephone equipment.

Vocational Rehabilitation and Counseling (VR&C)

Previous *Independent Budgets* have discussed the problems confronting Vocational Rehabilitation and Counseling (VR&C) at length. As the fiscal year 1993 *Independent Budget* predicted, VR&C's workload increased substantially and, currently, it continues to rise.

VR&C services are provided at 56 regional offices or medical and regional office centers, 80 decentralized counseling locations, and many contract guidance centers. Eligible and entitled service-connected disabled veterans and servicemembers receive services and assistance they need to achieve maximum independence in daily living. This program also assists these individuals to become employable and to obtain and maintain suitable employment to the maximum extent possible.

In fiscal year 1991, Congress provided appropriations for 69 additional vocational rehabilitation specialists (VRSs), reducing their average workload from 256 veterans to 229 veterans by the end of FY 1992. In fiscal year 1993, the average workload increased to 230, and in fiscal year 1994, it was 236. The average workload should increase to 247 cases in fiscal year 1995 and, in fiscal year 1996, it will be 259 cases. Ideally,

125 cases per VRS would be a manageable workload.

The average amount of time between a veteran filing an application for vocational rehabilitation with VA to the veteran's first appointment decreased from 86 days in fiscal year 1991 to 74 days by the end of fiscal year 1992. This downward trend continued in fiscal year 1993, when the figure dropped to 71 days; unfortunately, it increased to 81 days in fiscal year 1994. Projections for fiscal year 1995 show a 71-day wait, still more than double the goal of 30 days.

VA predicts a continuing decline in VR&C's ability to provide timely vocational rehabilitation to service-connected disabled veterans, separating service members and eligible dependents.

Fiscal year 1996 projections are not good. VA predicts a continuing decline in VR&C's ability to provide timely vocational rehabilitation to service-connected disabled veterans, separating service members and eligible dependents. VRS case management workload continues to increase. This trend must not continue. Congress must provide VR&C with enough employees to restore timely vocational rehabilitation services to deserving veterans.

In fiscal year 1994, VA received 15,410 applications for Chapter 31 benefits as a result of the Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP). Initially, contractors handle much of the Chapter 31 workload. In this way, veterans are evaluated sooner. However, they still must see VA counseling personnel, and this is where delays occur. In one regional office, there is an 11-month backlog.

Contracting out for Chapter 31 services is a short-term solution and is also burdensome. While it has proven necessary to use contractors in some cases, it is more costly. Resources are needed for supervisory positions and contracting fees. In fiscal year 1994, VA paid $20 million out of the readjustment benefit appropriations for contracted work. Some legal issues have arisen from this, and it is possible that it will be legally determined that GOE must pay these funds.

Currently, VA contracts for about one-half of the education assistance under Chapter 36. Congress has earmarked $5 million for this purpose; however, current needs exceed this amount. If Congress could increase the cap on contract counseling fees and provide sufficient funds to handle all Chapter 36 assistance by contractors, VA could utilize counselors to assist Chapter 31 veterans.

Another temporary solution VA has used to deal with the increased workloads is overtime pay. Some regional offices still use this in fiscal year 1995, but we expect that VA might direct these overtime funds to other needs. The long-term solution is not more overtime pay, but more employees.

The IBVSOs have recommended that VR&C add a substantial number of employees to provide the level of service it provided in fiscal year 1992. Over the years, however, the President's Budget has reduced VR&C staffing. The fiscal year 1995 budget, for example, proposed to reduce staffing by 29 employees.

More disabled veterans continue to need VA's Vocational Rehabilitation Services. This should experience a steady workload growth rate of 10 percent over last year. Congress must provide VR&C with enough employees to meet the existing workload. An additional 600 employees would help it meet its goal and reduce funds spent on contracting.

Over the past several years, VR&C has been unable to provide vocational services in a timely fashion. Yet experts agree that, to be effective, rehabilitation counseling and training must begin as soon as practicable following injury or disease onset. Putting the disabled veteran back to work is cost-effective. A VA study of 3,083 veterans rehabilitated in 1991 points out the importance of vocational rehabilitation. Significant findings of this study provide us with the following information:

- The 3,083 disabled veterans' total annual income before entering vocational rehabilitation was $11.9 million.
- When they entered vocational rehabilitation, 66 percent had no income.
- When they entered training, 84 percent were at or below the poverty level.
- Following vocational training, these veterans'

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aggregate income increased to approximately $60 million—representing a 402 percent increase.

- After completing vocational rehabilitation, these veterans paid an estimated $3.7 million to Social Security.
- Following vocational rehabilitation, these individuals paid $13 million in total estimated state and federal income taxes.

If Congress could increase the cap on contract counseling fees and provide sufficient funds to handle all Chapter 36 assistance by contractors, VA could utilize counselors to assist Chapter 31 veterans.

In fiscal year 1994, VA placed 5,000 veterans in jobs. VA has estimated that these veterans, in their first year of full-time employment, will pay an estimated $21 million in taxes. VA also estimates that these veterans will have an average work life of 25 years.

From a purely economic standpoint, it is sound public policy to return disabled veterans to meaningful employment following injury or onset of disease. Not only do we assist these disabled veterans to quickly get on a sound economic footing and back to a productive life, but we also expand the tax base. This is certainly a win-win situation. To do this, VR&C will need an estimated 600 additional employees just to provide the level of services it provided in fiscal year 1992.

VA also ran out of money in 1994 for vocational rehabilitation revolving fund loans. Disabled veterans were denied these loans, even though repayment was guaranteed through deductions in the veterans' compensation or military retirement payments. As a result, some disabled veterans withdrew from training for financial reasons, which could have been avoided. We recommend that Congress enact legislation to make these loans available to all disabled veterans.

We also recommend that VA propose legislation to authorize non-paid training/work experience in the private sector. This type of program has been successfully in place in federal agencies for almost 20 years and in state and local governments for three years.

Recommendations

- Add 600 employees to VR&C.
- Increase the cap on contract counseling funds.
- Provide sufficient funding for vocational rehabilitation revolving fund loans.
- Authorize non-paid training/work experience in the private sector.

Insurance and Indemnities

VA administers seven life insurance programs, which provide insurance protection for veterans and servicepersons. At the end of fiscal year 1994, 2.9 million policies were in effect, with a total face value of $25.8 billion. In addition, VA also supervises the Servicemans' Group Life Insurance (SGLI) and the Veterans' Group Life Insurance (VGLI) programs which, by the end of fiscal year 1994, provided $481 billion of insurance coverage to 3.2 million veterans and servicepersons. The Service Disabled Veterans' Insurance and Veterans' Mortgage Life Insurance programs are the only VA-administered insurance programs still open to new issues. SGLI and VGLI are also open to new issues.

VA has two insurance centers (located in Philadelphia, PA, and St. Paul, MN) that have provided excellent service to America's veterans and their families through the years. The average time to process an insurance claim increased slightly from the fiscal year 1993 level of four days to five days in fiscal year 1994. The outlook for fiscal year 1995, based on a projection of 435 employees without any consideration of overtime pay, is the same—an average processing time of about five days.

The Insurance Service is also obtaining interactive voice response technology, which would allow policyholders to access their accounts through touch-tone phones to obtain information on their accounts. VA hopes that this new system will not only free up personnel from answering routine policy status questions, but also help to eliminate blocked calls. VA has successfully tested this technology and anticipates that this system will be operational in early 1995.

Finally, VA has made significant progress in modernizing the Insurance Service ADP system. Computer software has been rewritten for greater flexibility and easier programming. All workstations now have

these improvements. ADP modernization is important to the effective and efficient operation of the insurance program, and it enables VA to apprise the policyholder better about his or her policy.

In fiscal year 1994, VA placed 5,000 veterans in jobs.

Loan Guaranty

The VA's home loan program provides a guaranty on home loans to veterans by lenders. Administration of this program involves issuance of a certificate of eligibility; appraisal review and issuance of a certificate of a reasonable value, or monitoring lender appraisal; approval of loan application or review of lender closings; and issuance of guaranty certificates.

Veterans are provided information about their rights and responsibilities and the sale of property. Loan servicing comprises a major function of this program. Its purpose is to avoid or minimize loss by the veteran and the government while assisting the veteran in keeping his or her home despite financial difficulties. Loan servicers counsel veterans who are delinquent and suggest ways to bring loan payments current or help with developing repayment plans. VA helps the veteran sell the property or permits the veteran to give VA a deed in lieu of foreclosure when necessary.

VA pays the lenders' claims on foreclosed properties, manages these properties and arranges for their sale as quickly as possible to minimize loss.

Loan Guaranty Service operates a unit to monitor lenders. The Loan Guaranty Service Monitoring Unit (MU) continues to actively identify and limit the Service's vulnerability to fraud, waste, abuse and noncompliance with VA lending and servicing requirements. During fiscal year 1994, the Monitoring Unit staff completed 104 on-site reviews of lenders and servicers; 69 of the reviews were loan origination audits and 35 were servicing audits. Through fiscal year 1994, a cumulative total of 629 on-site reviews of lenders and servicers was completed by MU staff; 491 of these reviews were origination audits, and 138 were servicing audits. Over the past 4.5 years, the MU has audited 491 (74 percent) of the 663 lenders who annually closed 50 or more automatic loans.

As a result of these audits, VA has recovered losses in the amount of $1,027,729, accepted indemnification agreements in the amount of $2,826,675 and denied liability on loans with potential claim and acquisition costs totaling $664,940. The MU has also assisted the VA Office of Inspector General in the recovery of losses resulting from IG lender audits, which generated receipts of $1,290,561 for noncompliance with VA credit standards and savings of $251,366 in the denial of VA liability on outstanding loans.

Cumulatively, VA has received or avoided losses of $6,041,271 as a result of the Monitoring Unit's activities. The high priority placed on monitoring and controlling program participant compliance has not only resulted in the significant recovery of program losses due to unacceptable underwriting and servicing practices, but has helped to substantially strengthen the effectiveness of the credit program operations, thus minimizing VA's risk.

Recent changes in law have expanded eligibility to VA guaranteed home loans. Now eligible are reservists who are discharged because of a service-connected disability before completion of six years of service; servicemembers who cannot complete two years of active duty, which would otherwise be required except for their early release due to disability or military downsizing; and spouses of reservists who die as a result of service-connected causes.

This legislation authorizes restored entitlement, on a one-time basis, to veterans who have satisfied a prior VA loan but still own the property. Changes in the law also permit refinancing of an adjustable rate mortgage (ARM) to a fixed rate even if the fixed rate is higher than the current rate of the ARM. The Interest Rate Reduction Refinancing Loan (IRRRL) program is a major program that encourages veterans with high interest home loans to refinance to a lower rate.

Loan Guaranty Service also administers the grant program for specially adapted housing, available to certain severely disabled veterans. The eligible veteran is given personal assistance through each step of this process, from purchase of property to final payment of the grant.

The VA Loan Program marked its 50th anniversary with its highest volume year. VA guaranteed

602,244 home loans, totaling $55.1 billion, in fiscal year 1994. This exceeded the previous high of 600,507 loans in fiscal year 1956 and $34.8 billion in fiscal year 1987. This brings the total number of loans financed to date to 14,498,000, with 3.4 million loans outstanding. VA also administered 364 grants for specially adapted housing, totaling $13.5 million, during fiscal year 1994.

These record numbers are attributable to a combination of factors: the lowest interest rate in more than 20 years, implementation of sweeping changes in the program, and the campaign to encourage veterans to take advantage of lower interest rates by refinancing existing loans.

During fiscal year 1994, VA guaranteed 311,939 refinancing loans, of which 289,756 were interest rate reduction refinancing loans. This means that 53 percent of the veterans who obtained VA loans in fiscal year 1994 were able to refinance the loan on the home they owned. More than 93 percent of those refinancing were able to reduce the interest rate on the VA loan they had previously taken.

Reduction in payments for veterans under this program will result in an estimated savings of nearly $1.5 billion. Savings for the government because of lower foreclosure rates is estimated at $56 million.

Loan servicing continued to be a success story in fiscal year 1994. When a veteran is three months in arrears on loan payments, the lender notifies VA, and VA personnel initiate coptact with the veteran to help in the avoidance of foreclosure. In fiscal year 1994, there were 5,230 "successful interventions" in delinquent loans, resulting in an estimated $60 million in savings to the government. The number of foreclosures and foreclosed properties on hand continues to drop.

In addition to its regular programs, Loan Guaranty Service is undertaking a pilot program for direct loans to Native American veterans living on trust land. Authority for this program was provided by *Public Law 102-547* because lenders have been reluctant to make loans for properties on trust land due to title and access problems. The law requires the appropriate governing body of the Native American to enter into a Memorandum of Understanding with VA to provide for working with VA on originating, servicing and foreclosure, and allowing VA access to the trust land for these activities. VA has met with several groups and entered into Memoranda of Understanding with 20 Native American groups. Further meetings and negotiations are continuing.

Loan Guaranty Service is also involved with a program to provide housing for homeless veterans. Legislation enacted during fiscal year 1993 provided specific authority to lease acquired properties to organizations working on behalf of homeless veterans. VBA subsequently implemented a test program to lease 50 properties to homeless providers for up to three years at a rent of $1 per year. To date, 42 of the 50 properties have been leased, 27 of them during fiscal year 1994. An additional 12 properties were sold to homeless providers during fiscal year 1994.

Loan Guaranty Service is conducting outreach to veterans affected by military downsizing. It has established a program to provide assistance to servicemembers and veterans who, because of imminent or recent release from active duty as a result of base closing and downsizing of military forces, may be at risk of encountering financial difficulties and, perhaps, losing their homes. Letters were sent to over 200,000 recently discharged veterans, active duty servicemembers, DOD civilian employees and reservists to advise them of VA's programs and provide them with addresses and telephone numbers to receive financial counseling and discuss alternatives to foreclosure of their home loans.

Loan Guaranty Service continues to search for ways to improve its programs and services. Customer satisfaction surveys reveal that more than 90 percent of veterans responding who recently obtained VA loans indicated they were "satisfied" or "highly satisfied" with the treatment they received. Responses from lenders are also generally positive.

The Loan Guaranty Leadership Enrichment Program was held in September 1994. The program was designed to identify and enrich a diverse cadre of potential future leaders within the Loan Guaranty workforce. The 64 attendees, nonsupervisory, journey-level technicians, were competitively selected from 151 applicants. Attendees received briefings on presentation and writing skills and on major issues fac-

ing VBA and the Loan Guaranty program. They participated in challenging discussions and exercises with senior Loan Guaranty and VBA managers and developed group presentations on customer service.

Loan Guaranty Service conducted training for 91 loan technicians during the year. In addition to enhancing the overall level of knowledge among the more experienced loan specialists, the training stressed the importance of consistency in administering the Loan Guaranty program in all areas of the country.

Loan Guaranty Service is conducting a pilot project at the Oakland Regional Office to evaluate a significantly different way of doing business with participating lenders. In place of the current procedure in which a lender submits a report of a loan to VA and waits for evidence of the guaranty while VA conducts a comprehensive review of the entire file, lenders are completing a loan summary sheet and submitting it with the loan file. The data on the loan summary sheet is input directly into the Loan Production System and the Certificate of Guaranty is automatically issued. Ten percent of the loans are then selected for comprehensive review and another 10 percent are selected for post audit.

The results of the pilot have been so successful in speeding up the process of issuing the Certificate of Guaranty without any discernible decline in the quality of the cases submitted by the lenders that instructions for nationwide implementation of the revised procedure are nearly complete. Loan Guaranty Service expects to implement the procedure nationwide for loans closed on or after March 1, 1995.

In January 1994, the Loan Guaranty Program was selected as a pilot program for performance measurement under the *Government and Performance Results Act of 1993 (GPRA)*. In March 1994, VA developed and submitted a performance plan for FY 1994 to the Office of Management and Budget. Area directors were briefed on the Loan Guaranty GPRA performance plan at the Management Council meeting in April.

All the performance indicators in the performance plans are items the Loan Guaranty Service was previously measuring, except for customer and lender satisfaction surveys. The surveys were being developed before the passage of GPRA, as part of an increased focus on customer satisfaction. The survey results will be an important new indicator of program performance. The performance goals were based on standards already or soon to be in VBA manuals or circulars. Loan Guaranty Service will be preparing a circular to inform field stations of the nationwide performance goals included in the GPRA performance plan. 41

Loan Guaranty Service has been involved in the modernization program under the umbrella name of Loan Processing System (LPS). Several new computer applications, when fully implemented, will result in a comprehensive, production-oriented, on-line set of systems to serve the needs of the Loan Guaranty program.

Military downsizing and expansion of eligibility will bring additional applicants into the Loan Guaranty Program in FY 1996. Additionally, the recent increase in the maximum guaranty from $46,000 to $50,750 will have the practical effect of increasing the maximum VA loan for the purchase or construction of a home from $184,000 to $203,000 and will likely have an impact in higher cost-of-living areas.

In fiscal year 1994, FTEEs were shifted from the Loan Guaranty program to Compensation and Pension Service. This will have a negative impact on the Loan Guaranty program. The IBVSOs urge that Loan Guaranty staff not be taken from the service to cure the problems related to claims processing. This will ultimately only result in similar problems in the home loan service and will defeat many of the commendable efforts of this service to offer timely and satisfactory service to its beneficiaries.

The IBVSOs also urge Congress not to raise the loan funding fee in an attempt to raise additional money. This also defeats the purpose and advantages of a VA loan.

Recommendations

- Loan Guaranty staff should be retained in the Loan Guaranty Service and not reassigned to claims processing.
- There should be no increase in the loan funding fee.

42 General Administration

General Administration is funded under the GOE appropriation. This activity consists of the Office of the Secretary, six Assistant Secretaries and three staff offices. The *Independent Budget*, for this fiscal year, has recommendations for the Board of Veterans Appeals and the Office of General Counsel only.

BVA's primary objective is to decide cases promptly, consistent with statutory, regulatory and controlling precedent of the United States Court of Veterans Appeals (CVA).

Board Of Veterans' Appeals (BVA)

Title 38 U.S.C. Chapter 71 established the Board of Veterans' Appeals (BVA). Its chairman is directly responsible to the Secretary of Veterans Affairs. The President appoints BVA's chairman to a six-year term; the Senate confirms the appointment. Until July 1994, BVA contained up to 66 members, including a vice chairman, whom the Secretary appointed (pending Presidential approval) for nine-year terms. The BVA chairman recommends individuals the Secretary appoints for Board membership. Pursuant to *Public Law 103-271*, the 65-member cap (not including the vice chairman) was lifted.

On November 2, 1994, the President signed into law a multi-provisional measure, the *Veterans' Benefits Improvement Act of 1994, Public Law 103-446*, which affected a wide range of veterans' benefits and services, including changes at BVA. This measure eliminates term limits for board members other than the chairman and establishes job performance standards. The chairman will conduct and complete reviews at least once every three years. The Act also provides board members with the same basic pay that administrative law judges (ALJ) receive. The IBVSOs have supported pay equity for BVA board members in the last two *Independent Budgets*.

BVA enters final decisions on appeals to the Secretary of Veterans Affairs on matters involving VA-administered benefits. BVA's jurisdiction encompasses the range of veterans' benefits, including claims for entitlement to service connection, disability ratings, pension benefits, home loan guarantees, insurance and educational benefits. BVA's primary objective is to decide cases promptly, consistent with statutory, regulatory and controlling precedent of the United States Court of Veterans Appeals (CVA).

Adverse VA field office decisions are certified to the BVA for review, provided veterans have filed timely notices of disagreement with the rating board determination and VA receives timely substantive appeals following the issuance of the Statement of the Case. The Statement of the Case must outline the issue(s), evidence of record, pertinent laws and regulations, and reason for the decision. This statement is designed to assist veterans prepare written and oral arguments to BVA.

In the past, a panel of two or three board members signed BVA decisions. This changed when *Public Law 103-271* was enacted, allowing the chairman to assign appeals to an individual member or to a panel of at least three members. This law also revised the reconsideration process, prohibiting the original decision-makers from participating in the reconsideration.

In an effort to hasten the appellate process, Congress also provided, under *Public Law 103-446*, that the Secretary of Veterans Affairs ensure that *all* remanded appeals be treated expeditiously. In addition, BVA may screen cases on appeal, to determine whether the record is adequate for decisional purposes and to immediately remand cases for which the record is inadequate. In this way, cases that BVA cannot finally decide can return to the regional office for additional development, instead of remaining in storage.

The *Veterans' Judicial Review Act (VJRA), Public Law 100-687* (November 18, 1988), established CVA, which is charged with reviewing appeals of BVA final decisions. Prior to the law's enactment, BVA was the final appellate authority for almost all veterans' benefits claims; veterans had no recourse to the federal court system. The BVA workload now includes cases that CVA remanded to BVA for development or action and the additional responsibility under VJRA for reviewing all fee agreements between claimants and attorneys for representation before VA (subsequent to a final BVA decision). BVA must also interpret CVA decisions and assist the General Counsel on certain

matters before CVA, such as memoranda on questions of law and certification of the record on all appeals before BVA.

There are no quick fixes for the problems BVA faces. The long-term solution seems obvious to us. Congress must provide BVA with resources to hire and train enough employees to adjudicate appeals in a timely manner.

Congress must provide BVA with resources to hire and train enough employees to adjudicate appeals in a timely manner.

In fiscal year 1992, BVA had 411 employees; this increased to 449 in fiscal year 1993. BVA staffing levels have remained essentially unchanged since then. To ensure that BVA can meet its workload with trained, qualified staff attorneys, it needs about 50 new employees. This will afford BVA an adequate pool of trained staff attorneys to draw upon to replenish its board member ranks. A staff attorney usually needs between seven and ten years of experience to be considered for board membership.

Congress must provide additional funding for BVA's training programs. This is critical. For too many years, BVA has neglected staff attorney training. BVA cannot render timely, sound decisions and achieve maximum cost-effectiveness without a well-trained work force.

Training is an investment that pays large returns in high-quality work, productivity, innovation and a highly competent work force. A small staff should exist to develop and coordinate BVA-wide training. BVA should institute a formal, on-going training curriculum for staff counsel and board members.

Congress must fully fund training activities for fiscal year 1996. The IBVSOs recommend $200,000 to support senior staff training and travel and on-site training activities for all staff employees. This is a modest amount compared to amounts the private sector invests in training.

Also, an important factor in producing timely, sound decisions is automation and a conducive work environment. To this end, Congress should ensure that BVA has sufficient funds to continue automation of board sections.

Recommendations

- An appropriation of $200,000 should support BVA's fiscal year 1995 training activities.
- Congress should increase BVA staffing levels by 50 employees.
- Congress should appropriate sufficient resources to continue ADP automation.

Office of the General Counsel

The General Counsel is VA's chief legal officer. The Office of the General Counsel (OGC) provides legal services to the Secretary of Veterans Affairs and all Department components in VA Central Office and the field offices. The scope of these services includes all matters of law arising within the context of VA's programs, operations and relations with its beneficiaries, other governmental entities and the private sector. OGC functions are distributed among seven professional staff groups:

- **Group I:** bankruptcy, education, loan guaranty, hospital collections, tort claims, vocational rehabilitation.
- **Group II:** compensation, pension, insurance, burial, and other miscellaneous benefits; national cemeteries.
- **Group III:** crimes and police matters, ethics, labor relations, medical care benefits, hospital administration personnel.
- **Group IV:** administrative procedures, appropriations, civil rights, information disclosure.
- **Group V**: Board of Contract Appeals, cemeteries, construction, environmental and historic preservation, procurement, real estate.
- **Group VI:** management and operations.
- **Group VII:** representation of VA in the U.S. Court of Veterans Appeals.

VA District Counsel and assistants are located in the VA field offices.

44 Specific responsibilities and activities of OGC include:

- Furnishing legal advice to all Department components and ensuring implementation of laws consistent with their meaning and intent.
- Examining for legal correctness all regulations, rules and directives.
- Collaborating with the Department of Justice on referred litigation.
- Resolving administrative tort claims filed against the Department.
- Initiating and responding to legal actions in state and federal courts arising under the loan guaranty, guardianship and debt collection programs.
- Issuing final Department decisions on discrimination complaints filed by employees and applicants.
- Collecting funds owed the federal government under the Medical Care Recovery Act, Workers' Compensation, medical insurance, educational overpayments, loan guaranty and escheat.
- Maintaining liaison with members and appropriate committees of both houses of Congress and monitoring state legislation affecting laws administered by VA.
- Supervising and coordinating matters pertaining to proposed state and federal legislation, executive orders and proclamations.
- Representing the government in matters before the VA Contract Appeals Board.
- Representing the Department in matters before the Merit Systems Protection Board.
- Representing the Department before the Court of Veterans Appeals.

In FY 1996, OGC's ability to provide timely, quality legal services will be determined by the adequacy of resources dedicated to that operation. Like other services within VA, OGC faces several tasks and challenges and an ever more complex environment, all of which make it important that it receive the needed support.

In FY 1994, OGC had to juggle its resources to meet unavoidable expenses, such as locality pay for field attorneys. Streamlining will have a profound effect on OGC. Its field operations will suffer the loss of offices, from 50 to 20. While the elimination of supervisory positions and the loss of these offices will no doubt affect services, OGC simply cannot afford to lose attorneys, who themselves will have to retrain and specialize.

OGC faces increasing needs in VA Central Office as well. It is becoming increasingly important to have attorneys permanently assigned to the Under Secretary for Health and the Under Secretary for Benefits, to be readily accessible and available on a full-time basis. At present, there are no available funds for that purpose.

With reduction in field offices, automated data processing systems, for availability of information, are a necessity. These systems are needed to maintain third-party billing and monitor field office activities, for example. The legal activities that will result from expanded health care reform within states will require additional attorneys.

OGC averts liabilities and costly litigation by a proactive approach. This approach requires it to practice preventive law through the identification and appropriate handling of problem contractors and physicians. And, it requires some restructuring of personnel involved in labor relations and contract matters.

OGC's largest single workload is personnel matters. With resources, OGC could train personnel department employees to handle investigations and cases at administrative levels, thus reducing some attorney work time. Similarly, contracting officers need training to enable them to perform better in handling contract matters. Medical center directors are in need of training to increase their awareness and understanding of their ultimate accountability in these areas. Health care reform will add to their responsibilities in matters with potential legal consequences.

With proper automated data processing systems, training could be more effectively accomplished in preventive law in these many areas. With an increasing need for training, and District Counsel available at fewer locations, travel needs are increased, for which additional funding is also needed.

In summary, despite decreasing FTEEs and tremendous increases in legal work, both in the field

and at the main office in Washington, DC. OGC is attempting to cope with these problems by upgrading its field automation equipment and streamlining the manner in which legal work is performed, including consolidation of some of OGC's current field offices. These initiatives cannot be accomplished without resources to pay for them. It is noted that, though the need for additional resources during the implementation stage will increase the OGC budget for FY 1996, expenditure of these resources should result in considerable future savings. The IBVSOs therefore urge that Congress provide the funding necessary for OGC to effectively accomplish its mission.

Congress and the Administration cannot continue to underfund NCS's maintenance and repair, equipment and FTEE accounts and expect service levels to remain high.

The Court of Veterans Appeals has, in several of its opinions, noted untimeliness, dilatory actions and other unprofessional conduct of VA attorneys practicing before the Court. Given the complaints about the conduct of members of Professional Staff Group VII, it is also suggested that there be an internal review by the General Counsel to determine what measures are necessary to prevent this conduct from recurring in the future.

Under the law, the General Counsel is empowered to issue precedent opinions that are binding on VA. With judicial review, several of these opinions have been overruled by decisions of the Court. The occasion for their review always arose out of their adverse effect upon VA claimants seeking benefits.

Because the Office of General Counsel is entrusted with the responsibility of impartially interpreting the law, it has an ethical responsibility not to favor its employer or any interest in these binding precedents. Therefore, the General Counsel should strive to reach conclusions that follow from a neutral analysis of the law and are not tailored to serve institutional objectives. If the General Counsel's opinions repeatedly appear self-serving, they will continue to provoke challenges by those prejudiced thereby and will likely not be accorded respect by the Courts.

Recommendations

- Additional funds in the amount of $150,000 should be appropriated to permit stationing of attorneys with the Under Secretary for Benefits and the Under Secretary for Health.
- Funding in the amount of $4 million should be provided for necessary automated data processing equipment.
- Funding in the amount of $400,000 should be provided for training in preventive law, personnel matters, contracting and Medical Center Director legal responsibilities.
- Additional funding in the amount of $400,000 should be provided for increased travel needs.
- General Counsel should conduct an internal review of the practices and productivity of Professional Staff Group VII.
- Necessary action should be taken to ensure that precedent opinions of the General Counsel are objective and unbiased.

National Cemetery System

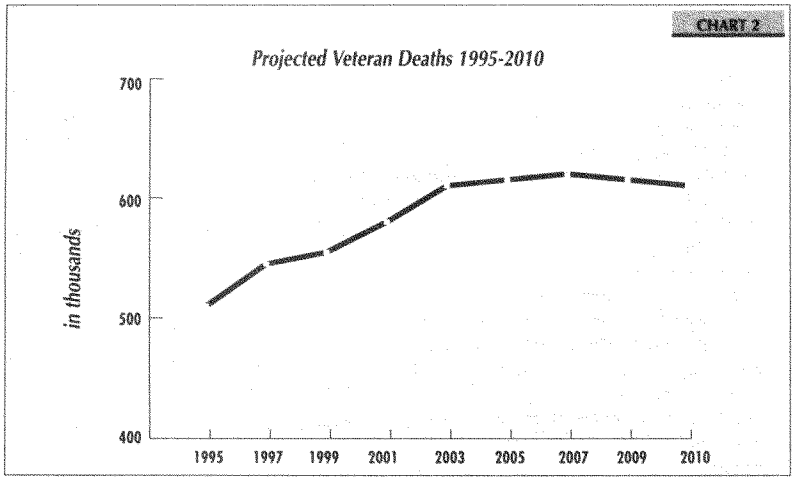
The National Cemetery System (NCS) continues to provide high-quality service despite continued underfunding. However, because the system is not attracting the funding necessary to ensure its long-term health, many of the long-term projects that will enable it to continue serving veterans and their families may not be accomplished.

NCS has three major missions. First, it maintains a system of national cemeteries, which by law are considered national shrines. Second, NCS provides burial benefits for veterans and eligible dependents. And third, it administers the Presidential Memorial Program, the State Cemetery Grants Program and the Headstone and Marker Program.

The System

The National Cemetery System currently operates 114 cemeteries and 34 other burial sites such as confederate cemeteries and soldier's lots. NCS now owns

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10,662 acres of land, of which 5,355 have been developed. Since the system's inception during the Civil War, NCS has conducted 2.3 million interments. To meet future needs, approximately 278,000 gravesites remain available on developed land, while the undeveloped acres can accommodate 1.6 million additional casket sites.

The IBVSOs' major concern regarding the future of the system is that it continue to expand to meet the needs of America's 27 million veterans. Chart 2 depicts projected yearly deaths in the veteran population. NCS statistics show that, historically, 10 percent of all veterans choose interment in national cemeteries. If the 10 percent figure continues to hold true, between 1995 and 2010 approximately 800,000 to 900,000 veterans will request burial in a national cemetery. Clearly, the existing developed acreage will not sustain that total, and Congress must support expansion of existing sites where land is available. That means that NCS faces a deficit of nearly 700,000 interment sites by the year 2010. Chart 3 shows the interment workload over the last 10 years.

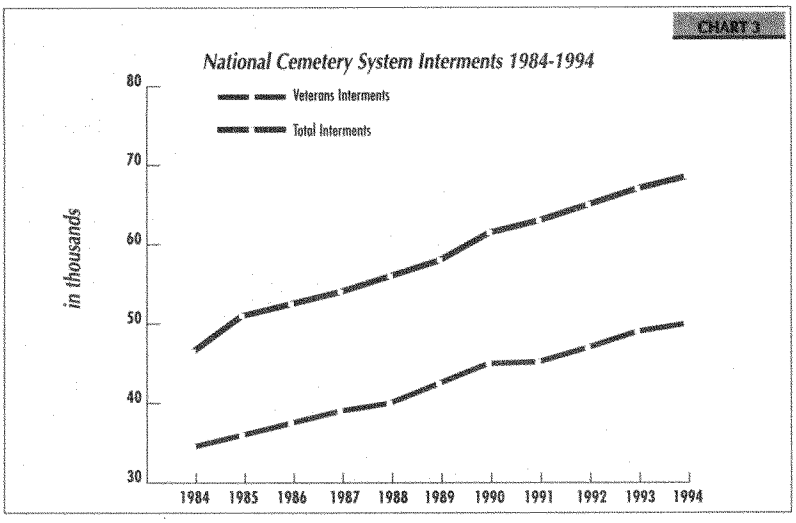
Residence and distance are also significant in the choice of a burial site. Many veterans' families are reluctant to cross state lines to bury a loved one, and 75 miles seems to be the maximum distance most consider a reasonable distance from home. For that reason, it is important that NCS develop and maintain open national cemeteries in each state.

Another problem facing NCS is the impending closure of many of its facilities due to lack of empty gravesites for initial (first-family-member casketed) burials. While many of these cemeteries will still accept cremains in their columbaria and second family members within occupied gravesites, veterans who live in those areas may not find space available for burial. VA estimates that by year 2000, it will declare seven more cemeteries closed to initial burial.

NCS has five new cemeteries in the planning stages in Albany, Chicago, Cleveland, Dallas and Seattle.

NCS Shortfalls

NCS faces a shortfall of 278 FTEEs in 1996 and will need 13 additional FTEEs just to maintain the current level of service. To achieve the expected levels of service, NCS will emphasize burial operations in lieu of other functions, such as maintenance and repair. The backlog in obsolete equipment for fiscal year 1996 is $8.2 million, a level that wipes out modest gains made in 1991 and 1992 when Congress voted additional funds to ease the equipment shortage.



The implications are clear. Congress and the Administration cannot continue to underfund NCS's maintenance and repair, equipment and FTEE accounts and expect service levels to remain high. Further, the overall condition of the cemetery system can only deteriorate. Last year, the *Independent Budget* pointed out NCS's problem in complying with historic preservation requirements. We again recommend relief for the NCS that would allow the system to tear down dilapidated buildings that pose a safety hazard and detract from the park-like setting of most cemeteries, even though they are potentially eligible for the National Register of Historic Places.

Secondary Missions

The matching grant program for state veterans cemeteries will assume more importance as national cemeteries close. Last year, VA awarded grants totaling $4,144,527 to seven states.

NCS also administers the Presidential Memorial Certificate program, which provided 282,552 certificates in 1994. To assist NCS in processing applications and to keep waiting times short, the IBVSOs recommend $500,000 to complete the Automated Memorial Application System (AMAS).

As part of the burial benefits program, VA provides a headstone or flat bronze grave marker to eligible veterans requesting the service. Last year, VA provided 300,754 headstones and markers.

Recommendations

- Add, at least, 15 more FTEEs to cover incremental workload increases.
- Provide at least $2 million in additional funds to reduce equipment backlog.
- VA should begin to study the feasibility of promoting a second national cemetery to ease the demand for space at Arlington National Cemetery. While the IBVSOs understand that it is not possible to duplicate the national appeal of Arlington, properly promoted and placed, a second site with national significance should be pursued.
- VA should aggressively pursue an open cemetery in each state.

48 • VA should aggressively pursue expansion of existing national cemeteries wherever possible.

• VA should recommit itself to a policy of an open national cemetery within 75 miles of 75 percent of America's veterans.

• VA should seek relief from historic preservation requirements at NCS facilities wherever appropriate.

Cost

• $82 million appropriation for fiscal year 1996.

The United States Court of Veterans Appeals (CVA)

President Reagan signed the *Veterans' Judicial Review Act (VJRA), Public Law 100-687*, into law on November 18, 1988. This law creates an Article I court, the United States Court of Veterans Appeals (CVA), which has exclusive jurisdiction to review final Board of Veterans' Appeals (BVA) decisions. Although unique in some aspects, CVA is in most respects a "traditional" federal appellate court.

The IBVSOs recognize that CVA is not part of the Department of Veterans Affairs (VA). It obtains its funding, however, from the same appropriations subcommittee—VA, HUD and Independent Agencies—that provides VA with funding and it so profoundly impacts VA that we include it in the *Independent Budget*.

CVA's primary mission is to review final BVA decisions for errors of law and erroneous findings of fact. On questions of law, CVA's standard of review is broader. CVA may set aside legal determinations from BVA or the Secretary on a number of grounds, including arbitrariness, capriciousness or abuse of discretion, or if decisions are not in accordance with law, are contrary to statutory or constitutional rights or do not observe legal procedure. CVA's authority to hold BVA findings of material facts unlawful is limited, and CVA may only set findings of material facts aside if the findings are "clearly erroneous."

CVA's primary mission is to review final BVA decisions for errors of law and erroneous findings of fact.

CVA received its first appeal in November 1989, and as of September 30, 1994, had received 7,621 appeals. It received approximately 1,130 new appeals during FY 1994, about 100 fewer appeals than in FY 1993. For the first two months of FY 1995, the number of appeals has increased slightly over the last year.

One of the biggest problems CVA still faces is the many *pro se* appeals filed. These *pro se* (unrepresented) appeals now comprise 80 percent of CVA's docket at the time the appeal is filed. This has decreased two percent since last year. More manpower hours are expended in *pro se* cases than in cases where VSOs or private attorneys represent veterans because most *pro se* veterans have never encountered the legal procedures required in federal appellate courts such as CVA and are unfamiliar with these legal procedures. This situation remains difficult, even though CVA has simplified procedures to enable *pro se* litigants to present their own appeals.

On a positive note, however, CVA has benefited from the Veterans Consortium *Pro Bono* Program. While 80 percent of appeals filed with CVA are *pro se*, the Pro Bono Program has cut that figure in half through its efforts to screen appeals for merit and to find representation for those cases with merit.

Despite the difficulties its large *pro se* docket presents, CVA disposed of 433 appeals in 1990, 925 appeals in 1991, 2,289 appeals in 1992 and 1,903

TABLE 11

Actual and Budgeted VA Workloads

(In Inpatients Treated and Outpatient Visits)

Activity	FY 94 (Budgeted)	FY 94 (Actual)	Percentage Difference (Budgeted Versus Actual)
Non-VA Hospital	18,866	20,377	8.0%
State Home Hospital	1,990	2,056	3.3%
VAMC Patients Treated	964,665	906,925	(6.0%)
Total Hospital	**985,521**	**929,358**	**(5.7%)**
VAMC Nursing Home	33,909	30,926	(8.8%)
Community Nursing Home	29,455	29,096	(1.2%)
State Home Nursing Home	19,701	17,873	(9.3%)
Total Nursing Home	**83,065**	**77,895**	**(6.2%)**
VAMC Domiciliary	20,265	18,244	(10.0%)
State Home Domiciliary	6,506	6,453	(0.8%)
Total Domiciliary Care	**26,771**	**24,697**	**(7.7%)**
Total Inpatients Treated	**1,095,357**	**1,031,950**	**(5.8%)**
VA Staff Outpatient Visits	23,748,000	24,134,839	1.6%
Fee-Basis Outpatient Visits	1,113,000	1,023,144	(8.1%)
Total Outpatient Visits	**24,861,000**	**25,157,983**	**1.2%**

Source: VA FY 1994 Budget Submission; VA Summary of Medical Programs for FY 1994

One recent study indicated that VA can reduce its hospital inpatient workload by up to 44 percent![3] Congress must allow VA to treat its patients in the most appropriate settings, and VA should divert its inpatients into more appropriate outpatient or long-term care settings. The *Independent Budget* specifies a strategy below for effecting this.

Recommendation

With appropriate budget authority, divert 300,000 inpatients treated (150,000 each in fiscal years 1996 and 1997) to outpatient and long-term care venues.

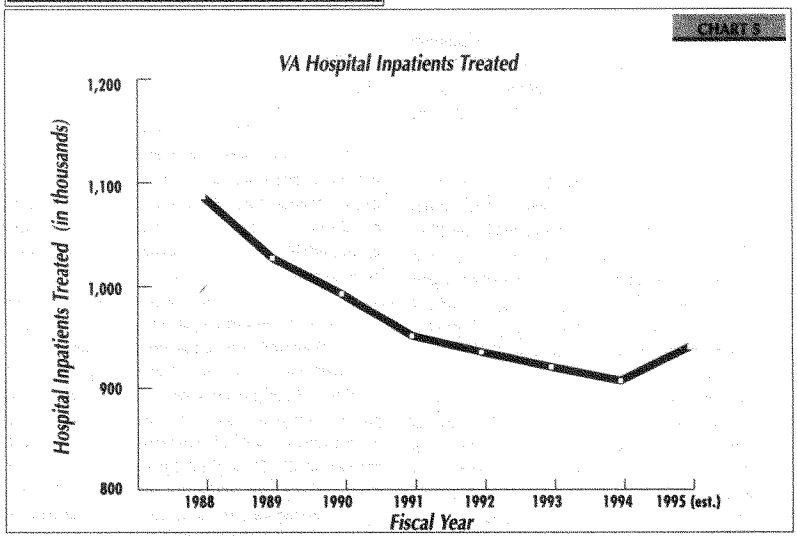
Cost

Under appropriate budget authority, VA would save $2 billion.

Intermediate Care

The intermediate care beds in VA hospitals serve a unique and important function. Veterans requiring a level of care between acute care and long-term or extended care are treated in these intermediate bed sec-

CHART 5



[3]Brenda Booth, Ph. D., et al. "*Nonacute Inpatient Admissions to Department of Veterans Affairs Medical Centers,*" *Medical Care* Vol. 29, No. 8, August 1991 Supplement.

Medical Programs

To reach the port of heaven, we must sail sometimes with the wind and sometimes against it—but we must sail, and not drift, nor lie at anchor.
Oliver Wendell Holmes,
The Autocrat of the Breakfast-Table

VA Medical Programs in FY 1996: Taking Stock for the Future

The Failure to Enact Comprehensive National Health Care Reform

Health care was a defining issue during the first half of the Clinton Administration and the 103d Congress. President Clinton introduced legislation that would have significantly affected the delivery and financing of health care in the United States. Despite much publicity, the Administration and the 103d Congress could not reach the consensus needed to bring health care reform legislation to the floor of Congress. Some pundits predict that the health care reform issue will resurface in the 104th Congress, but most believe that any enacted legislation will be more moderate in its approach to reforming health care delivery and financing than some of the proposals the 103d Congress introduced and the Clinton Administration's proposal.

The Administration's bill, *H.R. 3600*, promised veterans that all VA system patients would have access to the same standard benefits package that everyone else had in the new environment. This would have accomplished a long-standing VSO objective of providing VA patients with a full continuum of medically necessary services, whatever their levels of eligibility. The bill would have guaranteed each enrolled veteran or dependent access to basic benefits. New funding streams created through the Administration's proposal guaranteed that VA would recover the costs of delivering basic benefits to all enrollees—either from employers, from health alliances or from Congress.

In addition, the bill promised the VA system a new beginning, by offering a significant $3.3 billion investment fund to expand geographic accessibility to veterans and modernize and otherwise improve infrastructure so that VA could participate in the new health care environment. The Administration's proposal was the first to create a positive role for VA within the context of comprehensive national reform. Consequently, the veterans' community supported *this portion* of the bill as an acceptable starting point for negotiations with Congress and the Administration. The IBVSOs have used the Administration's VA reform agenda as the Fiscal Year 1996 *Independent Budget's* legislative platform.

52 What Is Health Care Reform Likely to Look Like in the Future?

Now the 104th Congress has the chance to propose national health care reform. With all of the controversy reform advocates faced in the last Congress, the new Congress may not address comprehensive health care reform. Congress may address some modest reforms, such as Medicaid expansions, insurance reform, small market reform, administrative streamlining and increased opportunities for community care. Medical savings accounts may re-emerge from the last Congress.

The 104th Congress will likely take a conservative approach to health care reform.

While the 104th Congress will likely take a more conservative approach to health care reform, the VSOs hope to work constructively with its members to create a positive role for VA within proposed health care reforms and to ensure that Congress adequately considers the consequences of proposed legislation on the VA health care system. The VSOs are concerned that some proposed changes to the larger health care community will adversely affect VA.

For instance, if the number of uninsured individuals grows because of continued federal entitlement cuts and federal inaction, use of the VA health care system as a "safety net" for veterans may increase. Consequently, if its current health care funding is imperiled, VA will have to ration care. To avoid that problem, VA must have access to new funding streams if its patient base grows. Congress will have to establish funding streams to support basic VA health care benefits, so that any growth in services or caseloads will not necessitate rationing care to VA's current users. We will address further this critical initiative below.

State Reforms

States are scrambling to identify means to expand coverage for their residents, as they seek to contain Medicaid costs and uncompensated care costs for their providers. While the federal government seems increasingly reluctant to grant waivers from federal law, such as Medicaid, Medicare or the *Employee Retirement and Income Security Act*, the federal government has given nine states some authority to relax program requirements. States' successes should serve as models for other states' or national reform. States will also continue to attempt to control spending and increase coverage within established parameters. States that are implementing or developing major actions are addressed in Appendix D.

Last year, the *Independent Budget* proposed a grant program for states. While most of the 103d Congress supported a bill to accomplish some of the IB-VSOs' proposed reforms, its state pilot reform bill faltered when Congress failed to reach a consensus on authorizing VA medical centers to match their states' benefits packages. The veterans' service organizations sincerely hope that Congress can enact legislation that will allow VA medical centers in states with reform agendas to integrate with their communities and retain their patients. VA medical centers must be able to provide, at competitive rates, at least the same benefits a state program offers its beneficiaries.

The *Independent Budget* goes further this year in proposing that Congress grant all VA medical centers authority to provide the full range of medically necessary care to any veteran entitled to VA care and, on a reimbursement basis, to higher-income veterans and veterans' dependents. Legislation is necessary, however, to allow VA medical centers to adapt in states with active reform agendas. Some of the 103d Congress's proposals would have liberated VA from oppressive contracting restrictions and allowed centers to sell benefits to non-veterans, but would not have authorized additional funding for the logical extension of services. VA medical centers must have the authority and funding to act as other providers in states with comprehensive reform. The VSOs support using state pilot programs to phase-in such authority.

Private-Sector Reforms

Private-sector reforms are occurring at a staggering pace. In recent years, health care providers have made (or lost) millions of dollars on mergers and acquisitions. Vertical integration organizes delivery systems to allow access to a full array of services through one provider. For instance, some hospitals have merged with nursing home chains, clinical laboratories or outpatient surgeries. Vertical integration is prevalent as providers attempt to

control costs. In-house services offer providers increased control over some operating costs. Instead of accepting a local hospital's bid for services, for example, a health maintenance organization could provide the care themselves and retain any profit.

> VA medical centers must be able to provide, at competitive rates, at least the same benefits a state program offers its beneficiaries.

The distinction between providers and payers blurs as more integration occurs. Providers are taking on payers' traditional roles and risks and vice versa. Most health facilities acknowledge that the day of the stand-alone facility is quickly vanishing. Partnerships in which organizations attempt to complement each other's strengths and weaknesses continue to form. For example, many academic medical centers are trying to identify ways to add primary care to their service menu. Partnerships with health maintenance organizations, private doctors' groups or their own staff physicians have blossomed as medical centers attempt to assure a steady patient flow for their specialty services. Minnesota is basing its reform on these "integrated service networks." Yet VA medical centers are not allowed to enter these partnerships. The more time elapses without VA participation in these partnerships, the more private-sector planning and action will occur, forcing VA into competitive, rather than collaborative, relationships.

Particularly at risk are VA's relationships with its academic affiliates. VA has always enjoyed the support and cooperation of its affiliates, on whom it relies for residents, equipment and contractual relationships with specialists. Congress must authorize VA to act to preserve these highly beneficial relationships. Augmenting some services, such as primary care and women's health programs, and sharing must be part of VA's plan. The academic medical centers are natural partners for VA in expanding into these areas of care. If VA had the authority for forming joint ventures, working with academic medical centers would benefit both the veteran and the community. Congress must loosen the binds on VA medical centers and allow them to integrate with their communities' providers before they are forced to remain isolated players in the emerging, tightly aligned environment.

VA Reform

VA's Central Office and the field leadership recognize the challenges that beset the system. Several internal and commissioned studies have identified key obstacles VA must overcome and strategies that may help Central Office and medical facilities resolve chronic problems. These studies similarly identify a rigid, over-centralized, bureaucratic management style; too little local collaboration with medical facilities' communities and too little local initiative; duplicative and inefficient service delivery; and leadership's reactive, rather than proactive, stance to changes in the health care environment.

Separately, each report offers its own definition of VA's problems and suggested resolutions. Together, they indicate that VA and its employees are ready for massive reforms to ensure the system's place in the new health care order. We commend VA for its demonstrated willingness to scrutinize itself and propose meaningful changes to the comfortable status quo.

Current Reform Proposals

A few of VA's most visible proposals are addressed below.

THE VA NATIONAL HEALTH CARE REFORM TASK FORCE

During the 103d Congress, VA convened more than 250 individuals representing all aspects of its health care system to explore needed improvements. Modeled after the White House's "toll-gate" process, the Task Force was divided into smaller working groups who identified VA issues that national health care reform would affect. The working groups explored such topics as financing, marketing, external relations, management issues, delivery structures, clinical care issues and services VA should offer, along with other topics. The Task Force emphasized VA's need to adopt a "managed care" practice style, stressing preventive and primary care and efficient service delivery through better patient management.

Although the Task Force based its reform around the enactment of the President's proposal, which would have opened VA to all veterans and veterans'

54 dependents, allowed them to receive the full continuum of medically necessary VA care, and created additional funding streams for VA, many of its proposals are still valid. For example, the VSOs, who also participated in the process, agree that VA must adopt a managed-care approach, integrate with their communities, and meet or exceed local communities' quality and performance standards. Some in the veterans' community, however, believe the Task Force overemphasized the "Kaiser Permanente" model for VA, rather than suggesting that it mobilize its resources around its own unique specialized missions in veterans' health care, education and research.

THE "FARSETTA" REPORT

Proposed Management Improvements: Draft Report by the Resource Planning Methodology Field Oversight Committee

VA formed another internal task force, comprising primarily field managers, to investigate how VA could more efficiently use its staff and funding. The proposal came in response to Vice President Gore's *From Red Tape to Results* recommendation that the executive branch cut staff across-the-board in each of its agencies. The report enumerated several options to streamline and consolidate administrative functions on a facility-by-facility basis without harming the quality of patient care. The veterans' community greeted this claim with a fair amount of skepticism. The Committee, however, is to be commended for its efforts to deal constructively with VA's loss of resources.

The Office of Management and Budget and VA Secretary Brown have since negotiated the size of VA's staffing cut. Congress also intervened, with legislation that established a floor for the number of Department of Veterans Affairs employees. These two efforts will help to assure that VA must not drastically cut its personnel levels and, thus, damage patient care.

The VSOs generally support efforts to consolidate non-medical functions such as administration. That said, the VSOs believe that a personnel reduction as significant as the one the Gore recommendation might have imposed on VA, as one of many affected government agencies, would have been detrimental to patient care. This is particularly true if VA is to expand community care and implement VA medical center programs that correspond to other programs operating for state residents. While VA will remain a distinctively different type of health care provider from other community providers, it must offer similar benefits and services if it is to participate in the emerging health care environment.

THE "THIBAULT" REPORT

The Task Force Report on Veterans Health Administration Central Office Reorganization

VA Central Office and field managers, private-sector representatives and professional consultants comprised this task force. The group has presented its report to the new Under Secretary, but because he has not had time to thoroughly review it, VA still considers the report a draft.

This newest report proposes some details for decentralizing functions now assigned to VA's Central Office. It stresses the need for Central Office to become a corporate "National Headquarters" that concentrates on creating policy and monitoring standards, rather than its current emphasis on operations and crisis management. Correspondingly, the report also recommends empowering employees closest to patients, by encouraging innovative and informed local decision-making. The veterans' community is pleased with the draft, which offers a strategy to provide VA managers with a more flexible, less bureaucratic structure that permits local, patient-centered decision-making. The IBVSOs strongly support VA's need to decentralize management and, in fact, have expressed, in our own policy statements and testimonies, the need for such reforms.

THE "DETERS" REPORT

The Task Group on Veterans Health Administration Field Reorganization

VA's new Under Secretary for Health, Kenneth Kizer, MD, has most recently proposed a slightly revised version of the "Deters" report's recommendations on VA restructuring to the Secretary of Veterans Affairs. Like the Thibault report, the Deters report recommends that VA decentralize management and foster local, patient-centered decision-making to the extent possible and pragmatic. The report advocates creating "networks" within the system, to streamline and inte-

grate services. The Under Secretary has embraced and plans to quickly implement many of the Task Group's recommendations. The VSOs appreciate the Under Secretary's responsiveness to needs these reports define. At the same time, we plan to continue to work with the Under Secretary to address residual concerns, particularly about establishing accountability for maintaining the integrity of VA's specialized missions and services.

Legislative reforms are critical to any strategic improvement of VA's medical care system.

Critical Reform Initiatives and What VA Needs to Implement Them

Various roadblocks, such as the lack of a permanent Under Secretary and national health care reform, have impeded VA leadership from proposing and lobbying for a comprehensive legislative agenda. Now that these are no longer factors, VA can identify the legislative agenda it needs Congress to enact. Legislative reforms are critical to any strategic improvement of VA's medical care system.

In this *Independent Budget*, the veterans' service organizations concentrate on the reforms—both those that Congress must authorize and those that VA can implement now—that VA needs *today* to survive in the current health care environment. Without these reforms, VA medical centers cannot adequately care for current patients or prepare for the future. The next time national health care reform is proposed, VA must not be dismissed as a hopeless anachronism or its unique contributions to the U.S. health care system will be lost.

IMPROVING VETERANS' ACCESS TO COMPREHENSIVE HEALTH CARE SERVICES

Believing that enactment of the President's health care reform proposal would accomplish much of the long-standing VSO objective of eligibility reform, the veterans' community temporarily tabled its independent pursuit of this legislative initiative. Now that comprehensive health care reform is unlikely and the accompaniment of significant new funding even less probable, the IBVSOs are re-asserting eligibility as a key component of our legislative agenda. The IBVSOs believe that Core Group or mandatory veterans must have access to the full continuum of care, from primary through long-term care. We also believe that it is essential to include those with catastrophic disability in the mandatory category for veterans' health care benefits.

The Clinton Administration's health care reform proposal would have provided veterans and other Americans access to a *continuum* of basic health care services. The program would have also continued to allow VA to provide Core Group veterans with "additional" *Title 38* services beyond the basic benefits package established for other Americans. VA has several specialized missions that merit identification, including spinal cord injury medicine, medical rehabilitation services, prosthetics and sensory aids services, blind rehabilitation services, mental health programs, geriatrics programs, long-term care programs and specialized programs to ameliorate exposure to environmental hazards such as Agent Orange, ionizing radiation and toxic agents used during the Gulf War.

Of these services, spinal cord dysfunction medicine, blind rehabilitation services, prosthetics and orthotics services, amputee clinic teams and Preservation Amputee Care and Treatment (PACT) Program, and post-traumatic stress disorder treatment are the core of VA health care, because they treat veterans for conditions they experience disproportionately and for which VA has established unique expertise. If VA does not focus on these special missions and services, it loses its heart and its identity as a *veteran's* health care provider.

The proposal also set up a new funding stream, which implicitly involved a capitated entitlement account from which the Congress would fund basic benefits for VA medical care system enrollees. In an enrollment system, a guaranteed funding source is critical, to ensure that VA can provide, without rationing, comprehensive services to eligible veterans. This topic, too, is addressed in more detail below.

Congress developed VA's current criteria for access to VA health care around a delivery style that prevailed in the 1950s—one that centered its care continuum on hospital care and therapeutic medicine. As the practice of medicine has evolved in the private sec-

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tor and other care venues, these outdated eligibility criteria have severely impeded VA's evolution and adoption of new care settings and delivery styles.

Eligibility is established on two bases for veterans. First, a veteran is classified within an eligibility category; the veteran's classification then determines which care and services VA can provide that veteran. For instance, veterans with service-connected disabilities rated at 50 percent or above have the highest priority for services within the system. They are entitled to receive all hospital and outpatient care, whether or not that care involves their service-connected disability. These veterans with highly rated service-connected disabilities comprise the only group that has almost complete access to the system. No other eligibility classification has unbridled access to outpatient care.

Some veterans have access to inpatient care only and some veterans have access to inpatient care only under certain conditions. No veteran has entitlement to nursing home care. Another group that may completely lack access to VA consists of non-mandatory catastrophically ill veterans. These veterans must impoverish themselves and their families before they become mandatory veterans. We have implored Congress to entitle these veterans to the same medical care services mandatory veterans receive at the onset of injury or illness, rather than to allow this impoverishment to occur. Congress should enable VA to provide these veterans with comprehensive services and allow them and their families better resource bases from which to rebuild their lives after rehabilitation or recovery. (See Table 6 for a detailed explanation of eligibility for VA medical care benefits.)

These complexities and restrictions make it difficult to organize a managed-care practice style. Only veterans with highly rated service-connected disabilities have unrestricted access to the primary and preventive care on which managed-care systems focus. Since managed-care systems oversee patients' care through assigned primary care teams or clinicians, opportunities to manage the VA patient's care are limited to only the highly rated service- related group who have access to primary care.

Some VA medical centers have interpreted more liberally a clause within the eligibility code, "obviate the need for inpatient care," to establish outpatient case-management programs for high-risk populations such as hypertensive, diabetic, chronically mentally ill or frail elderly patients. Other pilot projects, such as the Sepulveda VA Medical Center's Pilot Ambulatory Care and Education, have successfully eliminated many of the breakdowns in the seamless

TABLE 6

Entitlement Criteria for VA Medical Care Benefits

CATEGORY A	HOSPITAL	OUTPATIENT	NURSING HOME
SC 50-100%-any condition SC 0-40%-service-connected condition Discharged for disability	Entitled	Entitled	Eligible
SC 30-40% NSC condition Pensioner & income < $12,855 Section 1151 (injured in VA)*	Entitled	Entitled, but limited to pre- & post-hospitalization & to obviate the need for inpatient care	Eligible
Prisoner of war World War I veteran Pension with A & A Mexican War veteran	Entitled	Eligible	Eligible
SC 0-20% for NSC condition NSC income $12,855 to $20,469 (with no dependents) AOR, radiation, Medicaid eligible	Entitled	Eligible, but limited to pre- & post-hospitalization & to obviate the need for inpatient care	Eligible
NSC income >$20,470	Eligible with co-pay	Eligible with co-pay, limited to pre & post-hospitalization and to obviate the need for inpatient care	Eligible with co-pay

*Limited to condition

Source: Title 38, U.S. Code

continuum of care that other VA medical centers' patients suffer. To succeed as more than a "safety-net" program within today's health care environment, VA must provide a continuum of medically necessary health care services for its clients. It must also provide efficient care management, as do some private-sector providers, as it emphasizes the specialized missions that have characterized the VA system and contributed to its unique identity.

The IBVSOs realize that VA cannot reform its system of access to medical care overnight. It needs the proper infrastructure, including increased capacity in its primary care, ambulatory surgical and long-term care programs, to ensure that VA can divert hospital inpatients into more cost-effective and appropriate venues of care. VA must immediately begin, however, to implement the changes that will allow this to occur. For this purpose, the IBVSOs have proposed increments in the Construction and Medical Care budgets (see Construction Section, page 119) and budget authority to execute necessary changes.

RESTRUCTURING TO ALLOW DECENTRALIZED MANAGEMENT

Most in the veterans' community recognize that VA's practice of centralized management is no longer viable in a rapidly evolving health care environment that necessitates anticipating and implementing changes in the local environment. Instead, to maintain its primary missions and goals, VA must establish national parameters into which VA-approved medical facilities must fall. While this recommendation suggests curtailing and refocusing Central Office management functions, it *does not* diminish or eliminate Central Office's significant role in creating and enforcing guidelines for field performance. However, VA must implement these parameters locally with minimal Central Office intervention. Central Office or intermediate-level staff should intervene only if a local facility has failed to perform at an expected level.

The first task VA's Central Office and field management must accomplish is re-defining and re-assigning local VA facility missions. Together, Central Office and the field must critically assess VA's current use of resources and define a plan to increase efficiency while creating maximum access to care for veterans. This will clarify for local facilities the programs and services that Central Office expects them to operate and affirm that missions assigned best meet the needs of individual areas' veterans. While VA Central Office will define each medical center's mission, local management should have a formal advisory role in deciding what services the facility should provide. Without local support for re-assigned missions, management and employees are unlikely to be willing participants in reform. Granting a planning role to local facilities better ensures local involvement and acceptance.

The veterans' service organizations recognize that VA cannot greatly expand certain components, such as outpatient primary and preventive care and long-term care venues, without re-directing resources from other venues and creating economies by integrating and regionalizing certain programs. Several proposals for restructuring VA to facilitate implementing these initiatives have emerged. Many of these plans have merit, in that they identify natural referral patterns in VA utilization and, correspondingly, propose alternative management structures that could bring management closer to the patient. These proposals attempt to build into the system flexibility and empowerment of local management. The veterans' service organizations support a national structure that enhances efficiency and productivity, but preserves the specialized programs for which the Department of Veterans Affairs is renowned.

The second task VA staff confront in reorganizing is in establishing practice parameters on which the health care and veterans' communities concur. The private sector is furiously debating some of these issues. VA can lead the clinical community in defining appropriate "critical paths" or "care maps" for functions in which VA has special expertise, such as prosthetics, spinal cord injury medicine or treatment of bio-psycho-social disorders. Developing guidelines requires the counsel and agreement of many practitioners with divergent perspectives, training and backgrounds. Therefore, reaching a consensus could be timely, costly and contentious.

Service issues demand a different focus oriented to the market and patient satisfaction. Some providers are establishing "report cards" that consumers can use

58 to make educated decisions regarding health care providers. Report cards attempt to determine the "value" of services, from the consumer's perspective. Because providers are not required to make this type of information available now, and in fact may not even collect such data, only the best providers have any incentive to disseminate quality information to their consumers. This is the only means through which the consumer can make educated decisions in selecting a care provider.

Despite the nascent state of such measurements, both sets of practice parameters—for service and clinical care—are imperative for quality assurance. VA medical centers must work *as part of* their local health care environments to determine the characteristics consumers in individual communities expect. They must then feed that information to VA's Central Office so that, together, they can create a national minimal standard that meets local consumers' expectations.

Consumer involvement is also imperative to making local management accountable to community care standards. In addition to accounting for compliance with national standards to VA's Central Office and intermediate management, each VA medical center should account to a local advisory board that can critically assess VA's adherence to *local* standards and strategic plans for delivering clinical care to veterans. Advisory boards should also report breaches in nationally established standards. For example, if local management refuses to correct quality problems, the advisory board should report these breaches to the next management level and recommend amendments. Local VSOs should participate in these boards to voice their constituents' opinions.

Guidelines for Sharing and Joint Ventures

Among the guidelines VA's Central Office and field managers should develop are conditions under which facilities may share resources. The VSOs are not alone in identifying the need to clarify the protocol for sharing relationships. The General Accounting Office (GAO) has recently reported military hospital commanders' and VA medical center directors' lack of awareness of authority and opportunities for enhanced sharing.[1] In addition to this lack of awareness that inhibits sharing, incipient agreements sometimes shatter when participating agencies' officials disagree on sharing terms. GAO asserts that, by not entering into more agreements, VA loses opportunities to access significant new funding from CHAMPUS—funding that the local facility keeps under the legislation authorizing VA/DOD agreements!

In each of the last six *Independent Budgets*, the IBVSOs express support for appropriate sharing agreements. Still, the VSOs are sometimes viewed as uncooperative and inappropriately territorial in their response to proposed sharing arrangements. Often this is not so. The VSOs believe that the system should not displace any veteran, and that VA medical centers should maintain their identities as providers for veterans. We generally approve of sharing when VA shares services and facilities or sells services to military personnel and CHAMPUS beneficiaries. These agreements have generated more resources for veterans. In some locations, sharing has allowed VA to expand where veterans' demand for services alone would not have justified a VA facility. We believe sharing is positive, in most cases, for veterans and non-veterans receiving the services.

Problems arise when federal officials do not inform the veterans' community about potential sharing agreements. The Rural Health Initiative, which would have opened six VA medical facilities to Medicare and Medicaid beneficiaries, met some strong veteran protest, because the initiative was brokered without the VSOs' knowledge. Had the VSOs had an opportunity to comment on the proposal, obtain VA's assurance that the agreements conformed to guidelines established for other sharing arrangements and educate their members as to the agreements' benefits, the Rural Health Initiative might now be a permanent fixture within the VA delivery system. Communication and participation with the veterans' community are essential to the success of major VA reforms. Without such participation from veterans in the decision-making process, VA should expect resistance and misunderstanding.

[1] United States General Accounting Office. *VA/DOD Health Care: More Guidance Needed to Implement CHAMPUS-Funded Sharing Agreements* (GAO/HEHS-95-15). Washington, DC: 1994.

VA medical facilities may have opportunities (and should seek opportunities) to share with community providers and, when appropriate, other federal providers. Currently, if arrangements are not framed as sharing, VA lacks the authority to enter into them unless they are deemed necessary for obtaining scarce medical resources. Authority may not exist for entering into ventures designed to create profit. Congress must liberate VA medical centers from legal restrictions that impede their ability to enter profit-making ventures. VA medical centers should be able to establish partnerships with their academic affiliates and other community providers to ensure their viability in the local health care network.

Leasing

The *Independent Budget* has supported facility leasing as an excellent way of expanding availability to veteran patients while allowing VA management authority over its own staff and resources. The last two *Independent Budgets* have suggested that VA use leasing to expand its nursing home capacity. VA can also consider leasing in expanding primary and preventive care services. Many patients will travel to access specialty care, but they are less willing to travel for primary care. Beneficiary travel funds are not available, and few veterans can afford to travel to access an uncomplicated service. Leasing will allow VA to place additional clinics in areas with dense veteran populations without making the permanent investment for construction.

VA has already designated some "storefront" operations (not necessarily using leased facilities) to serve homeless populations. These programs will screen, diagnose, and refer users to larger "parent" facilities. Putting services in the community where they are easily accessible to those they are meant to serve is key to an effective prevention service. VA has several facilities in the community, such as vet centers and community residential centers, that it could use to develop its local medical presence. Many non-VA community medical facilities also have excess capacity that VA could lease.

Contracting for Non-VA Services

VA should, as much as possible, maintain operational control of its medical services. It should continue to manage care for patients for whom it purchases contract services. This policy will preserve the identity of VA services and assure veterans that the system created to serve them is not abdicating its responsibility. Such an arrangement is the antithesis of the proverbial "mainstreaming" of VA patients. When VA contracts for services, it must ensure that providers offer high-quality, accessible services that offer veterans no less than they would receive from VA facilities. VA should also have information management systems that communicate with contract providers, so that both may share and update patient information.

Identification of Cost and Resource Management

Congress must authorize mandatory funding based on the costs of delivering a basic benefits package to entitled veterans. VA must take at least three critical steps VA to define an appropriate payment for basic benefits. First, it must decide exactly which services to classify as basic benefits. Second, VA must accurately determine the costs of delivering this package. Third, after Congress reforms entitlement, VA must enumerate entitled veterans who are likely to use these services.

Once VA performs this exercise, it can use the capitation formula to allocate funding to facilities responsible for offering these basic benefits to entitled veterans. VA must have additional funding for facilities involved in teaching, research, execution of the contingency mission and specialized care missions that fall outside the scope of basic benefits. State-of-the-art information systems that are expeditiously fed with reliable data are essential to identifying costs and equitably distributing resources.

Development of Information Systems

Care Management

Information resources management is integral to VA's ability to track patients through diversified care sources. As mentioned earlier, VA needs information systems that accurately measure outcome indicators to ensure that VA and contract facilities provide high-quality care. These systems should be user-friendly and, to the extent possible, databases that already exist should feed them, so that little additional data entry is necessary.

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Cost Recovery

Medical care cost recovery efforts have improved significantly since collection efforts began nine years ago. Not only has VA collected increasing amounts of funding, it has become more efficient at doing so. A smaller share of the collected funds are needed for administrative costs each year the program has operated. These collections are extremely important in the funding strategy the IBVSOs recommend (see pages 107-9).

VA needs an information system that interfaces with private- and public-sector third-party payers. VA already collects from veterans' insurers for the cost of their non-service-related care. Officials assert that VA collects only about 80% of potential funding from this source. As private and public sectors integrate, their information systems will have to correlate, allowing them to bill consistently and efficiently. Only by having such systems can VA identify resources available to help it recover the cost of delivering care to veterans, when it is appropriate to do so.

Cost Identification

VA has implemented a pilot project, the Decision Management Support System (DMSS), to more accurately identify its costs and cost centers. While the VSOs still have concerns about the data systems that feed the program, DMSS greatly improves upon the other cost-identification programs VA has used previously. As VA becomes more aggressive in its cost-recovery efforts, it must identify its costs and share them with insurers and consumers. As discretionary funding sources dwindle, VA must also provide this information to Congress, to strengthen arguments for the limited resource pool it must share.

As information continues to become available to consumers, cost identification may enable VA to market itself as a cost-effective care provider—not only to consumers, but also to payers such as Medicare and Medicaid. Cost information also helps managers make effective decisions about service delivery. For all of these reasons, it is imperative that VA have a cost-identification system.

Resource Allocation

Once in place, a cost-identification system should be VA's base for allocating resources. While there are certainly reasons to justify cost-outliers (services and facilities that cost a great deal more or less than normal), adherence to a reasonable cost standard that accounts for factors such as local market conditions and patient and service mix must be each VA medical center's goal.

Performance Standards

Health care providers are rapidly developing more sophisticated measures of both patient satisfaction and clinical care outcomes. While many care providers want their services to conform to a "gold standard," today there is little agreement as to what defines "high-quality" practices and outcomes. In this transitory environment, VA is not alone in having trouble distinguishing which standards are valid and implementing them. Both the public and private sectors apply existing standards inconsistently.

INVESTMENTS IN INFRASTRUCTURE

The Clinton health care reform initiative would have provided VA facilities with $3.3 billion over its first three years of implementation. The Administration identified the need for such funding, to allow VA to "compete" with other health care providers and motivate veterans to choose VA health care over other cost-competitive alternatives. The IBVSOs recognize the same challenges the Clinton Administration recognized in calling for an investment fund. While we have not proposed an investment fund *per se*, we have addressed many of the same funding needs the Administration's fund recognized in the Medical Care and Construction budgets.

Veterans' advocates have long recognized the problems VA confronts as it strives to become a provider of choice. VA medical centers are often geographically inaccessible or inconvenient, particularly for routine care needs. While veterans accept the need to travel some distance for intensive or specialized care, they are not so willing to travel for primary and preventive care. Primary and preventive care are becoming the center of VA's care continuum and primary care must be local—VA must find means to provide it in sites that are convenient to as many VA users' homes or businesses as possible. Wherever demand is great enough, VA must establish and oper-

ate outpatient clinics to meet it; but VSOs support contract care for some veterans, if demand does not dictate the need for a VA clinic. VA can also capitalize on its existing sharing agreements and develop more to meet some demand.

VA has many old and unattractive facilities. Some facilities lack private-sector amenities. System-wide strategic investments in modernizing and improving facilities that serve many veterans are more appropriate than building new hospitals. VA should consider new hospital construction only in areas with high demand.

VA also must assign appropriate missions to facilities to allow for more intelligent investment of VA's scarce resources. For example, VA must specify which facilities will primarily provide long-term or outpatient care. It may also wish to consolidate surgical services and other high-cost, labor-intensive services as appropriate. Once these missions are defined, VA should provide facilities' funding to convert space and thereby increase capacity for these patient care missions.

VA may need additional funds to provide the full continuum of care to its entitled patients, if entitlement is "phased in" through the states without mandatory funding. If the 104th Congress does not enact a proposal that promotes a new VA funding stream, investment funding must cover costs to expand services. If additional funding is not available to VA medical centers in "pilot" states, VA medical centers in other localities will bear the brunt of those states' additional spending.

VA must find means to provide primary care in sites that are convenient to as many VA users' homes or businesses as possible.

COLLECTION AND RETENTION OF FUNDS

VA lacks the authority to collect funds from Medicare. The General Accounting Office recently confirmed that Medicare could be a significant funding source for VA's dually eligible patient base.[2] In its report, GAO claims that one-half of VA's users are eligible for Medicare. Often they use VA for services such as prescription drugs, inpatient psychiatric care and long-term nursing home care, that Medicare does not cover. Patients who use VA for these services often lack private coverage for these or other services. Since Medicare does not cover them, VA would gain little in billing for them. Congress, however, must allow VA to collect Medicare funds for non-Core-Group veterans and others, including veterans' dependents who may become eligible to use the system. The fiscally austere posture the new Congress will likely adopt will severely limit discretionary funds; hence, VA needs expanded authority to collect and retain third-party reimbursements from private insurers and Medicare. This authority may determine VA's ability to survive and perform in the health care environment of the near future.

VA also lacks incentive to collect private insurance reimbursement for veterans that have it, because all collected funds now revert to the U.S. Treasury. According to the last *Survey of Medical System Users*, 67 percent of VA's users lack any private coverage. Approximately half of those with insurance describe their coverage as fairly comprehensive in covering all or most of their hospitalization and physician office visits. About 15 percent of VA users have coverage from whom VA could reasonably expect to extract payment. Congress should encourage VA collection efforts by allowing local facilities to retain a significant share of the monies collected. It should allow the rest to be posted in a general fund and used for system projects to which Central Office gives high priority.

ORIENTING STAFF TO A CONSUMER-DRIVEN DELIVERY STYLE

VA employees are, for the most part, dedicated to the patients they serve. VA professes commitment to its courtesy and caring campaign, "VA—Putting Veterans First," which it began to implement in July 1993. Many veteran patients still believe they are treated like numbers, however, or—as one VA official said—like "cattle" as they are channeled through the system. The system's inability to provide appropriate patient care,

[2]United States General Accounting Office. *Report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives: Veterans' Health Care: Use of VA Services by Medicare-Eligible Veterans* (GAO/HEHS-95-13). Washington, DC: 1994.

62 due to bureaucracy and micromanagement from various sources, frustrates staff. Many of these problems are not within the local directors' control; however, innovative directors can train and empower employees to be more responsive to their customers' needs. Some initiatives to engender this responsiveness are discussed below.

Innovative directors can train and empower employees to be more responsive to their customers' needs.

Customer-Service Training

VA medical facilities should send employees to training sessions or provide in-house training to better equip them to treat veteran patients as consumers rather than captive users. Skills VA should foster include empathetic listening, defusing patients' complaints and acting appropriately on those patient complaints, and courteousness. VA medical centers may be able to use existing personnel who will receive or have received appropriate training (such as social workers or human resources managers) to train the VA workforce. VA can look to the private sector to model customer service training.

Employee Empowerment

Management must also empower VA employees to be effective patient care advocates. VA employees need clear direction about their expected performance. Further, management must encourage them to exceed the parameters of their jobs when appropriate. For example, Central Office has sometimes discouraged employees from helping veterans complete necessary paperwork, on the grounds that this distracted them from fulfilling their own job responsibilities. While providing this help may not be within a VA employee's job description, it is sometimes necessary. Such practices should be rewarded, not discouraged. Hospital directors should define more flexible job descriptions and allow employees to be more responsive to patients when necessary.

Again, some private-sector initiatives offer ideas for successfully directing employee initiative. An American, Edwards Deming, found much more acceptance for his ideas of "quality circles" in Japan in the 1950s. The premise of "quality circles" is that employees know processes best and can suggest procedural improvements. VA, in turn, has implemented its "Blueprint for Quality" at various levels. Individual facilities might also use these techniques to find answers to their own dilemmas and to cultivate employees' commitment by empowering them to solve problems. Employees who participate in developing new protocols and procedures are more likely to accept and commit to performing them well.

Employee Recognition

Central Office and Congress must also enable local directors to hire, fire, adjust pay scales and reward and punish job performance without the bureaucracy that impedes fulfilling these functions. When employees excel, VA managers should more routinely reward their performance; various VA hospitals already have some recognition programs, such as "employee of the month." Veterans' service organizations also offer awards such as plaques, scholarships, fellowships and training for some outstanding employees. VA medical centers should take advantage of revolving funds to offer bonuses for exemplary performance. VA should also be able to take appropriate disciplinary action in response to poor performance. VA employees should know that, even if customer service is not an expressed part of their job performance, management will answer rudeness or unresponsiveness to a patient's needs, even if that response involves only a reprimand from a supervisor.

The organizational culture must be recognizable to employees through consistent management. Nonmonetary rewards may be just as meaningful as monetary rewards to employees in different situations. Directors might make a habit of calling employees whom patients commend, who find innovative ways to save the facility money, or who show initiative in solving problems. They might send exceptional employees for additional training or to meetings they express interest in attending. Exceptional employees may also want to augment their responsibilities. Hospital directors and managers with initiative will explore what their outstanding employees value and how to reward them in ways that are meaningful and consistent with the organization's values.

Patient Representatives

Patient representatives can make systems less impersonal and confusing. Patients with complaints often just want someone to acknowledge their situation or answer their questions. Successful patient representation programs offer not only a sympathetic ear, but a real explanation or solution to a patient's problem. Strong programs must have the overt support of the leadership. They must also have the respect of the medical staff, who must answer many of the patients' questions.

The primary hospital accrediting organization reports that all VA medical centers meet or exceed its standards.

The Augusta VA Medical Center in Georgia implemented its patient representative program in October 1990. The hospital director strongly supports the program, to ensure that staff members readily recognize the organization's commitment to the program and cooperate with patient representatives. Signs throughout the hospital promote the program. Patient representatives try to see every new hospital patient to explain patient rights and address concerns. This proactive approach to problem-solving is also present in the outpatient clinics. Patient representatives "float" through clinics to identify potential problems before they erupt. The patient representatives also have extended hours to help families with concerns. Patient representatives work holidays and Sundays, which are big visiting days, so they can better assist families. Most complaints are resolved, and patients return to the facility for future care needs.

Volunteers

Most VA medical centers have a dedicated volunteer corps and all have a chief of volunteer services. In fiscal year 1994, volunteers donated 14.1 million hours of service to the system! Unfortunately, hospital officials candidly admit that some work plans for volunteers are insufficient; volunteers are not given the types of activities that could challenge them and often lack appropriate staff supervision to make significant contributions. To ensure that their services are used effectively, an integrated, inter-disciplinary health care team needs to include volunteers. All medical center programs should identify areas in which they could use volunteers. Creative uses for a strong, active volunteer workforce are innumerable.

QUALITY MANAGEMENT

Patients judge the quality of medicine by two equally important standards: how good their medical care is and how well they are treated. Providers who want to ensure themselves of a devoted patient base must attend to both perceptions; that is, they must assure patients they are performing medical care services competently, and they must ensure that patients perceive the quality in the care they receive and are satisfied with service issues.

Media reports that portray the system as an inferior care provider have tarnished the VA medical system's reputation in recent years. This is unfair and undeserved. Unfortunately, VA has not responded well on its own behalf to correct this image. A common misunderstanding exists in the veterans' community and elsewhere that VA does not provide high-quality health care.

Yet VA does much to ensure high-quality medical services for its patients. The quality of care it provides is often equal or better than that provided in the private sector. The Joint Commission on Accreditation of Health Care Organizations (JCAHO), the primary hospital accrediting organization, reports that all VA medical centers meet or exceed its standards. The 48 VA medical centers reviewed last year received the maximum three-year accreditation, earning a mean score of 86. This is several points higher than the average score non-VA hospitals earned in the same survey. VA-administered home-care programs garnered similar reviews. Of the 74 home-care programs JCAHO surveyed last year, 52 scored a perfect 100, and the average score was an impressive 96.8.

In its continued pursuit to improve quality, VA should also seek certification from the Commission on Accreditation of Rehabilitation Facilities (CARF). CARF certifications will offer VA rehabilitation services the same recognition and credibility private-sector rehabilitation providers currently derive from it, in an increasingly competitive market for rehabilitative services. Its facility categorization system and resource standards are recognized and applied nationwide. CARF standards define treatment processes and

64 outcomes in services for people with disabilities. CARF standards for medical rehabilitation services are developed through the consensus of experienced, highly qualified clinical and research experts. The current standards have been refined over 20 years, with the involvement of service providers, consumers and service purchasers, such as insurers.

A veteran facing a choice of providers should have a creditable peer review organization's assurance that VA programs meet or exceed the same standards that other rehabilitation providers satisfy. Third-party payers frequently seek CARF accreditation when choosing contract rehabilitation service providers, to assure high-quality services and optimal functional medical outcomes following long and costly rehabilitation. As VA seeks more local interaction, rehabilitation programs must invite CARF accreditation surveys and participate in the Commission's advisory committees, to have a voice in the ongoing review and development of national standards for medical rehabilitation services.

In VA's "Blueprint for Quality," a strategic plan the Office of Quality Management created, programs in risk management, utilization management and quality assessment are key activities for documenting and improving the quality of VA care. Like many other providers, VA wants to assure high-quality medical outcomes, pushing the current "technological envelope" of standards. Outcome measures depend on information systems that the American health care system has not widely implemented. Many state health care reform proposals rely on this information being available for consumers to use in making educated health care purchases. Like others, VA needs such systems in place to make this information available to its consumers.

Two quality assessment programs, the Quality Improvement Checklist (QUIC) and the External Peer Review Program (EPRP), have garnered praise from quality management professionals for demonstrating quality of care. QUIC is a computerized database that uses clinical indicators to measure hospital performance. It allows VA facilities to compare the quality of care they provide with that of other hospitals in the system. EPRP screens five percent of discharges at each VA medical center. Computers pull random cases and an abstractor screens them on site, using nearly 1,000 questions to measure process and outcomes. Anything that fails a critical question is passed on to peer review.

An annual report of the EPRP showed that in 1993, VA met or exceeded JCAHO standards of care in 95.5 percent of cases reviewed. During the first quarter of 1994, that number rose to 98.18 percent, and 14 VA medical centers with enough externally reviewed cases for statistical validity actually met JCAHO standards in 100 percent of cases reviewed. State policy makers and private-sector experts view both of these innovative and highly successful programs as models for ensuring quality of care in this era of state and market-driven health care reform.

Both as a system and as individual facilities, VA should ensure that veterans are "satisfied" with the health care they receive. The Office of Quality Management is currently revamping its customer service surveys of outpatient and nursing home care. The new Patient Satisfaction Survey will reportedly better reflect patient concerns, feeding back information to health care decision-makers, to allow them to resolve perceived problems in a more timely manner. Most marketing professionals adhere to the adage that consumers discuss their negative experiences ten times more than their positive ones. Assuming this is true, hospital directors who want to keep their customers will work hard to adhere to a reasonable quality benchmark and even harder to correct patients' perceptions of their care, as positive word-of-mouth is essential to the system's future success.

Medical Care

The Medical Care appropriation provides for health care delivery in VA medical centers and other VA health care facilities. This care includes inpatient hospital care, outpatient care at hospitals and free-standing clinics, institutional long-term care in nursing homes and domiciliaries and several types of non-institutional long-term care. The Medical Care appropriation also provides for veterans' care in non-VA hospitals, nursing homes, domiciliaries, and physicians' offices, in circumstances under which VA is authorized to pay for such care. In addition, the Medical Care appropriation covers the costs of large-scale education and training programs in VA health care facilities.

TABLE 7

Independent Budget *Medical Care Recommended Appropriation and Budget Authority*

FY 1995 Current Services Level		**$16,232,756,000**
FY 1996		
Payroll Related Increases		
Retirement Programs		83,343,000
Annualization of 1995 Pay Raise		51,492,000
Annualization of 1995 Federal Employee Health Benefit Program		6,216,000
Pay Raise 1996		164,995,000
Within Grade Pay 1996		76,367,000
Federal Employee Health Benefit Program 1996		16,154,000
Workday Change		37,755,000
Other Personnel Costs		50,000,000
Inflation		547,959,000
Facility Activations (Including Capital Investments)		200,000,000
Property Rental		6,039,000
Adjustments for Rate Changes		
State Nursing Homes		80,660,000
State Home Hospitals		2,561,000
State Home Domiciliaries		10,405,000
Community Nursing Homes		27,247,000
Contract Hospitals		14,449,000
FY 1996 Current Services Level		**$17,608,398,000**
Additional Initiatives 1996		
Outpatient Workload Increase		335,530,000
Extended Care Programs Increase		274,668,000
Bio-Psycho-Social Programs		16,500,000
Homeless Initiatives		20,000,000
Blinded Veterans Programs		500,000
Spinal Cord Medicine Programs		500,000
Prosthetics Programs		7,700,000
Education and Training		32,750,000
Decentralized Hospital Computer Program		100,000,000
Equipment Backlog		173,782,000
Non-Recurring Repair and Maintenance Backlog		160,719,000
Facility Activations for Leased Clinics		35,000,000
Facility Activations for Leased Nursing Homes		5,250,000
FY 1996 Recommended Appropriation		**$18,771,297,000**
Authorization for Medicare Reimbursement for Higher Income Veterans		$133,677,000
Retention of Full Collection of Third Party Reimbursements		$800,000,000
Authorization to Retain Payments from Dependents and New Veteran Users		$2,006,828,000
Reform of Access Criteria		
Shift Inpatient to More Appropriate Outpatient or Nursing Home Care	(2,856,492,265)	
Additional Workload Shifted from Inpatient Venues to Nursing Homes	68,541,525	
Facility Activations for One Additional 120-Bed Leased Nursing Home	2,625,000	
Additional Workload Shifted from Inpatient Venues to Outpatient Care	637,504,968	
Subtotal for Initiative		($2,147,720,772)*
Total Budget Authority Recommended		**$19,564,081,000**
Discretionary Funding Required from Congress Under New Budget Authorities		**$16,623,576,228**

*The exact impact of shifting workload could vary due to a number of factors.

66 The Meaning of the *Independent Budget*

This fiscal year 1996 *Independent Budget* assesses Veterans Health Administration (VHA) funding requirements based on veterans' needs. Past *Independent Budgets* have effectively countered administration budgets that lacked sufficient funding to maintain the reputation for quality and service that VA built in the decades after World War II. This *Independent Budget* offers a vision of what the veterans' health care system should be and concrete recommendations to prepare it for its role in the rapidly changing national health care system.

Funding for Veterans' Health Programs—FY 1980 to FY 1995

Funding Trends

During the past 16 years, VA spending in constant dollars has declined while national health care expenditures have increased exponentially. In fiscal year 1980, VA funding amounted to 4 percent of the federal budget; by fiscal year 1990, it was only 2 percent. In fiscal year 1985, VA received 7.7 percent of the federal health care dollar; in fiscal year 1995, VA will receive about 4.5 percent. Because health care inflation has outstripped general inflation, and because, under past administrations, the Office of Management and Budget (OMB) has consistently understated inflation, level funding for VA has in fact steadily eroded VA's buying power. Chart 1 on page x presents a clear picture of an institution that is losing the struggle to meet increasing demands with static resources.

Conclusions from the Data

VA's funding crisis results from perennially inadequate adjustments to an inadequate base—a process that, over the last decade, has amounted to "reverse compound interest." Each year, the accumulated shortfall has been built into the budget development process to justify a systematic withdrawal of support from the veterans' system. Until fiscal year 1988, VA responded to budget shortfalls by delaying equipment replacement, maintenance, information resource modernization and other activities not directly related to patient care. By fiscal year 1988, VA could not accommodate the accumulated shortfall as a result of this "cannibalization," and VA had to reduce its workload. VA has been forced to ration veterans' care—first, by delaying elective procedures and clinic appointments and, more recently, by referring patients to state or other federal providers.

The most destructive effect of budget constraints, however, has been VA's inability to adapt to the changing health care needs of aging veterans and to keep pace with the evolution of modern medical practice. VA has not had the resources to increase sufficiently its capacity for the outpatient care, community-based long-term care and nursing home care that veterans—particularly World War II veterans—require.

Independent Budget Methodology

Principles

The concept of the *Independent Budget* was developed in the late 1980s when its authors recognized the need to aggressively confront the progressive deterioration of VA funding. The *Independent Budget* objectively assesses VA's resource requirements. It counters the President's budget, which fiscal and political considerations, such as the overall federal budget and the deficit, temper. While the *Independent Budget* coauthors understand these issues' significance and the need to find solutions to the ever-increasing growth in national spending and debt, Congress and the Administration should not view compromising veterans' rights as a means to achieving their political objectives. Veterans' entitlements have not contributed to the deficit, and spending for veterans' health care has not kept pace with medical care inflation or the federal health budget's inflation rate. The *Independent Budget's* recommended Medical Care appropriation is shown in Table 7.

"Current Services"

VA funding levels became severely deficient in the 1980s. During that time, the *Independent Budget* coauthors tracked spending using a "current services level" approach. Past documents defined "current services" as the amount needed to support a fiscal year 1988 workload, adjusted to compensate for VA's progress toward *Independent Budget* goals since that time. The *Independent Budget* used fiscal year 1988 as

TABLE 8

Selected Comparisons of VA Medical Care Activity Volume
Inpatients Treated and Outpatient Visits
FYs 1988-1994

Activity	FY 88	FY 90	% Change FYs 88-90	FY 92	% Change FYs 90-92	FY 94	% Change FYs 92-94	% Change FYs 88-94
Total Hospital	**1,116,681**	**1,016,430**	**(9.0%)**	**956,315**	**(6.0%)**	**929,358**	**(2.8%)**	**(16.8%)**
Non-VA Hospital	27,377	20,968	(23.4%)	19,193	(8.5%)	20,377	6.2%	(25.6%)
State Home Hospital	2,848	2,404	(15.6%)	2,030	(15.6%)	2,056	1.3%	(27.8%)
VAMC Patients Treated	1,086,456	993,058	(8.6%)	935,092	(5.8%)	906,925	(3.6%)	(16.5%)
VAMC Psychiatric	214,512	191,469	(10.7%)	185,786	(3.0%)	190,529	2.6%	(11.2%)
VAMC Surgical	290,569	262,442	(9.7%)	249,590	(4.9%)	232,749	(6.7%)	(19.9%)
VAMC Medical	581,375	539,147	(7.3%)	499,716	(7.3%)	483,647	(3.2%)	(16.8%)
Total Nursing Home	**83,676**	**71,026**	**(15.1%)**	**71,422**	**0.6%**	**77,896**	**9.1%**	**(6.9%)**
VAMC Nursing Home	27,220	27,067	(0.6%)	30,404	12.3%	30,928	1.7%	13.6%
Community Nursing Home	42,232	28,851	(31.7%)	25,062	(13.1%)	29,096	16.1%	(31.1%)
State Home Nursing Home	14,224	15,108	6.2%	15,956	5.6%	17,873	12.0%	25.7%
Total Domiciliary Care	**24,018**	**25,670**	**6.9%**	**25,501**	**(0.7%)**	**24,897**	**(2.4%)**	**3.7%**
VAMC Domiciliary	16,607	18,895	13.8%	19,384	2.6%	18,244	(5.9%)	9.8%
State Home Domiciliary	7,411	6,775	(8.6%)	6,117	(9.7%)	6,453	5.5%	(13.0%)
Total Inpatients Treated	**1,224,375**	**1,113,126**	**(9.1%)**	**1,053,238**	**(5.4%)**	**1,031,950**	**(2.0%)**	**(15.7%)**
VA Staff Outpatient Visits	21,473,403	21,396,334	(0.4%)	22,788,431	6.5%	24,134,839	5.9%	12.4%
Fee-Basis Outpatient Visit	1,759,492	1,203,198	(31.6%)	1,102,090	(8.4%)	1,023,144	(7.2%)	(41.9%)
Total Outpatient Visits	**23,232,895**	**22,599,532**	**(2.7%)**	**23,890,521**	**5.8%**	**25,157,983**	**5.3%**	**8.3%**

Source: Summary of Medical Programs

a baseline year. After fiscal year 1988, workload dropped precipitously, predominantly in community settings, as VA began to experience severe medical care funding shortfalls, as shown in Table 8.

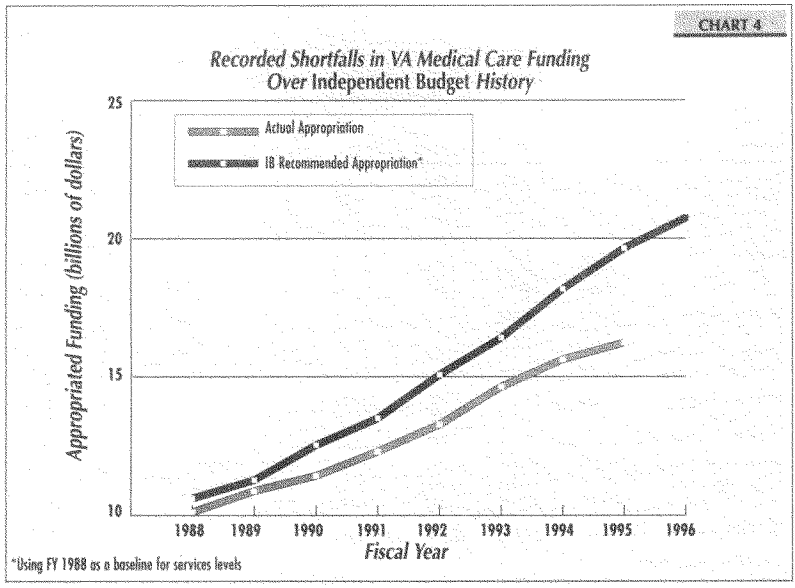
Each year since fiscal year 1988, the *Independent Budget* has adjusted the current services level to cover increased payroll costs; to accommodate a reasonable inflation rate; to fund facility activations; to fund the past fiscal year's legislative and administrative initiatives; and to allow for per diem rate changes in contract and state home programs. The *Independent Budget* added funds to accommodate the workload increments VA has achieved toward *Independent Budget* targets in past fiscal years. Incorporating these inflationary costs to maintain the fiscal year 1988 service level and accommodating the VA's progress toward meeting *Independent Budget* objectives resulted in a new current services level for each fiscal year.

This year the *Independent Budget* departs from this methodology and displays the funding that would result from using a fiscal year 1988 base for comparison only (as shown in Chart 4). Because of expected fiscal constraints for upcoming years, the fiscal year 1996 *Independent Budget* will use Congress's appropriation for fiscal year 1995 as the base on which to build VA's future. However, the IBVSOs also believe it is critical to continue to document the erosion that VA budgets have suffered since the years of more adequate budgets. To our new base, we will add the usual uncontrollable and inflationary costs and some of the *Independent Budget*'s own initiatives under current legislation, which we feel are critical to VA's patients.

The fiscal year 1996 *Independent Budget* also, for the first time, projects a budget authority. A budget authority accommodates legislative initiatives as well as programs operating under current authorization. Projecting a budget authority allows us to specify the funding we hold necessary to implement our most important legislative initiatives, including eligibility reform and collection and retention of third-party reim-

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CHART 4



bursements. A detailed methodology for our Medical Care budget authority is outlined in Appendix A.

PAYROLL COSTS

Medical care is labor intensive. Payroll costs for fiscal year 1994 made up more than 60 percent of VA's Medical Care budget. Lately, like other health care providers, VA has had to face shortages in the medical care labor market. Because it must vie for the same scarce personnel as private-sector medical care providers, VA must offer increasingly competitive pay and benefits.

Although the VA pay raise rate is capped at the level Congress enacted for federal employees, Congress has recognized the Department's need to make concessions to the labor markets in which its facilities operate. Congress's recent initiatives to enhance VA recruitment and retention have included locality pay (increased pay for high-cost areas), new wage structures and special pay. These initiatives have become part of VA's payroll costs and increased the *actual* inflation rate VA realizes, beyond the congressionally enacted federal pay raise rate, for its labor.

Labor costs in the overinflated medical care sector are drastically different from those in other markets, and VA needs more funding to accommodate inflation in the medical care labor market. Special pay initiatives can help bridge the gap between VA and the private sector if VA adequately surveys market needs and can implement initiatives at appropriate funding levels. Underfunded and poorly implemented "special pay" initiatives undermine VA's ability to recruit and retain valuable medical care personnel.

INFLATION

VA applies the OMB-determined inflation rates to non-personnel items—excluding rate changes for contract care arrangements—to determine its inflation costs. OMB determines both a medical inflation factor and a non-medical factor. Examples of items subject to the medical inflation rate include pharmaceuticals, x-ray equipment, contract services, land and structures,

TABLE 9

Actual and Projected Inflation Rates

	Economic Assumptions Used to Formulate VA Budgets		Actual Economic Rates		Differences in Estimated Inflation Rates Used in VA Budget and Actual Inflation		
	Medical CPI	Non-Pay Deflator	Medical CPI	Non-Pay Deflator		Medical CPI	Non-Pay Deflator
FY 1996 OMB	5.3%	2.0%	-	-		-	-
FY 1995 OMB	4.9%	2.0%	-	-		-	-
FY 1994 OMB	5.4%	2.5%	4.9%	1.4%	FY 1994	0.5%	1.1%
FY 1993 OMB	5.8%	3.7%	5.7%	2.7%	FY 1993	0.1%	1.0%
FY 1992 President's Budget	6.4%	4.1%	7.0%	2.7%	FY 1992	(0.6%)	1.4%
FY 1991 President's Budget	5.7%	4.2%	7.8%	4.0%	FY 1991	(2.1%)	0.2%
FY 1990 President's Budget	5.9%	3.6%	8.8%	3.6%	FY 1990	(2.9%)	0.0%
FY 1989 President's Budget	6.1%	3.9%	7.2%	4.4%	FY 1989	(1.1%)	(0.5%)
FY 1988 President's Budget	5.3%	3.7%	6.3%	2.0%	FY 1988	(1.0%)	1.7%
					Average	(1.1%)	0.7%

Source: Budget of the U.S. Government and the Department of Veterans Affairs

and thermometers. Examples of non-medical items include paper, printing and transportation costs.

Table 9 shows the difference between the actual medical inflation rate and OMB-projected rates. Although for the last two years OMB has actually overestimated the cost of medical inflation, the difference between these two rates still averaged 1 percent between fiscal year 1988 and fiscal year 1994. Other non-medical inflation rates are often too low. OMB applies the non-defense inflation factor to all non-medical items, from laundry to gasoline. For the mix of items VA must purchase, a "market basket" rate, which accommodates various similarly classified items, may weight items with little inflation too heavily, and thus be inadequate. Applying an inadequate, OMB-imposed inflation rate to past years' purchases consistently produces an underestimation of actual inflation costs for medical items. Currently, VA must accommodate, from monies appropriated for other purposes, the shortfall for items that have higher-than-projected costs.

The *Independent Budget* also projects its own inflation rate using historical differentials between OMB-projected rates for medical items and actual rates VA has experienced. The IBVSOs apply this inflation factor to VA's costs to determine a dollar amount for inflation for each fiscal year. Despite the fact that VA appropriations have grown annually, VA's purchasing power has stagnated, while growing demand and mandated expansion have increased the Department's resource needs. The shortfall results in redirected funding ("cannibalization") and delay and denial of care.

FACILITY ACTIVATIONS

VA requires certain funds to staff and equip facilities that come on-line construction and renovation projects are completed. VA funds new or additional equipment and employees through the facility activations account.

Anticipating construction delays, OMB applies a "slippage" factor, to avoid providing funds to activate facilities that are not ready by their scheduled completion dates. The slippage factor applied in past years has been too high. OMB should re-estimate this rate on the basis of recent VA experience. Lack of activation funds leaves newly constructed or renovated facilities unstaffed and unequipped when they are ready to open their doors. Veterans receive nothing to justify the money spent on construction, and VA must use medical care funds to support inactive facilities that cannot provide medical care.

Activation of facilities scheduled for completion in fiscal year 1996 will require approximately $200 million. This includes the cost of capital investments in equipment for these activations.

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TABLE 10

VA Medical Care Workload Distributions

	Actual FY 1988 (Baseline)	Actual FY 1993	Actual FY 1994	Estimated FY 1995	IB Target FY 1996
VA-Sponsored Programs					
Community NH ADC	12,405	8,418	8,981	8,456	10,487
Community Hospital ADC	571	338	339	325	325
State Home NH ADC	8,666	10,601	11,369	11,876	12,846
Fee Outpatient Visits	1,759,492	1,091,699	1,023,144	1,092,000	1,880,000
VA-Operated Programs					
Hospital Inpatients	1,086,456	920,311	906,925	940,000	940,000* / 721,647**
Nursing Home ADC	11,344	13,476	13,502	14,459	14,743* / 15,171**
Domiciliary ADC	6,061	6,197	6,051	6,325	7,600
Outpatient Visits	21,473,403	23,144,396	24,134,839	23,791,000	24,000,000* /27,500,000**
Other VA Programs					
Hospital-Based Home Care	68	75	75	75	171
Adult Day Health Care—VA	15	16	15	15	40
Adult Day Health Care—Contract	35	28	83	83	83
GEMs	80	113	133	141	171
GRECCs	12	16	16	16	25
Respite Programs	1	136	136	136	171
Hospice Programs	2	171	171	171	171
Community Residential Care	125	135	135	135	171

*Under current law
**Recognizes shift eligibility reform allows

Source: Summary of Medical Programs and the Independent Budget

Initiatives

Below the "current services" line, the *Independent Budget* proposes funds for critical VA initiatives, to enhance its ability to respond to veterans appropriately and cost-effectively.

The *Independent Budget* coauthors also recommend incrementally funding its workload targets. These workload targets are displayed in Table 10. This year, the *Independent Budget* has two different types of targets. Under current budget authority, the *Independent Budget* recommends workload growth and programs that do not require new legislation. We also suggest some initiatives that new legislation must authorize. The full budget authority we recommend assumes Congress will grant VA the authority to treat its patients efficiently under reform of access (eligibility reform) legislation. While the *Independent Budget* funding recommendations assume that VA will accomplish the workloads it projects for the next fiscal year this has not always been the case as Table 11 shows. VA may actually need additional funding that our budget does not account for to achieve their workload targets if VA does not reach its projected workloads.

VA Programs

Hospital Inpatient Care

The inpatient care that VA medical centers provide is a vital component of the veterans' medical care system. VA hospitals are the cornerstone of the entire medical system, serving as the center of research, graduate medical education and care delivery activities. Without these important institutions, VA could not support effectively its vital outpatient, community and long-term care programs.

In fiscal year 1994, the 171 VA medical centers provided hospital inpatient care to 906,925 individuals, with an average daily census (ADC) of 39,953. This was a decrease of 13,386 from the previous fiscal year's figure and a decline of 19.8 percent since fiscal year 1988 (see Chart 5). Increased reliance on other modes of care, such as outpatient clinics and community-based care, partially explains the decline.

TABLE 11

Actual and Budgeted VA Workloads

(In Inpatients Treated and Outpatient Visits)

Activity	FY 94 (Budgeted)	FY 94 (Actual)	Percentage Difference (Budgeted Versus Actual)
Non-VA Hospital	18,866	20,377	8.0%
State Home Hospital	1,990	2,056	3.3%
VAMC Patients Treated	964,665	906,925	(6.0%)
Total Hospital	**985,521**	**929,358**	**(5.7%)**
VAMC Nursing Home	33,909	30,926	(8.8%)
Community Nursing Home	29,455	29,096	(1.2%)
State Home Nursing Home	19,701	17,873	(9.3%)
Total Nursing Home	**83,065**	**77,895**	**(6.2%)**
VAMC Domiciliary	20,265	18,244	(10.0%)
State Home Domiciliary	6,506	6,453	(0.8%)
Total Domiciliary Care	**26,771**	**24,697**	**(7.7%)**
Total Inpatients Treated	**1,095,357**	**1,031,950**	**(5.8%)**
VA Staff Outpatient Visits	23,748,000	24,134,839	1.6%
Fee-Basis Outpatient Visits	1,113,000	1,023,144	(8.1%)
Total Outpatient Visits	**24,861,000**	**25,157,983**	**1.2%**

Source: VA FY 1994 Budget Submission; VA Summary of Medical Programs for FY 1994

One recent study indicated that VA can reduce its hospital inpatient workload by up to 44 percent![3] Congress must allow VA to treat its patients in the most appropriate settings, and VA should divert its inpatients into more appropriate outpatient or long-term care settings. The *Independent Budget* specifies a strategy below for effecting this. 71

Recommendation

With appropriate budget authority, divert 300,000 inpatients treated (150,000 each in fiscal years 1996 and 1997) to outpatient and long-term care venues.

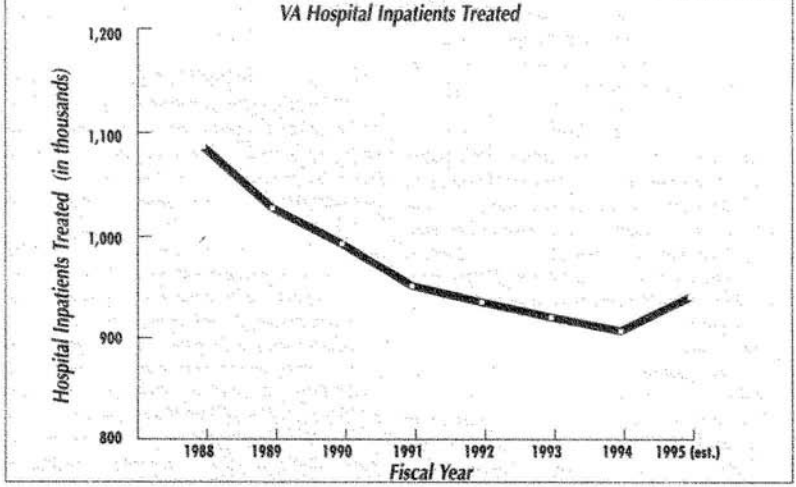
Cost

Under appropriate budget authority, VA would save $2 billion.

Intermediate Care

The intermediate care beds in VA hospitals serve a unique and important function. Veterans requiring a level of care between acute care and long-term or extended care are treated in these intermediate bed sec-

CHART 5



[3]Brenda Booth, Ph. D., et al. *"Nonacute Inpatient Admissions to Department of Veterans Affairs Medical Centers,"* Medical Care Vol 29, No. 8, August 1991 Supplement.

72 tions. Often, these patients have nowhere else to turn, because of the intensity or complexity of their condition, their lack of support networks or their lack of financial means.

Unfortunately, these beds are not always used appropriately. Often, a veteran receiving treatment in an intermediate care setting would be better (and less expensively) served in a nursing home. In other cases, a domiciliary or community residential program would provide the most effective care. VA often utilizes intermediate care beds, however, when other types of beds or programs are unavailable. Veterans with specialized needs for such disorders as Alzheimer's disease, mental illness and AIDS are frequently treated in intermediate care settings because VA lacks capacity to treat them in a more appropriate setting or veterans lack eligibility to receive care on a less intensive level. VA should examine the types of patients treated in its intermediate care beds and restructure its resources to care for these patients in the most effective settings for their conditions.

Eligibility reform, which would allow veterans access to the full array of care, would remedy many veterans' misplacement. Without eligibility reform, however, restructuring resources to use more appropriate care settings will not be possible. The IBVSOs remain committed to the idea that eligibility reform is necessary for VHA to allocate its resources adequately and treat its patients suitably.

Domiciliary

The domiciliary care program is VA's oldest health care program. It was first initiated in the 1860s to provide homes for disabled volunteer soldiers of the Civil War. For many years, these homes were considered "old soldiers' homes," but today's domiciliaries go beyond this original mission. VA's modern domiciliary care programs adapted to the changing veteran population and the changing health care system. Some of these programs provide necessary medical care and physical, social and psychological support services in a sheltered environment and include initiatives to return capable veterans to community living. Domiciliary programs address the complex care demands of the homeless and those with needs associated with AIDS/HIV disease, substance abuse, traumatic brain injury, geriatric rehabilitation and chronic mental illness.

This program has proven to be cost-effective. VA places veterans who would otherwise be destitute or institutionalized in this appropriate environment. The average cost for care in a domiciliary is approximately $115 per patient-day. This compares favorably with the average daily cost of $215 for nursing home or hospital care, to say nothing of the social costs to those left without care.

VA domiciliary care programs supported an average daily census of 6,051 in fiscal year 1994. VA estimates that the domiciliary program will grow to an ADC of 6,325 in 39 programs in fiscal year 1995. VA must develop its domiciliary care capacity to meet the *Independent Budget*'s recommendation of a 7,600 person ADC in VA-operated programs and 4,000-person ADC in the state home program in fiscal year 1996.

Recommendation

Expand VA domiciliary care capacity and accommodate an average daily census of 7,600 in VA's own programs and 4,000 in state home domiciliary care programs in fiscal year 1996.

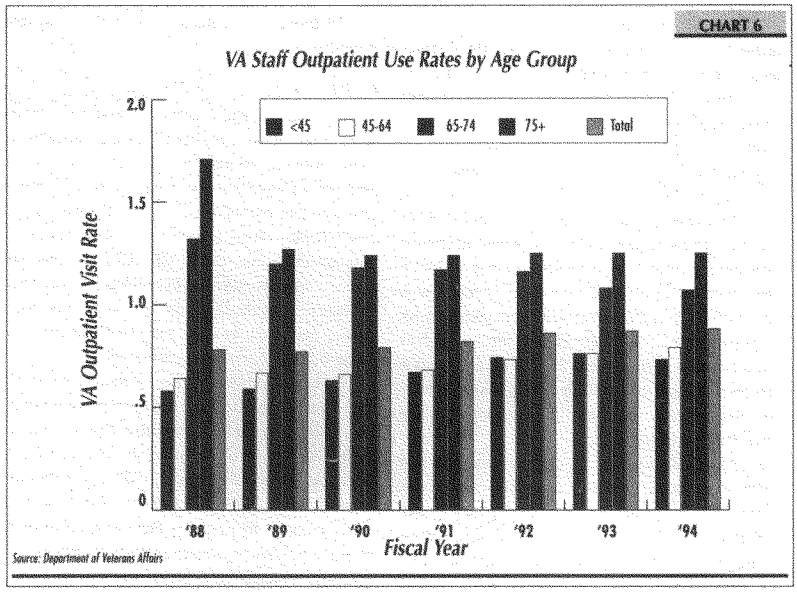
Cost

$52 million (included in recommended appropriation for extended care).

Outpatient Care

VA outpatient service delivery has gained increasing importance as a cost-effective, appropriate alternative to inpatient care. Patient and doctor often prefer outpatient care, because it eliminates or shortens uncomfortable, costly and sometimes inappropriate hospital stays.

Unfortunately, VA has been unable to capitalize fully on the virtues of outpatient care because of antiquated eligibility criteria that control patients' access to certain modes of care. Law often prohibits VA physicians from providing necessary care in the most proper setting; instead, they must admit patients to more intensive care delivery sites in order to provide any care at all. These eligibility criteria bar some veterans—whose only option for medical care is VA—from receiving care in outpatient settings. Changing the current law governing eligibility (or access)—a top



priority for the IBVSOs for fiscal year 1996—should abolish such costly and inefficient episodes of care.

Despite these difficulties, VA has demonstrated a commitment to providing innovative, high-quality outpatient care. Programs such as the mobile clinic pilot program make medical care available to veterans who could not otherwise receive care through VA or any other source. This program targets its outreach efforts at populations with high concentrations of service-connected and poor veterans and in areas that lack health service providers. Mobile clinics were implemented at six sites in September 1992 and began treating patients that October. Preliminary data from these sites indicate that the patients treated at mobile clinics are those who otherwise would never have visited a VA medical center or clinic.[4] VA must continue, strengthen and expand these types of innovative programs to meet both VA's future challenges and the needs of an increasingly diverse veteran population.

To continue expanding outpatient access for veterans, the IBVSOs recommend that VA establish 50 "storefront" clinics in its current vet centers. These clinics could provide basic referral services and some primary care to veterans in their local communities and could operate with only one full-time nurse practitioner or physician assistant and one-half-FTEE clerical assistant. The success of the mobile clinic pilot program demonstrates the demand for these types of community-centered and -administered care modes for veterans. Establishing clinics in the vet centers would provide veterans with access to basic medical services and enable VA to take advantage of the important community resources the centers provide. Vet centers already boast VA's lowest average cost per visit and cost per veteran for treatment of post-traumatic stress disorder.[5] VA could apply this efficient model to primary care provision and medical referrals.

[4]Department of Veterans Affairs, VA Central Office. *Senior Management Directory: Issues and Updates*. Washington, DC: 1993.
[5]Ibid

74 In planning outpatient care delivery, VA must also pay special attention to its women veterans. The goals of the VA Advisory Committee on Women Veterans include increased vigilance in behalf of women veterans' needs. In the event that VA cannot provide appropriate services to these veterans, access to private-sector providers must be ensured. VA health care services for women veterans are addressed more fully on page 95.

VA provided 24,134,839 staff visits and 1,023,144 fee visits in fiscal year 1994. Outpatient utilization rates are projected to increase in the future. Chart 6 shows that use of outpatient treatment increases with age. In fiscal year 1988, outpatient treatment rates for users older than 75 were almost three times as high as those for users younger than 65. While the age discrepancy in fiscal year 1993 decreased, older veterans still demonstrate significantly higher outpatient use rates than younger groups.

Under eligibility reform, Congress must grant new access to outpatient services to many veterans VA now serves. This will result in a shift from inpatient to outpatient workload. In the first year, VA may see 3.5 million additional outpatients as a result of this shift. The *Independent Budget* recommends that outpatient treatment at these levels be increased to 27,500,000 staff outpatient visits and 1,880,000 fee visits in fiscal year 1996.

PREVENTION

Preventive services, such as inoculations, cancer screenings and regular physical exams, have proven effective in the early detection of disease. Early detection often diminishes the cost of treating more advanced and serious cases of disease and lessens the patient's pain and suffering. VA has not provided consistent and regular preventive care to its patients, however. VA will recognize savings and improve patients' quality of life by offering routine diagnostic work for early disease detection and more effective, less intensive treatments.

Preventive health care needs to be an integral part of all health care delivery within the VA medical system. Expanding VA's current preventive health measures will result in long-term financial and health benefits and will contribute to the department's ability to offer services comparable to those offered by other providers.

OUTREACH AND EDUCATION

The outreach and education activities are another form of preventive care that VA must continue to promote. Bringing veterans into the system early in their lives allows VA to introduce young veterans to preventive care and other practices that will promote good health habits. These activities also allow VA to educate veterans about the ill effects of smoking, substance abuse, poor diet and hypertension. Also, health insurance is increasingly difficult and expensive to obtain, and many veterans may find that their only entry to health care services is through VA.

Congress can ensure that veterans are aware of their benefits by activating and appropriately funding the Veterans Benefits Administration's Transitional Assistance Program (TAP) and the Disabled Transitional Assistance Program (DTAP). The resulting increase in the use of VA services will benefit VA medical centers by providing them with a diverse mix of patients. VA physicians often treat patients with primarily chronic care needs that do not readily respond to therapeutic intervention. Acute phases of injury or illness, more common in a young population, are often more conducive to therapy and, therefore, more satisfying and interesting to physicians. Supporting a patient base of younger patients needing acute care is important to maintaining strong academic affiliations, as well.

The Patient Health Education (PHE) program in the ambulatory care program is an example of VA's important patient education and outreach activities. This program is designed to help chronically ill patients follow treatment regimens, to promote patient wellness and to ensure appropriate health service utilization. Each VA medical center currently has a patient health education coordinator or a patient education contact representative who, on a part-time basis, coordinates, plans, implements and evaluates local prevention efforts. Each region also has a coordinator who is supervised at the national level. PHE programs teach veterans self-care skills, share health status

information with patients, and promote wellness through diet, exercise, and smoking cessation programs. These activities allow VA to provide integrated, high-quality care to America's veterans.

CASE MANAGEMENT

In an attempt to control health care costs and to improve quality, many health care providers have adopted managed care techniques, including the use of case managers. These individuals monitor care and ensure that patients receive the most appropriate, timely and efficient health care possible. The case manager guides patients through the system, exposes the patient to preventive interventions, and fosters patient education.

VA can improve patient management and service accessibility in several ways. We discuss below some needed improvements with suggestions on how to make them (innovative VA medical centers have already implemented many of them).

Information and Triage

VA should inform patients about their medical care whenever possible. For instance, staff should ensure that patients know where to find answers to questions about their conditions or scheduling. If appointments are running late, personnel should tell patients why. They should explain patients' conditions and treatment regimens in a way patients and families can understand. Finally, patients need opportunities to ask questions.

Some VA medical centers, like Portland VA medical center in Oregon, have established successful triage programs. Originally begun as a telephone care program (from which patients could receive medical advice) and a primary evaluation clinic in 1989, the center now includes a phone-in pharmacist, a primary care nursing component and an eligibility hotline system. With this approach to triage, the Portland VA medical center has reduced its emergency care unit workload by 20 percent and its outpatient visits by 10 to 15 percent. Getting nonemergency conditions out of the emergency/screening room is critical to smoother operations; physicians in Portland determined that three-fourths of triaged veterans had nonurgent conditions.[6]

In the Portland VA medical center, nurses can counsel veterans whose concerns do not require immediate medical attention. Nurses are trained to make initial assessments over the phone and refer patients to appropriate specialty care or schedule diagnostic work. Primary care nurses provide patient education, case management and continuity of care between outpatient visits. This also reduces the need for outpatient care. These initiatives have increased patient satisfaction and efficiency and reduced waiting times. VA has issued a directive instructing all VA medical centers to emulate Portland's initiatives.

Waiting Times

Waiting times seem to be a special nightmare at many VA facilities. Problems are so severe that they seem intractable; directors are frustrated into inaction. It is important to realize that private-sector patients, for whom VA may soon compete, take for granted that they will be seen within a reasonable period. Correcting the problems in waiting times—unless the end results significantly *exceed* private-sector standards—will not win patients for the VA system. Reasonable waiting times are something patients in the private sector simply expect.

To correct its waiting times, VA must accommodate two types of visits: (1) scheduled appointments, and (2) unscheduled walk-in appointments to the emergency/screening room. Because they are the system entry point at most VA medical centers for all care venues, VA emergency rooms are overburdened. According to GAO, 75 percent of the conditions VA emergency room staff see do not require emergency or even urgent care. With better triage protocols (which allow a veteran to phone a nurse or pharmacist to determine the urgency of the problem and schedule an appointment at the appropriate clinic, for example), VA could generally schedule appointments for such cases, better control its workload and relieve the excessive burden on emergency room staff.

Often, VA emergency clinics are misnamed and misused. According to GAO, 57 percent of emergency clinics do not even try to schedule appointments. Many veterans using the emergency clinics could and should

[6]U.S. General Accounting Office. *VA Health Care: Restructuring Ambulatory Care System Would Improve Services to Veterans.* (GAO/HRD-94-41. Washington, DC: 1993

76 make appointments at a general medical clinic. Yet too often these clinics are not available or do not offer the veterans opportunities to schedule appointments directly. Instead of systematically routing patients through the emergency room, staff could directly refer and schedule patients for treatment in general medical clinics. At that visit, the general medical clinic staff can refer them to special clinics that can most appropriately respond to their initial diagnoses. This lack of scheduling promotes chaos. Natural fluctuations in patient flows make staffing insufficient at one time and excessive the next. While some VA emergency rooms do staff to accommodate these trends, others should consider carefully monitoring queuing patterns and staffing their facilities accordingly.

Dallas VA medical center has significantly reduced patient waiting times by improving patient flow. Dallas administrative officials have identified bottlenecks in its previously used six- or seven-step check-in service. The process of checking in with clerks, evaluators, nurses and—finally—a physician was frustrating and confusing to many patients. Dallas now also optimizes its use of automated patient records to avoid these extra check-in requirements. These innovations have reduced waiting times for unscheduled appointments from about two hours to an average of 27 minutes! Dallas used *no additional resources* to implement this "one-stop check-in" service for unscheduled appointments.

Specialty Clinic Schedules

According to the VA's inspector general, not enough clinics meet acceptable waiting times for scheduled appointments. Veterans using private-sector providers seem to believe that a 30-minute delay in a scheduled appointment time is generally an acceptable threshold.[7] Since VA policy prescribes a maximum of a 30-minute wait, this should be the goal for which all facilities strive. At many facilities, it is not uncommon for patients with appointments to arrive in the early morning with a packed lunch. Patients who must wait from 9:00 a.m. until 3:00 p.m. will leave the system if they have a choice.

Too many VA facilities still practice block scheduling (telling too many patients to come at the same time) and overbooking (not giving physicians enough time for appointments). These practices are inefficient and ineffective. By using them, VA surrenders control of its workload and frustrates its patients and staff unnecessarily. VA facilities must implement effective scheduling procedures to retain or capture VA health care users.

Like other medical systems, VA has significant queuing problems at its specialty clinics. According to GAO, at 721 clinics surveyed, veterans wait an average of 62 days for appointments at specialty clinics. Often, patients have three- to six-month waits for clinic appointments. For some appointments, check-ups or screenings, for example, some waiting time is acceptable if it will not exacerbate a problem. When conditions are likely to worsen, however, this wait is unacceptable. More complicated problems are more difficult to treat, may cause the patient unnecessary discomfort and require greater labor and facility resources. Pressure ulcers, which plague immobilized patients, are a prime example. If a pressure ulcer is treated in its initial stage, a 10-minute office visit with a dermatologist can solve the problem that, left untreated, may require months of inpatient care. The same principle applies to countless other problems frequently encountered in high-risk patient populations.

A better triage system could solve some of these problems. VA medical centers must better identify disorders in which preventive or primary care can be most effective, particularly in high-risk populations.

Effective triaging is probably the single best thing facilities can do to reduce their scheduled appointment waiting times. One facility implemented a case-management program that used a primary care physician to screen all patients. This practice allowed the specialty clinics to drop their clinic waiting times to 30 days. When care is administered in the appropriate clinic, it reduces pressure on specialty clinics. GAO suggests that medical personnel periodically review their clinic's patient records and redirect some patients to general medicine clinics.

[7]Paralyzed Veterans of America. Focus Groups. Washington, DC: Summer 1993.

Patient follow-up offers a better alternative to overbooking clinics and controls workload more appropriately. Staff should remind patients of appointments by phone call or postcard before their scheduled appointment. If rescheduling is necessary, VA personnel should also confirm the new appointment by phone call or postcard.

Again, Dallas VA medical center offers a successful model for improving waiting times within existing resources. Patients know that providers will see them within 30 minutes and are not allowed to check-in more than 30 minutes before their scheduled appointments. At Dallas, laboratory and x-ray work are scheduled as separate appointments up to two hours before the physician appointments, so that physicians may receive test results and make informed decisions in treating patients. The efficiency of this practice exceeds that of many private plans' protocols. Health summaries easily accessed through the decentralized hospital computer program have expedited the process.

Implementing a program like Dallas's is not easy. Medical centers that want the same results must shift resources and personnel to optimize their utilization. They must educate patients about changes, so they will know what to expect on their next visit. Still, Dallas has developed a system that seems to work. Clear patient protocols have improved access for all users and reduced consumer complaints at the ambulatory care center. Dallas VA medical center is promoting its quicker and less complicated scheduling process because *now* it has a better product to sell.

Additional Clinic Hours

Many VA medical centers also recognize the need for longer clinic hours on weekdays and some weekend hours to make the clinic more accessible. If a medical center explores this option, it must adjust its staffing patterns to allow staff to see veterans within a reasonable amount of time whenever they enter the clinic. This is an option, however, that VA should explore *after* using other measures to shorten waiting times during regular clinic hours. VA should not attempt to run additional clinic hours that will spread scarce staff even more thinly and exacerbate problems during normal clinic hours.

Practice Style

Practice style has to do with the manner in which care is delivered to patients; it often corresponds with the way care is financed. Most VA medical centers still rely too heavily upon episodic inpatient care, rather than the coordinated, ambulatory-based care the private sector is embracing. For VA, this lack of coordination fragments care delivery and alienates many patients from their care providers. Too many VA patients never see the same provider twice. Their care delivery lacks continuity, and even medical records fail to track vital information from one visit to the next. This often leaves veteran patients feeling abandoned in a system in which they have too little control.

To compound the problem, veterans believe they have little recourse when problems occur, because they think no one in the system cares. Too often, no one is familiar with their faces, their names or their case histories. Yet some VA medical centers prevented or ameliorated these problems. For example, the yet-to-be-opened West Palm Beach VA medical center in Florida plans to assign each patient to a primary care provider.

Veterans want to choose their care providers. Asked what they value most about their private-sector health plans, surveyed veterans' most common response was their ability to choose their own physicians.[8] Because of its academic affiliates' rotation schedules for medical residents, VA may not always be able to offer this option. There are ways, however, in which VA can enhance a patient's sense of control over his or her choice of provider.

First, VA medical centers should assign patients to one provider or team of providers. To provide continuity for the patient, the patient's "point person" or the team leader must be a VA full-time employee, rather than a rotating resident or intern. Some VA medical centers could allow patients to choose their physicians or teams rather than randomly assigning patients. If allowing this initial selection by patients does not work, centers should certainly allow patients to select other

[8]Paralyzed Veterans of America Focus Groups. Washington, DC: Summer 1993.

78 providers or teams if they wish to. Granting patients at least this control enhances their confidence in their providers and therapy and increases satisfaction.

A single contact point greatly enhances a patient's perception of the system's accessibility and his or her satisfaction with it. Case management also has other benefits, such as more appropriate care utilization, better triaging and improved health status. Implementing a case-management system for all veteran patients is probably the single most important thing the VA can do to compete against better funded private-sector medical facilities. The Pilot Ambulatory Care and Education (PACE) Program operating in Sepulveda VA medical center is proving an excellent model for other VA medical centers. PACE developed academic global care teams who are fully responsible for randomly assigned patients' care. Although these teams are ultimately accountable for ensuring their patients access to and treatment in appropriate settings, even more rigorous case management is available for VA's most needy patients.

In many ways, VA is well suited to further adopting the principles of managed care, without becoming another mainstream health maintenance organization. VA is most suited to the role of a "staff-model" HMO, to further develop its integrated care system. Physicians are salaried in VA. Because VA offers a full spectrum of health care services, patients often use the system as their sole source of health care.

VA also has obstacles to overcome. Some VA facilities are not appropriately staffed to emphasize the primary care services managed care providers offer. Managed care is also an integrated delivery system that pulls interdisciplinary teams together to treat patients. VA facilities often fail to appreciate the long-term benefits of coordinating care through a team approach, because of the tremendous start-up effort involved. VA recognizes the need to adapt a managed-care paradigm. Staff at some VA facilities are already working toward more integrated delivery, as discussed below.

Recommendation

Appropriation

- Increase outpatient workload to achieve the *Independent Budget* target of 27,500,000 staff and 1,880,000 fee-based visits.

- Fund 50 "storefront" clinics in vet centers and provide resources for 50 nurse practitioners or physicians' assistants and 50 one-half-FTEE clerical staff members and additional funding for beneficiary travel to VA medical centers.

Budget Authority

- Add 3.5 million staff outpatient visits to accommodate shifts from inpatient to outpatient venues of care in fiscal years 1996 and 1997.

Cost

Appropriation: $335.5 million
Budget Authority: $637.6 million

Long-Term Care

Long-term care services VA offers are increasingly important as demand for these services grows. Dramatic growth in the elderly veteran population has pressured a system designed to care not only for older veterans, but also for those with disabilities and other health conditions that require chronic care. In 1990, one-third of the U.S. adult male population were veterans, and one in four veterans was older than 65. VA estimates that, by the year 2000, more than 60 percent of the U.S. male population over 65 will be veterans. In 1980, 3 million veterans were older than 65 years; by 1990, that number had skyrocketed to 7.2 million, a 136.5 percent increase. Currently, 50 percent of the veteran population (13.5 million veterans) are older than age 56. This growth in the elderly population should continue, despite projections that the total veteran population will decline 26 percent during the years 1990 to 2010, from 27.2 million to 20 million veterans.[9]

This high concentration of older veterans forces VA to confront a crisis of increased demand for long-term care and geriatric services. Veterans with service-connected disabilities offer VA the additional

[9]Department of Veterans Affairs. National Center for Veteran Analysis and Statistics. "Our National Veterans' Changing Population." Washington, DC: 1993.

challenge of delivering specialized long-term care to those with disabilities. Private-sector providers will not face these predicaments in the general population for another decade. VA can thus serve the nation well by experimenting with cost-effective long-term care now, before most of the general population reaches an age at which they need long-term care. VA's mission to care for populations who are aging or have service-connected conditions makes it an ideal setting for testing ways to meet the nation's future long-term care needs.

VA has a unique opportunity to set the pace for efficient, effective long-term care delivery in the next decade. As an integrated system, VA endeavors to care for patients within its own programs. VA must build on its successes in developing and evaluating innovative, integrated care delivery, especially comprehensive and coordinated long-term care. Each VA medical center must participate in and help develop its local system of care. As the population ages and health care needs change, VA must develop alternative uses for underutilized service capacity, including VA hospitals.

As a long-term care model, VA offers some services other private or public health care plans do not generally cover, including custodial care, social services and long-term rehabilitative therapy. These types of non-institutional long-term care are increasingly important, because VA nursing home capacity is strained. Where this capacity is limited, VA must expand these alternative sources of care.

To facilitate this expansion, VA must expedite action on the *Independent Budget*'s recommendations to convert excess hospital beds to nursing home beds, to construct new facilities and to enter into enhanced lease arrangements. When considering such expansions, VA plans should anticipate long-term hospital beds needs. The IBVSOs also maintain that sustained low occupancy rates in some VA hospitals indicate an opportunity to integrate hospital inpatient and long-term care facilities and to establish the multilayered, long-term care programs described below.

Because of insufficient funding and inadequate capacity, VA has not sufficiently expanded its long-term care programs in recent years. The Administration and Congress must support eligibility reform to encourage expanded access to these programs for older veterans. Congress should appropriate funds to expand nursing home capacity and implement innovative long-term care programs, to encourage the most cost-effective care for older and chronically disabled veterans.

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NURSING HOMES

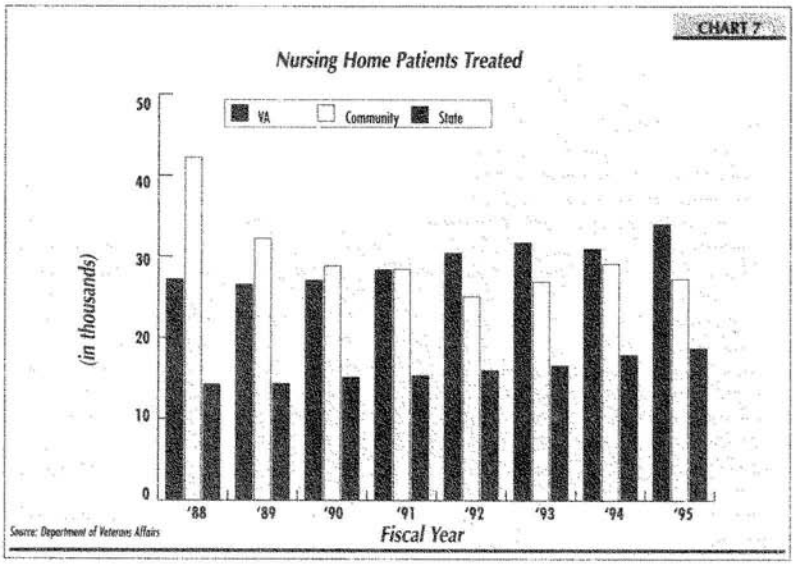
From fiscal year 1985 through fiscal year 1990, the average daily census of veterans in VA nursing homes or VA-sponsored nursing home beds remained almost constant. These programs' capacity should have expanded, however, with the increase in the number of older veterans and potential nursing home residents. As we have previously discussed, the veteran population is growing older and requires more long-term care services now, as it will in the future. To meet this demand, VA must adjust its nursing home capacity.

Deficiencies in the VA budget have constrained veterans' access to nursing home care. Hospital directors, experiencing budget shortfalls, must either cut programs or reduce service availability. Because nursing home care is not guaranteed to veterans, this service is often one of the first cut. Given eligibility constraints and limited capacity, VA often must deny veterans nursing home care; limit their lengths of stay; move veterans into more costly, intermediate-care hospital beds; or shift eligible veterans to Medicaid programs.

To assess the growing need for nursing home beds, both VHA and the IBVSOs base their models for long-term care demand on the 1985 National Nursing Home Survey. This survey indicates that approximately 20 percent of veterans in nursing homes, VA or non-VA, are placed there as VA patients. The *Independent Budget* assumes this rate to be VA's appropriate market share. Unfortunately, VA has not been able to maintain that share. In fiscal year 1988, VA realized a 19 percent market share; since then, that number has decreased to 16 percent. After fiscal year 1988, VA curtailed its nursing home workload even as growth of the elderly veteran population dictated that it expand services (see Chart 7). The VA integrated planning model now defaults to a 16 percent market share. The *Independent Budget* will use this 16 percent share as

80

CHART 7



the appropriate market share, funding workload incrementally to achieve the average daily census VA's planning model identifies for 2005.

VA provides nursing home care in three settings: VA-operated homes, state-owned nursing homes, and, by contract with private-sector providers, community homes. Beginning in 1988, the average daily census of VA or VA-sponsored nursing home care has changed unpredictably (see Chart 8). The number of patients treated in community-based nursing homes has dropped by more than 30 percent, while state nursing home care has grown by approximately 20 percent. VA's own nursing home capacity has made only limited progress toward its goals for expansion and is not nearly what is needed to compensate for the drastic cuts in community nursing home care venues.

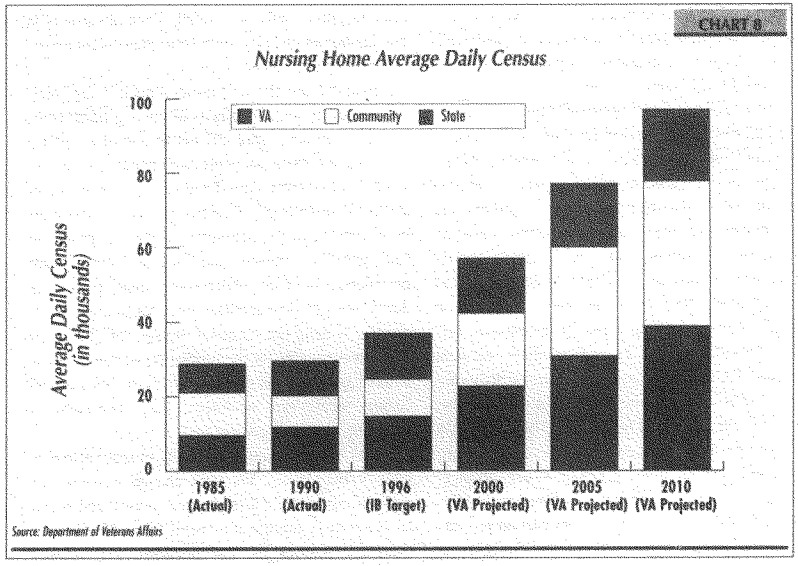
The fiscal year 1996 *Independent Budget* goals for average daily census levels in VA nursing home programs are 30 percent in VA facilities, 30 percent in state homes, and 40 percent in community-based nursing homes. Again, these reflect the OMB planning model for VHA and VA's own default settings used in the integrated planning model (see Table 12). In fiscal year 1994, VA's actual distribution was approximately 40 percent in VA facilities, 34 percent in state homes, and 26 percent in community-based nursing homes. VHA's projected workload for fiscal year 1995 is similarly distributed.

TABLE 12

Comparison of Nursing Home ADC in VA Operated and Sponsored Settings

Type of Facility	FY 1996 *Independent Budget* Goals (ADC)	Office of Management & Budget Goals (ADC)	Actual Distribution FY 1994 (ADC)	Projected Distribution FY 1995 (ADC)
VA	30%	30%	40%	40%
State Home	30%	30%	34%	35%
Community-Based	40%	40%	26%	25%

Source: *Summary of Medical Programs*



In fiscal year 1994, VA supported an average daily census of 13,502 veterans in its own nursing homes and treated 30,926 patients. VA projects that 96,980 veterans will need nursing home care by 2010. This far exceeds its current capacity. With an average daily census of 11,369 in 72 programs, state home nursing homes contributed to VA's overall nursing home capacity, and community-based nursing homes provided 8,981 average daily census to VA's nursing home capacity in fiscal year 1994. The *Independent Budget* targets for our recommended fiscal year 1996 appropriation are 14,740 average daily census in VA nursing homes, 9,920 average daily census in community nursing homes, and 12,420 average daily census in state home nursing homes.

Despite the need for increased community-based nursing home care, VA has not restored capacity in these settings. In fact, it has reduced care in the community every year since fiscal year 1988. This trend discourages the IBVSOs; we hold that VA should not abandon the goal of providing care in the community. Community-based care can be an effective means of expanding nursing home capacity, particularly as a temporary measure pending expansion of VA's own nursing home capabilities. VA can accomplish this expansion by converting hospital bed wards, expanding leasing of nursing homes and enhanced-use leasing, and building new nursing homes.

VA often eliminates community-based care first, rather than reducing care provided within the system. VA should examine the incentives hospital directors have for furnishing care within their own walls and create incentives for using other equally attractive, cost-effective long-term care venues.

VA Nursing Homes

VA's nursing home program provides care to individuals who do not need hospital care, but who do require nursing care and related medical or psychological services in an institutional setting. This important program provides continuing health care, 24-hour

82 nursing care and rehabilitation to achieve veterans' highest possible degree of independence and well-being. VA currently operates 128 nursing home care units with 14,851 beds.

These facilities supported an average daily census of 13,502 and current services level of 30,926 patients treated in fiscal year 1994. The *Independent Budget* bases its nursing home workload targets on feasible expansion of VA nursing home programs and realistic programmatic growth in state and community nursing homes. The *Independent Budget* recommends increasing the average daily census of these systems to 14,750 in fiscal year 1996. With appropriate authority to change criteria governing access to health care services, and thus relieve hospital medical inpatient workload, VA should increase to an average daily census of 15,080 in fiscal year 1996. We maintain that this is an achievable goal for the next fiscal year. VA can accomplish this through hospital bed conversions, appropriate exploitation of enhanced-use arrangements and facility leasing programs. Congress's obligation of funds for nursing home construction projects must allow VA to fulfill its commitment, however, to veterans' long-term needs.

Hospital Bed Conversions

VA has not met its planned level of hospital bed conversions. In fiscal year 1994, VA converted 269 hospital beds, far fewer than the expansion for which the IBVSOs had hoped or that VHA had originally planned. VHA plans to convert 924 more hospital beds to nursing home care beds between now and fiscal year 1998. VA has fallen far short of previous targets, however, and current conversion levels do not satisfy the critical need for nursing home beds.

The *Independent Budget* recommends that VA convert 360 hospital beds to nursing home beds in fiscal year 1996. VA has historically been slow to implement these conversions, primarily because of budget constraints and hospital directors' resistance to mission changes. VA facility directors have been unable to convert many hospital beds to nursing home beds because of short funds, even though long-term savings would result from such an investment. VA nursing home days of care are considerably less expensive than the hospital inpatient or intermediate care days that are often inappropriately substituted. Lack of capacity in nursing homes and eligibility restrictions often underlie these unsuitable choices.

Hospitals are also sometimes limited in their ability to convert acute care beds to nursing home beds. Changing an acute care mission to one of long-term care can devastate an entire community's care network. Long-term care facilities require different staffing than acute care facilities. Conversions to long-term care facilities necessitate replacing physician staff with less trained, and thus less costly, care providers. In many underserved areas, physicians derive most of their incomes from VA and could not practice without this financial supplement. In effect, VA subsidizes care for the general population in areas without great veteran demand. Without VA medical centers' acute care resources, many communities would be medically underserved.

Lack of large, contiguous blocks of space also prohibits conversions. VA must change missions for entire wards and add areas for recreational and social areas to satisfy space requirements for nursing homes. Congress, through its appropriations, and hospital directors have severely restricted construction funds to convert space to meet this need.

Had VA adhered to its own goals for hospital bed conversions, it would not be so far behind Independent Budget targets for nursing home care. Two years ago, information the IBVSOs requested from VHA stated that 4,750 nursing home beds were targeted for conversion by fiscal year 1998. This year, VHA sets its targets at 924 conversions between fiscal year 1995 and fiscal year 1998. These goals demonstrate that, in policy, VHA is willing to develop VA nursing home capacity through hospital bed conversions, but must temper its efforts to do so because of fiscal constraints. The IBVSOs encourage VA to move more aggressively toward these goals.

Nursing Home Construction

The *Independent Budget*'s standing recommendation for nursing home construction is that Congress authorize VA to build four 120-bed nursing homes, adding 480 new beds to the system each year. Implementation of this work must begin immediately to meet increasing need.

Chronic underfunding of VA nursing home construction programs has forced VA to find alternative solutions to meeting the needs of a growing elderly population. Historically, VA has been unable to build and activate nursing homes in less than six years. This document's "Construction Programs" section discusses current VA initiatives to expedite construction. But until VA fully implements programs to redress the problems in its construction protocol, it must find alternative ways to meet veterans' immediate need for long-term care.

The "Construction Programs" section, which begins on page 119 of the *Independent Budget*, details current VA initiatives and other requirements still necessary for our proposals.

Nursing Home Leases

Another option for expanding VA's nursing home capacity is through increased leasing arrangements. The resulting capacity can alleviate some need while additional nursing homes are constructed. The IBVSOs recommend that VA lease two 120-bed nursing homes it can manage and equip; if VA receives authorization to reform access to health care services it will need one additional 120-bed nursing home (with the other two leased facilities, a total of three) in fiscal year 1996. The Medical Care budget initiatives include activation funds for these leased facilities.

Enhanced-Use Leases

In addition to leasing nursing homes, VA must exploit enhanced-use arrangements to add 180 to the average daily census of its nursing homes. Under enhanced-use leasing, unoccupied or underoccupied VA facilities lease space to an external party for an activity that benefits VA.

Ample opportunity exists for VA to enter into additional enhanced lease programs at its medical facilities. When circumstances prevent VA from utilizing its facility resources, all parties' best interests are served when outside parties lease space and provide additional services to veterans. VA can attract potential participants by making sufficiently large spaces available and "fronting" reasonable funds for enhanced-use leases.

VA must expand its enhanced leasing programs through aggressive solicitation and outreach. Even within VA, a clear understanding of the initiatives' objectives or the extent to which VA is involved in these programs does not exist. To entice additional partners, VA may need to explore the cost-effectiveness of advancing funds to potential partners for renovations and improvements to the physical plant.

Enhanced lease arrangements can help VA to compensate for its lack of nursing home capacity. The *Independent Budget* asks that VA add 180 to its average daily census through these arrangements. Such programs cannot and will not meet VA's need for expanded nursing home capacity, however. Leasing is too expensive to provide any more than a short-term solution to this continuing problem, and VA must plan for future demands.

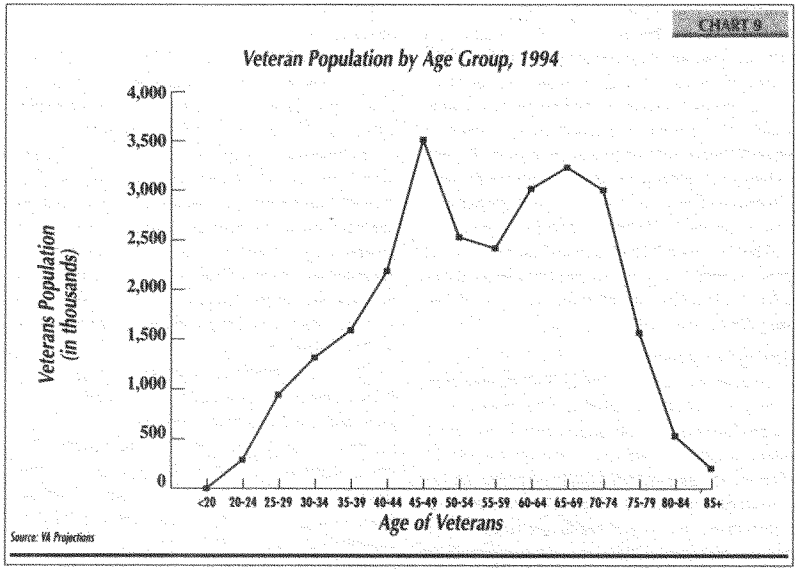
Because long-term care requirements will increase in the future, short-term leasing does not release Congress and the Department from their obligations to construct or convert facilities for future veterans. Veterans' demand for nursing home care will only increase. As different service-era cohorts age and use more nursing home care, VA will need to expand its capacity dramatically (see Chart 9).

The aging veterans of the World War II service era will quickly be followed by those of the Korean Conflict. The age distribution of this generation and the Vietnam generation may provide a slight temporary reduction in the need for nursing home beds around the year 2010. VA must look beyond temporary trends and instead develop capacity to care for future generations of veterans. Drastic increases in VA nursing home capacity are required. Perhaps the most cost-effective and efficient way to accomplish this is by converting hospital beds. This will provide VA with additional capacity until it constructs more nursing homes.

Recommendations

- Increase the VA nursing home average daily census to 14,740 (and 15,170 under new authority) in fiscal year 1996 by converting three 120-bed hospital wards, leasing three 120-bed nursing homes and entering enhanced-use leases for another 180 beds.
- Add Major Construction funds for four new 120-bed nursing homes in fiscal year 1996.

84



Cost

- Cost of constructing new nursing homes included in the Construction budget.
- $23.7 million for VA nursing home workload increase included in recommended appropriation; $35.7 million additional included in recommended budget authority.
- $7.9 million for activation funds for leased nursing homes.

State Home Nursing Homes

An additional way in which VA attempts to meet veterans' long-term care needs is through approved state home nursing homes. These state homes include facilities for nursing home care; some, unlike VA's nursing homes, admit veterans' dependents. VA subsidizes these facilities' construction and operation contributing up to 65 percent of the state's construction costs. The Federal government also encourages state participation by offering matching operations funding and allowing states to collect their shares from program beneficiaries' Social Security disbursements.

State homes have demonstrated the greatest potential to develop VA-sponsored nursing home capacity. Currently, 72 homes in 38 states provide nursing home beds for veterans. In fiscal year 1994, VA-sponsored beds in state homes supported an average daily census of 11,369. Plans call for an additional 534 average daily census and nine new units in fiscal year 1995. VA also expects to add 1,030 additional state nursing home beds through construction projects during that period. The fiscal year 1996 *Independent Budget* recommends an average daily census of 12,420 under current authority and 12,850 under expanded authority.

While state programs' workload growth has been somewhat more substantial in past fiscal years than workload growth in VA-sponsored community venues or in VA itself, VA has missed considerable opportunities for expanding these cost-effective care venues. VA's goal is to fund all approved state

applications for state home grants. It has not done so in recent years, and requests for state grants approach $200 million. Our request for Grants to State Extended Care Facilities is discussed in the "Construction" section.

Expanding use of state homes to provide nursing home care to veterans is sound fiscal policy. States bear most financial responsibility for these programs, so VA spending is minimized. This allows VA to expand its average daily census for VA-sponsored patients without drawing funds from its own nursing home programs or community-sponsored arrangements. State homes are extremely cost-effective; the fixed per diem cost to VA for state homes is $35, compared to $215 for VA nursing home care. VA should increase its contribution to state nursing homes to equal one-third of state home operating costs (or approximately $51) based on its 1986 agreement with them. The *Independent Budget* uses this agreement on state home per diem reimbursement to project growth for state home programs in its initiatives and to add to current services. Given VA's commitment to expanding its average daily census of nursing home patients, state homes provide an attractive, cost-effective way to reach its goals. The savings realized by placing veterans in the less expensive state homes quickly compensate VA for its contribution to construction funding.

Increasing the number of veterans in state homes will require more VA dollars to meet the federal share of per diem costs. The recommended appropriation for extended care initiatives includes state home operating funds. The *Independent Budget* gives recommendations for grants to fund construction of additional state home beds on page 125-6.

Recommendations

- Increase state nursing home average daily census to 12,850 for fiscal year 1996. This assumes considerable growth in bed availability.
- Fulfill the obligation to compensate state homes for one-third of the average per diem cost of care for veterans in those homes.

Cost

$10.7 million included in the appropriation for extended care; $8.5 million additionally requested in the recommended budget authority.

Community Nursing Homes

The community nursing home program places veteran patients requiring nursing home care in community nursing facilities at VA's expense. This contracted community nursing home care is designed to complement the VA nursing home program by providing skilled or intermediate nursing home care. Veterans in transition from hospitalization in VA medical centers can remain in these nursing homes for up to six months. Veterans hospitalized primarily for service- connected disability are exempt from the six-month limitation.

Under current law, veterans are not entitled to nursing home care. Therefore, when dollars are constrained, VHA hospital directors restrict access to this discretionary service and reduce the nursing home census. Because hospital directors choose to keep funding within their facilities, this restriction has been particularly severe for community providers of nursing home care. Each year since fiscal year 1988, the average daily census level has declined, decreasing by 32 percent between fiscal year 1988 and fiscal year 1994.

In fiscal year 1994, VA offered community-based nursing home care to an average daily census of 8,981. The IBVSOs remain committed to their belief that VA should furnish long-term institutional care in the community as a means of expanding the system's nursing home capacity expeditiously and cost-effectively. The rates VA negotiates with community nursing homes allows it to provide care less expensively than in-house. This being the case, we recommend that VA expand care in the community to the extent possible. VA must use community capacity to care for needy veterans, meet its own construction goals and expand its own capacity.

Recommendation

Increase community-based nursing home census to 9,920 in fiscal year 1996 under current authority; under enhanced authority add 570 to the census, for a total of 10,490 average daily census.

86 *Cost*

$62.6 million included in the recommended appropriation for extended care; additionally, $24.4 million recommended for the budget authority.

NON-INSTITUTIONAL LONG-TERM CARE ALTERNATIVES

The increase in the number of elderly veteran patients will continue to require that VA adapt its programs to meet future long-term care needs. As a long-term care model for the nation, VA should continue to supplement its institutional programs with more non-institutional types of care. VA has been committed to increasing the number and diversity of non-institutional extended care programs aimed at enabling independence and reducing system costs; it needs to further these efforts. Programs such as hospital-based home care, community residential care and hospice and respite care have saved VA money and increased patient satisfaction.

Some of these care modes—specifically home-based care, respite care, and hospice programs—operate interdependently and merit coordination by a case manager. For instance, case managers could assist patients using home-based care or community hospice programs who require periodic admission to an inpatient care setting. Also, VA may wish to develop its own community hospice programs through hospital-based home care teams.

Using ambulatory care, rather than inpatient resources, allows VA to augment its resources with those of patients' caregivers. Case management allows VA to use its resources more effectively; physicians and nurses are freed from some administrative details that case managers deal with more effectively. These programs would allow VA to serve more veterans within its budget constraints than would the alternative—repeated hospital admissions for chronic and terminal conditions.

Hospital-Based Home Care

The hospital-based home care (HBHC) program was established in 1970 as a demonstration project under a VA regulation authorizing outpatient follow-up services. In fiscal year 1973, VA secured funding for six demonstration hospitals. Since that time, HBHC has grown to comprise 75 programs system-wide.

HBHC provides services to patients in their homes through hospital-based interdisciplinary teams. This program serves homebound veterans whose caregivers are willing and able to assist in their care. Studies regarding HBHC's effectiveness and its patients' satisfaction have shown that it greatly assists early detection of treatable secondary conditions, such as infections, and provides timely, cost-effective care. Also, HBHC reduces the inappropriate use of hospitals, emergency rooms and outpatient clinics and limits its premature nursing home placement. Studies conducted for VA have clearly shown that discharge personnel consider nursing homes a last resort when hospital-based home care is an option.[10]

The 75 HBHC programs currently in operation supported a 5,069 average daily census in fiscal year 1994. VA has accomplished most of this program's expansion with existing resources, because no funds are specifically allocated for initiating HBHC programs. It is important to recognize that such progress is possible, even within VA's budget constraints.

Recommendation

Activate HBHC programs, in fiscal year 1996, at the 96 remaining hospitals that lack them.

Cost

$82.1 million.

Respite Care Programs

The VA respite care program was authorized under *Public Law 99-576*, and Congress first provided program guidance in establishing a respite care program to medical centers in November 1987. VA medical centers' respite care programs provide periods of care for homebound veterans and rest for caregivers. This program uses unoccupied VA hospital or nursing home beds. Generally, veterans are admitted for one to two weeks to alleviate strain on the family and primary caregiver.

It is widely recognized that most chronically ill persons who do not need hospital services can be most effectively cared for if, through the assistance of family or other household members, they can live at home. At the same time, it is understood that such arrange-

[10]Gerontological Society of America. Congressional Testimony. May 19, 1993.

ments for care of a patient at home may severely burden the caregiver and household physically and emotionally, necessitating some form of respite care program. Providing respite services can prolong the time a caregiver is able to care for the patient in the home and delay the patient's entry to an institution.

Recommendation

Activate respite programs at the 35 hospitals that lack them in fiscal year 1996.

Cost

Included in hospital-based home care funding initiative.

Hospice Care

Hospice care is a coordinated program of palliative and supportive services provided in home and inpatient settings for patients in the last phases of incurable diseases. Hospice care requires acknowledgment by the patient, family and physician that the illness is terminal and a mutual agreement that they will no longer pursue aggressive treatment. VA has established a program of specialized hospice consultation teams, each consisting of a physician, a nurse, a social worker and a chaplain, to administer some hospice care programs. These teams provide an organized approach to the care of terminally ill patients and their families and coordinate program planning, education of staff, consultation and treatment responsibilities, and coordination of services.

VA medical centers provide access to hospice care in several ways: (1) referral of eligible veterans to community-based hospice care under veterans' Medicare eligibility; (2) purchase of community- based hospice care for eligible veterans or those who are ineligible for Medicare benefits; and (3) placement in a VA-operated hospice program with a dedicated inpatient unit and a hospice care unit. These programs provide various options for terminally ill veterans seeking hospice care.

VA reports that, as of fiscal year 1994, all of its medical centers had established a hospice consultation team. It had also established 45 inpatient hospice units. VA could expand access to this important program by creating its own community-based program with existing HBHC teams.

Recommendation

Expand the VA hospice program by creating community-based programs with existing HBHC teams.

Cost

Included in hospital-based home care initiative.

Adult Day Health Care

Congress authorized VA's adult day health care (ADHC) programs in November 1983 through *Public Law 98-160*. The motivation for this development was the need to develop strong programs for the growing number of chronically ill elderly veterans. ADHC programs today focus on a broad spectrum of rehabilitative and maintenance therapies and provide primary health care in a day setting for elderly, functionally disabled veterans who might otherwise require institutionalization. This therapeutically oriented outpatient program is aimed at vulnerable populations, such as the frail elderly, those with functional or cognitive impairments, and those with multiple interactive medical problems, significant social issues and psychological needs.

VA provides this service both directly and through contracts with other providers. The 83 contract ADHC programs serve patients who live in the program's primary service area with a reliable transportation system. During the past 10 years, VA's own ADHC programs have grown in number from 5 to 15. In fiscal year 1994, these programs together supported an average daily census of 939. The *Independent Budget* goal for fiscal year 1996 is 40 programs. The IBVSOs recommend that VA maintain its 83 contract ADHC programs in fiscal year 1996.

Recommendation

Increase the number of hospitals with VA or VA-sponsored adult day health care programs from 98 to 123.

Cost

$11.5 million

Community Residential Care

The community residential care (CRC) program provides room, board and limited personal supervision (at the veterans' expense) plus VA nurse and

88 social worker home visits and outpatient care for the veteran. CRC facilities are most appropriate for patients who require care for medical or bio-psychosocial conditions and lack the needed supervision and supportive care from family or friends to live independently. The population of veterans served by CRC includes patients with long-term psychiatric conditions and mildly impaired elderly people. Because VA pays only the administrative costs of the program, CRC is highly cost-effective. Its programs are especially cost-effective, considering their potential for reaching members of a marginal population who have some means, but cannot manage their lives without this formal support.

In fiscal year 1994, community residential care programs served an average daily census of 10,388 in 135 programs. The *Independent Budget* urges VA to expand this program to all VA medical centers by the end of fiscal year 1996.

Recommendation

Establish community residential care program at 36 VA medical centers.

Cost

$4.5 million

ACCOMMODATING VETERANS' LONG-TERM CARE NEEDS

Multilevel Long-Term Care Facilities

With its unique patient base, VA is in an excellent position to develop model multilevel geriatric and long-term care centers. VA should select one secondary care hospital near a tertiary referral VA medical center in each of four geographically diverse areas nationwide. By converting its beds and mission, VA should dedicate that secondary care hospital to long-term care. Each such center would offer a nursing home, a geriatric evaluation and management program, ambulatory clinics, an adult day care center, a home care team, a respite program and a hospice program. The long-term care center staff should include appropriate numbers of geriatricians, internists, psychiatrists, psychologists and social workers. The center should feature ample facilities for functional rehabilitation, physiotherapy and occupational and recreational therapy and should cooperate with other community-based, long-term care facilities and programs. Implementing this plan would create four new multilevel geriatric care facilities. The *Independent Budget* has supported development of these facilities since fiscal year 1990.

Implementing these concepts, which the IBVSOs have encouraged for years, has become even more urgent as the veteran population ages. With the budget restricting care delivery even as veterans' needs grow, VA must provide care in more cost-effective, efficient ways. The concepts outlined above can enhance VA's ability to deliver more economical, yet high-quality, care to elderly veterans.

Recommendation

Establish four multilevel, long-term care facilities.

Cost

No incremental funding required.

Geriatric Evaluation and Management Programs

VA pioneered Geriatric Evaluation and Management (GEM) units. These unique centers provide specialized services in an inpatient or outpatient setting where an interdisciplinary health care team performs multidimensional evaluations on a targeted group of high-risk elderly patients. This team approach to patient assessment is followed by an interdisciplinary plan of care, including treatment, rehabilitation, health promotion and social service interventions. Studies of GEMs' efficacy demonstrated improved patient survival rates, reduced nursing home and hospital admissions, and improved functional status.[11] These inpatient units coordinate and plan care so well that patients live longer with less disability and fewer episodes of rehospitalization and institutionalization.

Most VA medical centers now operate GEMs. The *Independent Budget* calls for all VA medical centers to implement geriatric evaluation and management units by the end of fiscal year 1996. In fiscal year 1994, 133 GEMS operated throughout the VA medical care system. The IBVSOs urge that VA add 38 GEMS to increase all veterans' access to this care mode.

[11] *Annals of Internal Medicine*. "New Technologies of Geriatric Evaluation Units." Quoted in the Gerontological Society of America's Testimony to the Senate Committee on Veterans Affairs. Washington, DC: May 19, 1993.

Recommendation

Increase the number of geriatric evaluation and management units from 133 to 171.

Cost

No incremental funding.

Geriatric Research, Education, and Clinical Centers (GRECCs)

In 1976, VA established the GRECC program to focus attention on the aging veteran population, to increase basic knowledge of aging, to transmit that knowledge to health care providers and to improve the quality of care to the aged. These "centers of excellence" were developed concurrently with the creation of the National Institute on Aging of the National Institutes of Health.

The best of long-term care comes together in the GRECCs. In these 16 facilities, staff members coordinate efforts in a focused health care area affecting the elderly, such as nutrition, diabetes, dementia or osteoporosis. GRECC research is a balanced portfolio of projects, including those seeking to understand the biology of disease, to evaluate treatment and to assess health care delivery alternatives. GRECCs train clinicians and researchers and disseminate their findings widely to an eager audience of caregivers within and outside VA. The IBVSOs urge that VA expand the GRECC program, so that these innovations and effective discoveries are developed more rapidly.

One area that would greatly benefit from the focused efforts of GRECC research is the care of elderly patients with spinal cord injuries. As medical technologies and skills have advanced, spinal cord injured individuals are surviving their injuries and living long lives. The IBVSOs recommend that VA establish one GRECC dedicated to the study of aging in the spinal cord injured patient. The increased understanding that results from this study, and all GRECC research, will benefit veterans and the general public.

VA needs more GRECCs to fulfill its original goals and meet new missions. In 1986, *Public Law 99-166* authorized an increase in the number of GRECCs from 15 to 25. Since that enactment, VA has added only one GRECC, however, and it does not propose an increase in fiscal year 1996. The *Independent Budget* recommends that VA institute 25 GRECCs by fiscal year 1996. 89

Recommendation

- Establish nine geriatric research, education and clinical centers (GRECCs), including one GRECC dedicated to spinal cord injury treatment and research in fiscal year 1996.
- Initiate an overall VA GRECC coordinator to expedite sharing of resources and personnel to enhance each of the centers, coordinate the GRECC research agenda with the National Institute on Aging, and further develop the program.

Cost

$28.2 million.

Bio-Psycho-Social Programs

As a group, veterans are susceptible to certain bio-psycho-social disorders, including PTSD, severe psychoses, substance abuse and homelessness. These conditions tend to contribute to one another, and it is imperative that providers coordinate care to dispense an integrated response. The Robert Wood Johnson Foundation recently conducted a study demonstrating that, while services exist to care for the general chronically mentally ill population, they are too few and too fragmented, and that only by a concerted "systems approach" to services and providing housing and case management can their future be improved.[12] As one of the few national integrated delivery systems, VA comprises an ideal test site for further research and exploration of innovations in the delivery of mental health services.

Traditionally oriented toward institutionalization, VA must continue to seek out and treat chronically mentally ill veterans in the community and to establish and evaluate alternatives to institutionalization, such as new types of board and care homes, domiciliary care and home care. Those with schizophrenia and manic-depressive disorders account for 71 percent of all veterans who currently receive 100-percent disability

[12]M.F. Shore and M. D. Cohen. "The Robert Wood Johnson Foundation Program on Chronic Mental Illness: An Overview." *Hospital and Community Psychiatry*, 41 (1990): 1212-1216.

benefits for psychiatric disorders. VA must increase its commitment to research on services for people with such severe mental illnesses as these, to identify the most economical and efficacious treatment programs in hospitals and communities.

VA's bio-psycho-social programs address the veteran patient population's unique characteristics. These specialized services offer access to treatment that is often unavailable in the private sector. Issues such as post-traumatic stress disorder, homelessness and substance abuse are all addressed within the context of a veteran's military experience.

One program that has been extremely effective at this is the Community Support Group, operated within the Mental Health Clinic at Bay Pines VA Medical Center in Florida. The Community Support Group provides specialized services to veterans in settings appropriate to their needs and abilities. Patients are divided into groups of those needing intensive therapy at the Center, those able to meet weekly in community-based settings, and those whose needs are best met in a small, intensive treatment group. An auxiliary of family members, friends and supporters has also promoted this program.

VA psychiatric programs also serve patients who would have little or no access to mental health care outside the VA system. These veterans are less likely than the general population to have health insurance and particularly need access to VA's bio- psycho-social programs.

HOMELESS VETERANS PROGRAMS

The U.S. Conference of Mayors' *10th Annual Survey of Homelessness*, released in December 1993, found that veterans make up 21 percent of the homeless population; 250,000 veterans are homeless in the United States. On any given night, this means that one-third of homeless adult males are veterans. These numbers are as high as 40 percent in San Diego and 35 percent in Salt Lake City.[13] Most of these homeless veterans are believed to be Vietnam-era veterans. The large number of veterans within the homeless population requires VA to act aggressively to alleviate homelessness and its consequences. Homeless veterans must have access to a full continuum of services, which includes outreach, medical and psychiatric assessment and treatment, transitional residential care, supported permanent housing, and case management services.

Programs for homeless veterans or those at risk of homelessness need to recognize that health problems and homelessness often go hand in hand. Tuberculosis, HIV infection, pulmonary diseases, hypertension, alcohol and drug abuse, and serious mental illness affect homeless people at higher rates than the general population. Individuals diagnosed with PTSD also exhibit more cardiovascular and gastrointestinal disorders than other populations. It is estimated that more than 44 percent of the veterans who participate in the homeless chronically mentally ill (HCMI) program reported physical health problems at the time of intake.[14] For veterans who are uninsured and already living paycheck to paycheck, a serious illness can be financially devastating, leading to the loss of earnings, depleted savings and, for some, a downward spiral into homelessness. The environmental hazards inherent in homelessness can also complicate pre-existing illnesses, inhibit access to health care and even lead to other health problems.

VA has established and funded many programs to ameliorate veteran homelessness, including those listed in Table 13. These programs provide treatment and assistance to approximately 20,000 veterans every year. The HCMI program aids veterans who need psychiatric and medical care through outreach; community-centered, residential rehabilitative services; and case management. The domiciliary care for homeless veterans (DCHV) program provides bio- psycho-social treatment and rehabilitation, in a hospital-based, low-intensity setting, to individuals whose problems have contributed to their homelessness. Also, each VA medical center has a social worker or homeless services coordinator who collaborates with appropriate organizations to determine unmet needs and develop appropriate interventions. A recently implemented pilot program features drop-in centers that serve a portion of the veteran population that is often difficult to reach

[13]Department of Veterans Affairs. *Newslink*. Washington, DC: December 1994.
[14]Personal correspondence form Central Office, Department of Veterans Affairs. Washington, DC: November 23, 1994.

TABLE 13

Programs for Homeless Veterans

Homeless Chronically Mentally Ill (HCMI) Programs
Number: 68 sites provided 144,868 visits in FY 1994
Purpose:
1. Aggressive outreach
2. Medical and psychiatric examinations
3. Treatment and rehabilitative services in community-based facilities
4. Case management services

Domiciliary Care for Homeless Veterans (DCHV) Programs
Number: 33 programs treated an estimated 3,500 veterans in FY 1994
Purpose:
1. Residential rehabilitation
2. Individualized treatment of unmet clinical needs
3. Stabilization of underlying causes and resulting manifestations of homelessness

Drop-in Centers
Number: 2 pilot centers
Purpose:
1. Daytime shelter
2. Programs and activities that enhance daily living skills
3. Provision of meals, shower and laundry facilities
4. Entry to more serious treatment or rehabilitation

Veterans' Industries (Compensated Work Therapy/Therapeutic Residence Programs)
Number: 37 program sites (7 run exclusively for homeless veterans)
Purpose:
1. Therapeutic work activities
2. Supervised living in VA-owned community homes
3. Substance abuse interventions

VA Supported Housing (VASH) Program
Number: VA staff at 30 sites have dispersed 2,050 rental assistance vouchers to homeless veterans
Purpose:
1. Provide permanent "Section 8" (federally subsidized) housing (for which the disabled, including mentally impaired, and other categorically defined groups are eligible) through HUD
2. Link housing to ongoing case management and VA clinical services

Homeless Provider Grant and Per Diem Program
Number: 33 grants for $5.6 million
Purpose: Provide grants and per diem payments to public and nonprofit providers of transitional assistance to homeless veterans

Joint Social Security Administration/VA Pilot Project
Number: 4 high-intensity and 7 medium-intensity pilot program sites
Purpose:
1. Expedite homeless veterans' claims for Social Security benefits to which homeless veterans are entitled
2. Locate homeless veterans
3. Merge VA data with Social Security Administration data to determine homeless veterans' benefits status

Joint VBA/VHA Project
Number: 1 Project
Purpose: Monitor and evaluate services provided to homeless veterans

Comprehensive Homeless Centers
Number: 6 Centers
Purpose: Serve as an umbrella for such programs as:
1. HCMI
2. DCHV
3. Veterans' Industries
4. VASH
5. SSA/VA pilot project

and treat. These day programs offer the veteran a supportive but unobtrusive means of receiving assistance. Tables 14 and 15 list other services for veterans with psychiatric and substance abuse problems, both contributing factors to homelessness. 91

The IBVSOs applaud these VA efforts to address veteran homelessness, including the Secretary's Summit on Homelessness, which took place in February 1994. Current programs for homeless veterans provide valuable services to many needy individuals. For example, the HCMI program provided 144,868 visits to its 68 units in fiscal year 1994. The DCHV program saw 3,500 patients treated in fiscal year 1994, yet was able to provide care to only a fraction of veterans who need such services.

Recently, VA implemented the Homeless Provider Grant and *Per Diem* Program, which allows VA to fund private- and public-sector organizations to provide supported housing and supportive pensions for homeless veterans. In its first funding cycle, VA awarded 33 grants worth $5.6 million.

Recommendation

- Expand homeless veterans programs that enhance veterans' independent living skills. VA currently runs many innovative programs through its Health Care for Homeless Veterans programs and should continue to utilize this venue.
- Expand care at new and existing sites through the types of programs shown in Table 13.
- Continue to develop drop-in centers in communities with unmet needs and in metropolitan areas and establish new HCMI and DCHV programs.
- Continue to develop collaborative projects and partnerships with other federal agencies, state and local governments, and nonprofit organizations, including veterans' service organizations, to expand services for homeless veterans.

Cost

$10 million for programmatic enhancements; $51.5 million included in extended care recommendation to enhance domiciliary care.

92 LONG-TERM PSYCHIATRIC CARE

VA's psychiatric care programs rely heavily on custodial care to treat chronically mentally ill veterans. In fiscal year 1994, VA treated 190,529 veterans on an inpatient basis in psychiatric beds. Without these beds and VA's other long-term psychiatric care programs, many mentally ill veterans would have no access to shelter, food, adequate clothing or medical care. These difficulties are often compounded when veterans turn to alcohol or substance abuse as a substitute for rehabilitation and treatment.

TABLE 14

Programs for Chronically Mentally Ill Veterans

- 30 VA medical centers designated as long-term psychiatric care facilities
- Intensive psychiatric community care programs
- Psychiatric transition wards
- Mental hygiene clinics

VA operates many programs targeted at alleviating the causes and symptoms of mental illness. Some of VA's programs for this vulnerable population attempt to rehabilitate mentally ill veterans and allow them to regain their independence. VA's programs for chronically mentally ill veterans are listed in Table 14. For example, community residential care provides minimal supervision and encourages development of independent living skills These types of programs also have a therapeutic value for the less impaired veteran who might otherwise be institutionalized. VA should establish short-term care settings that provide more intensive therapy to augment services to the chronically mentally ill.

Recommendation

Develop innovative psychiatric care programs that treat mentally ill veterans in less restrictive settings and expedite their return to the community; bolster institutional programs.

Cost

$13.5 million.

SUBSTANCE ABUSE TREATMENT PROGRAMS

Substance abuse continues to overwhelm private and VA capabilities. Despite persistent attempts to eradicate, or even stem, the spread of alcohol and drug abuse, the number of those affected continues to rise and the severity of the impact intensifies. This epidemic has particularly troubled veterans, and VA's programs to treat substance abuse are stretched to the limit. Recent data show that between 25 percent and 50 percent of veterans presenting themselves for treatment at VA medical centers have substance abuse disorders, in addition to their other medical and psychiatric conditions.[15]

VA's commitment to addressing veterans' substance abuse problems traces back to 1946 and the publication of a policy statement affirming that VA would provide treatment for veterans with alcohol use disorders. VA's first drug-dependence treatment program was established at the Washington, DC, VA medical center in October 1970. In 1980, VA began contracting with non-VA community halfway houses for rehabilitation services for veterans with substance abuse problems.

TABLE 15

Programs for Veterans with Substance Abuse Problems

- Inpatient chemical dependency treatment
- Outpatient chemical dependency treatment
- Substance abuse outreach programs
- Substance abuse community halfway houses
- Veterans' industries
- Domiciliary substance abuse program
- Substance abuse relapse program
- Specialized substance abuse programs for spinal cord injured, geriatric post-traumatic stress disorder and other groups

Today, VA provides a broad range of substance abuse treatment options, from acute inpatient to intermediate, outpatient and residential care, including a contract program for halfway-house placement in the community. Tailoring programs to problems underlying veterans' substance abuse (such as aging, homelessness, unemployment, spinal cord dysfunction or

[15]Department of Veterans Affairs. *VAnguard.* April 1992.

post-traumatic stress disorder) has also proven effective. Many of VA's domiciliaries also include substance abuse treatment programs. VA operates the programs listed in Table 15 for veterans suffering from alcohol and drug abuse.

VA must use its limited resources effectively by implementing its most successful treatment protocols. Whenever possible, these programs must be flexible and deal with substance abusers' special medical needs. Individuals should have follow-up care that is supportive but allows those able to remain in the community to do so. It is important that VA continue to address the problems specific to each veteran's substance abuse. This type of disorder is often the manifestation of other problems and conditions, many of which may have a basis in the veteran's military service.

The federal sector, in general, should do far more to coordinate its efforts in both studying and treating substance abuse. Agencies that deal with the problem—for example, the Department of Veterans Affairs, the Office of National Drug Control Policy, the National Institute on Drug Abuse and the Center for Substance Abuse Treatment—all work toward treatment of substance abuse, yet few joint research and treatment projects or policy statements exist. Because VA's substance abuse and other bio-psychosocial programs offer a continuum of integrated services to a limited number of veterans who are eligible for care, VA offers an ideal setting for research into the efficacy of various types of substance abuse treatment. VA also has a greater need for the additional funding that other federal programs could provide because substance abuse is more prevalent among veterans than other Americans. Also, as one of the few federal entities providing direct health care, the VA medical care system is a "natural" for federally coordinated treatment and research projects.

Recommendations

- Enhance substance abuse programs for veterans, whenever possible in their communities.
- Pursue opportunities to enter into research and treatment projects with other federal programs that fund such projects.

Cost

$10 million, included in funding recommendation for homeless and long-term psychiatric programs.

VETERANS' INDUSTRIES

VA has developed an innovative program to provide care, training and rehabilitation services for veterans with substance abuse problems or psychiatric, neurological, or physical disabilities. These veterans' industries programs have successfully treated homeless veterans' special needs.

Veterans' industries emphasize a work-oriented approach as a means to facilitate psychosocial rehabilitation. Different structures and activities accommodate the varying abilities and skills of individual veterans involved in the programs. The common denominator for all veterans' rehabilitation is some form of work or enterprise. The intensity varies, from programs for those receiving training in comprehensive living skills, to activities for those seeking enhancement of their work skills.

Substance abusers represent many veterans' industries program users. These veterans enter therapeutic residencies that provide substance abuse aftercare, transitional housing, compensated work therapy, vocational counseling and job placement. The North Chicago VA Medical Center operates a new, compensated work therapy model called PREP (short for Pride Residential Employment Program). The program provides a unique approach to treatment for veterans with substance abuse problems and serves as the next step following an inpatient treatment program usually lasting from 21 to 28 days. Four-year pilot programs are also in place at 13 other VA medical centers. The PREP program, which lasts up to nine months, allows the veteran to make the transition back into the community as a productive member of it.

These types of programs have had high success rates and should be further supported. Because of low staffing requirements and contractual arrangements with private enterprise and other federal government agencies, veterans' industries offer veterans valuable therapy at minimal cost. Congress should be congratulated for its efforts to enhance veterans' access to veterans' industries programs by authorizing VA to provide this therapy

94 as a nonprofit venture with private-sector providers and employers.

The IBVSOs strongly support these effective and resourceful programs that assist veterans with considerable hurdles to face. VA must continue to coordinate its programs with private, nonprofit organizations and the Department of Housing and Urban Development (HUD), and should especially focus on establishing housing sites for these programs.

Recommendation

Coordinate efforts with HUD and other agencies to house veterans in 75 new community residences.

Cost

$10 million, included in the Homeless Program initiative.

POST-TRAUMATIC STRESS DISORDER

The medical and veterans communities continue to recognize the importance of post-traumatic stress disorder (PTSD) as a manifestation of an individual's psychological response to war and other violent events. In post-traumatic stress disorder, a condition that affects many veterans, an intense event (or series of events) in the past, such as military combat or involvement in other highly stressful events, interferes with normal living in the present.

The number of war veterans suffering from PTSD is difficult to gauge. Some estimate that PTSD affects as many as 450,000 veterans. An additional 350,000 exhibit significant war-related PTSD symptomology. VA is the primary care provider for veterans suffering from PTSD. In fiscal year 1992, prolonged PTSD was the fifth most frequent primary diagnosis in VA hospitals nationwide. VA has led the way in PTSD treatment and research, and specialized PTSD treatment programs and clinical teams are located at VA facilities throughout the country. Veterans receive PTSD treatment in VA medical centers and mental health clinics and from a network of 202 veterans' outreach centers that provide counseling to veterans and their families for various readjustment problems. VA's National Center for PTSD has conducted research that has helped guide evaluation and treatment efforts as well. VA's multisite National Center, established in 1989, is a collaborative effort based at five VA hospitals.

VA's three major PTSD programs are its 23 specialized inpatient PTSD units (SIPUs), 202 vet centers, and 74 PTSD clinical teams (PCTs). Other support programs provide short-term inpatient treatment and aftercare or address such PTSD-related issues as alcohol and drug abuse and homelessness. VA mental health clinics and psychiatric wards also treat veterans suffering from PTSD, especially where no other PTSD programs exist.

In fiscal year 1994, VA's PTSD clinical treatment teams had 243,514 visits to their 74 programs. They estimate that, with the addition of eight proposed teams, the number of visits will increase to 263,514 in fiscal year 1995. In fiscal year 1994, 2,552 additional patients were treated at the 23 specialized inpatient PTSD units, and 2,776 patients were seen in evaluation and brief treatment centers.

Despite these admirable efforts, more remains to be done. A September 15, 1993, hearing of the House Veterans' Affairs Subcommittee on Oversight and Investigations revealed that VA has treated only 10 percent of veterans suffering from PTSD. This clearly highlights the need to expand VA's PTSD programs, especially the PCTs that are responsible for initial assessment and evaluation of veterans. VA officials indicate that this is particularly critical as veterans enter their 50s—these years offer the last opportunity to change destructive health patterns, such as alcoholism or drug abuse, and high stress, which may be associated with PTSD. Treating such disorders would likely prevent related health disorders in the near future. To accomplish this goal, VA should establish a PTSD treatment capability at every VA medical center with a mental health capability.

The IBVSOs commend Congress for recognizing this serious problem and hope to be able to acknowledge its continued support and expansion of these programs in the future.

Recommendations

- Continue to target eligible veterans and address their specific PTSD treatment needs with the types of programs shown in Table 16.
- Establish PCTs in ten additional VA medical centers .

- Enhance treatment resources at existing facilities.

Cost

$3 million

TABLE 16

Programs for Veterans with Post-Traumatic Stress Disorder

- Post-traumatic stress disorder residential rehabilitation program
- POW support groups
- Joint PTSD/substance abuse disorders unit
- Readjustment counseling

Resources Available in FY 1994

Specialized inpatient PTSD units	23
Evaluation and brief treatment inpatient units	16
PTSD residential rehabilitation programs	12
PTSD clinical teams	74
Veteran centers	202

Programs for Veterans' Specialized Care Needs

FEMALE VETERANS' HEALTH INITIATIVES

According to current estimates, 1.2 million female veterans make up 4 percent of the veteran population and 2 percent of hospitalized veterans nationwide. By the year 2040, it is projected that 10.9 percent of all veterans will be women. The growing number of female veterans who will seek care at VA facilities presents VA with the challenge of meeting female patients' needs in a health care system historically oriented toward men. Female veterans and their providers need to be especially vigilant about women's health, because female veterans suffer from the same increased incidence of disease as male veterans. The 1985 Survey of Women Veterans found that female veterans have a 9 percent lifetime prevalence rate of cancer, nearly twice the rate reported for American women in general.

Like their male counterparts, female veterans entitled to mandatory care are those with an illness related to their military service or are lower-income veterans. VA directives require that each female inpatient receive a complete physical examination upon admission, including breast and pelvic examinations. Pap smears are provided on a regular basis. When a VA facility lacks sufficient demand to maintain these specialized services on the premises, eligible female veterans' needs are supposed to be met through referral to sharing partners or by VA's purchase of the services locally.[16]

However, the VA's Inspector General (IG) recently investigated women's health care centers at VA facilities and found some services deficient. For example, of the 166 facilities surveyed, 75 offered no on-site women's health care clinics. Of eight such facilities the IG visited, two opened their women's health clinics every other week for four hours, five facilities offered gynecological care on a contract basis, and only two facilities had rape kits and obstetrical kits available.[17] This lack of resources specifically designed for female patients' special needs creates a real barrier to high-quality health care for these veterans.

The U.S. General Accounting Office (GAO) has found that physical examinations, including cancer screening for female veterans, continue to be sporadic. This lack of continuity in women's services leads to insufficient preventive and primary care. VA must be particularly sensitive to the needs of female veterans and expand its gender-specific preventive services, such as mammography screenings. It must make every effort to ensure that all veterans, but especially this often neglected group, receive timely, comprehensive health care services. To accomplish these goals, VA should be appropriately funded and should increase staffing levels for preventive services. It also needs funds to purchase screening equipment. VA medical centers cannot provide adequate preventive care without the necessary medical equipment designed for such services.

The GAO report identified some other weaknesses in VA's services for female veterans. For example, they found that VA medical centers do not adequately monitor their in-house mammography programs to ensure compliance with quality standards. Also, VA medical centers have inadequate procedures to ensure that

[16]Department of Veterans Affairs. "VA Health-Care Programs for Women Veterans," VA Fact Sheet. Washington, DC: 1993.
[17]Representative Pat Schroeder. Testimony before the House Veterans Subcommittee on Oversight and Investigations. Washington, DC. June 23, 1993.

96 female patients have privacy and to correct problems with privacy limitations during facility renovations.

To address some of these deficiencies, in June, 1993, VHA launched a series of health care initiatives for female veterans, which included designating four comprehensive women's health care centers and four PTSD treatment teams, and hiring counselors in 69 locations to treat the aftereffects of sexual harassment and assault. Each women's comprehensive health care center will serve as a resource, providing a full range of services for female veterans in a specific geographic area, and each center will support a specified group of VA facilities. Each center will also demonstrate a pilot program for duplication throughout VA. Also, the Little Rock, Arkansas, VA medical center has opened a breast cancer screening center equipped with a mammography unit and computerized biopsy instrumentation. Authorized by the *Women Veterans Health Programs Act of 1992*, $7.5 million was appropriated in FY 1993 for these and other expanded services for a growing population of female veterans.[18]

VA has established a new division within the National Center for Post-Traumatic Stress Disorder devoted to studying the impact of military service trauma on women. The Women's Health Science Division is the first of its kind in the country. The division will exclusively examine the effects of PTSD, including problems caused by sexual harassment and sexual assault, on female veterans' mental health and physical well-being. VA and Congress should recognize and duplicate these innovative programs, aimed at providing appropriate, high-quality, gender-specific care for these veterans. These initiatives will help address problems related to female veterans' access to health care. In addition, the women veterans coordinators program, which assigns an individual to organize women's services within a center, is being expanded. There are now 21 full-time coordinators, and VA plans to increase that number to 61 in fiscal year 1995.

The IBVSOs are also pleased to see that one of Secretary Brown's first actions in office was to establish the goal of "zero tolerance" for sexual harassment within VA. The fiscal year 1994 *Independent Budget* had recommended that VA improve its employee grievance process for sexual harassment. Secretary Brown has met the IBVSOs' goal and decentralized the processing of discrimination complaints. Sexual harassment complaints are now reviewed simultaneously at the field facility and intermediate director level. VA headquarters will also review sexual harassment complaints.

These efforts will gain increasing importance as the number of female veterans continues to rise. These veterans deserve to have their health care needs met in the most appropriate manner possible, and the *Independent Budget* urges that VA take all steps to ensure that this happens.

Recommendations:

- Continue implementing recommendations of the VA Advisory Committee on Women Veterans.
- Continue to provide counseling to women veterans who have experienced sexual abuse while on active duty.
- Authorize funding for 50 new, dedicated FTEEs for the women veterans coordinators programs.

Cost

Funding for 50 new dedicated full-time women veterans coordinators at VA medical centers, included in the outpatient workload increase initiative.

PROGRAMS FOR GULF WAR VETERANS

Thousands of veterans who served in the Persian Gulf War are suffering from baffling symptoms and ailments. Speculation on the cause of these ailments has at one time or another focused on exposure to smoke from oil fire; desert parasites, unusual responses to vaccines; exposure to pesticides; fuels and other organic chemical substances, and some form of biological or chemical warfare agent. The volume, severity and intensity of these complaints have led VA to act.

Congress authorized a Persian Gulf Registry in 1992 to track the health of Gulf War veterans. The Registry has currently enrolled and examined more than 34,000 veterans. Secretary Brown also established the 16-member Persian Gulf Veterans Coordi-

[18]Department of Veterans Affairs. *VAnguard*. March/April 1993.

nating Board to coordinate VA research activities with other agencies exploring Gulf-related illnesses. A VA Expert Scientific Committee has convened to examine the possible health effects of military service in the Persian Gulf War, including multiple chemical sensitivity, chronic fatigue syndrome and post-traumatic stress disorder. VA's medical centers in Washington, DC, Houston, Texas, and West Los Angeles, California, now serve as referral centers for Gulf War veterans with undiagnosed disorders.

VA continues to collaborate with the Department of Defense, the National Academy of Sciences and the National Institutes of Health to review scientific, medical and other consequences of Persian Gulf service. VA researchers will undertake two major epidemiological studies to investigate the health effects of serving in the Persian Gulf War. One study compares symptoms and medical conditions of 15,000 Gulf War veterans to those of 15,000 veterans who were in the military at that time but did not serve in the Gulf conflict. This study will help determine whether anything sets Gulf veterans apart. A second study seeks differences in cause-specific death rates between Gulf War veterans and veterans who did not serve in the Persian Gulf. Congress has recently authorized VA to initiate a study to evaluate the health status of Gulf War veterans' spouses and children.

VA now compensates Persian Gulf War veterans who suffer from a chronic disability resulting from an undiagnosed illness that became manifest during or within two years of Gulf service. VA also tracked compensation claims of veterans who attribute problems to environmental exposures, such as oil well fires. VA has recently established environmental hazards centers in Boston, Massachusetts, East Orange, New Jersey, and Portland, Oregon, to conduct basic and clinical research on Persian Gulf-related illnesses. Congress extended special authority allowing VA to treat Persian Gulf War veterans for conditions that environmental hazards apparently caused. VA reimburses these veterans for any copayments they have made to VA for care that might have been necessary as a result of their exposure. Priority treatment is only authorized, however, until December 1995.

The *Independent Budget* urges Congress to pass a comprehensive measure that would provide a long-term authorization for Persian Gulf-related illnesses. The IBVSOs also encourage continued outreach to Persian Gulf War veterans. We commend VA for the surveillance and treatment efforts it has already undertaken and hope to see these programs extended. 97

Recommendations

- Extend authorization for VA coverage of Persian Gulf-related illnesses in veterans.
- Continue investigations into Gulf War veterans' unexplained ailments.
- Continue outreach efforts to provide services to Gulf War veterans.

Cost

No additional funding recommended.

DISABLED VETERANS' PROGRAMS

One of VA's strengths is its ability to provide specialized services for veterans who have suffered disabling injuries. These programs, such as spinal cord dysfunction medicine, blind rehabilitation services, prosthetics and orthotics, amputee clinic teams and Preservation Amputee Care and Treatment (PACT) programs, and post-traumatic stress disorder treatment, are without peer in the private sector. In cases where excess capacity exists in these specialized programs, the IBVSOs encourage VA to participate in sharing agreements with DOD, academic affiliates and other providers. Such agreements allow VA to demonstrate its expertise while granting high-quality care to disabled individuals who would otherwise not have access to VA's specialized care services.

As comprehensive reform of the nation's health care system unfolds, VA has an obligation to continue its mission to provide care for veterans with disabilities. It is unlikely that even a reformed national system with a comprehensive benefits package would completely meet the disabled population's specialized needs, and VA must maintain veterans' access to this care.

Prosthetics Users' Programs

Programs that provide care for prosthetics users are examples of the specialized, high-quality services VA provides for veterans with disabilities. Recently, prosthetics and sensory aids services have significant-

98 ly improved through implementation of VA's prosthetics improvement implementation plan. Centrally monitoring the use of funding designated for prosthetics has also enabled prosthetics services to provide devices without the long delays that were common in recent years. VA has centralized funding for the purchase of prosthetic appliances and now reviews it quarterly.

VA has established new prosthetic and sensory aids service programs at 52 sites in an effort to extend the availability of these services. It has conducted program site visits at 184 facilities. These visits are used to develop specific recommendations for each site about methods to improve service delivery.

Additionally, VA has standardized the process used to report delays in orders, to permit more accurate monitoring of service. Delays and waiting times remain a problem in the prosthetics service. The contract officer certification program, designed to allow direct purchasing by prosthetic program staff, focuses on reducing these delays and has already reduced order processing time by 57 percent. VA medical centers should support the efforts of this program to offer timely service to veterans.

VA must continue to improve its ordering process, to reduce waiting times. Increasing the number of orthotic labs will help prosthetic services meet the high demand for these services. By increasing this capacity, VA can more effectively and quickly provide services and aids for disabled veterans who require these devices.

The IBVSOs are pleased that the prosthetics service has implemented a prosthetic patient satisfaction program to judge VA's performance in prosthetics and sensory aids. The patient feedback gained through these surveys allows VA to manage its own achievements and weaknesses.

Recommendations

- Fully implement the prosthetics improvement implementation plan, particularly those elements that expedite purchasing.
- Fund additional FTEEs to staff continuing and additional programs.
- Continue to centrally monitor the prosthetics budget and operate it as a centralized account.
- Establish new orthotic labs to extend veterans' access to these services.

Cost

$7.7 million

Programs for Veterans with Spinal Cord Dysfunction

Spinal cord injury (SCI) is a catastrophic illness that requires not only multispecialty medical care, but significant social and economic resources as well. For more than four decades, VA has been at the vanguard of providing life-saving and life-sustaining treatment to people with spinal cord injuries. VA created SCI treatment centers following World War II.

VA's reputation for high-quality SCI services is now in jeopardy. The past 10 years have seen progressive erosion of VA health care services in general and a lessening of VHA's commitment to spinal cord injury programs in particular. SCI centers are caught in that same deteriorating spiral of annual budget shortfalls that erodes the entire VA health care system. Their rejuvenation depends, in part, on increased funding. Only adequate incentive pay will attract and hold SCI-qualified physicians and nurses.

VA has developed ambulatory SCI programs for supportive treatment of patients in satellite clinics. The IBVSOs strongly recommend that VA continue to organize these outpatient facilities under the chiefs of regional SCI referral centers. VA SCI centers should train and supervise satellite clinics' professional staff and monitor SCI patient care in the VA SCI outpatient clinics and wherever SCI patients receive it. In-service SCI training for clinic personnel is necessary for the successful development of satellite SCI programs.

In fiscal year 1994, 7,608 veterans were treated in VA's 1,232 dedicated spinal cord injury beds. Many veterans with spinal cord injuries receive care at VA hospitals without SCI centers. At a minimum, VA must train personnel in hospitals without SCI centers to care for paralyzed patients' special needs. VHA should continuously rotate trainees through its SCI centers, to expand its cadre of SCI-qualified physicians, nurses and therapists. VHA should provide spe-

cial pay to nurses and therapists who successfully complete these training programs.

VA recently implemented a new policy to create SCI primary care teams at each VA medical center that does not have a spinal cord injury unit. These teams will enable SCI veterans to contact an identified professional who will provide coordination and continuity of care. Team members should include a physician, a nurse, and a social worker, all familiar with spinal cord injured veterans' special needs.[19] The IBVSOs applaud these types of programs that enhance the training of medical personnel in the special needs of veterans with spinal cord injuries.

Veterans who become paralyzed through disease rather than injury should also have access to SCI centers. These veterans require care for the types of secondary complications that affect spinal cord injured veterans, such as urinary tract infections and decubitus ulcers. The resources, personnel and training required for treatment of these conditions are similar to those needed for treatment of spinal cord injured patients.

Progress in the ongoing care of people with spinal cord injuries and diseases has increased their life expectancies to nearly normal. As a result, studies in geriatric SCI care are needed. VHA should designate a geriatric research, education, and clinical center (GRECC) to focus on the needs of older paralyzed people.

The IBVSOs also recommend that Congress support the Independent Living Fund more fully. This program funds VA SCI programs that allow veterans with spinal cord dysfunction to participate as a group in other community recreational programs. Activities like these facilitate newly injured veterans' rehabilitation and reacclimation to the community. These individuals need the opportunity to socialize with other veterans with disabilities and interact outside the hospital.

Recommendations

- Expand SCI training programs and provide special incentives for SCI-qualified nurses and therapists.
- Designate an SCI GRECC.
- Establish a new SCI clinic.
- Fully fund the Independent Living Fund.

Cost

Additional $500,000; funding for the SCI GRECC included in extended care initiative.

Blinded Veterans' Programs

VA has pioneered comprehensive residential blind rehabilitation, establishing a tradition of excellence that has served as a model worldwide. Because the incidence of blindness increases dramatically with age, VA must re-examine blindness and its potential effects on veterans' lives as the veteran population continues to age. A conservative estimate of the current blind veteran population is approximately 93,000. By 2005, that number will reach 137,000. Among chronic disabilities of the aged, blindness is the third leading cause of dependency. VA must adequately support programs for blinded veterans to prevent these veterans from unnecessary and costly institutionalization.

Until recently, resource withdrawals compromised VA's reputation for high-quality treatment and rehabilitation for blindness. The centralized monitoring mechanisms VA has implemented for prosthetic services have helped VA restore the integrity of those programs and, in turn, for blind rehabilitation services.

Still, the aging veteran population has created a backlog of applicants for admission to rehabilitation programs. VA's nine blind rehabilitation programs, six blind rehabilitation centers and three blind rehabilitation clinics treated 1,136 veterans in fiscal year 1994. The average systemwide waiting time for these programs ranges from 10 months to a year. VA has set a goal to reduce these waits to 120 days and plans to activate one additional program in Tucson, Arizona, in fiscal year 1995, in an attempt to reach this objective. The need for services will be far greater, however, than the additional capacity this facility creates. VA should add operating beds to its blind rehabilitation programs through the creation of programs at additional facilities.

To meet growing demand, VA must also expand outpatient care services to eligible blinded veterans. VA pioneered the visual impairment services team (VIST), an innovative and effective program. Of the 98 VA medical centers that currently have these teams, only 90 have a full-time coordinator. A fully capable

[19]Angela Steven. "SCI Medicine." *Paraplegia News*. January 1994: 32-33.

100 VIST is the most effective means of identifying veterans who need blind rehabilitation training to live independently and avoid medical complications. The absence of independent living skills often results in greater dependence on VA, including acute hospital admission or nursing home placement. The *Independent Budget* recommends that each VA medical center with a VIST have a full-time coordinator.

VA should also use blind rehabilitation specialists in the outpatient setting to serve those veterans who either cannot access, or do not need, the intensive treatment of the inpatient programs. These specialists could be particularly useful at medical centers that do not operate dedicated blind rehabilitation programs. For some veterans, rehabilitation would be more effective if it were conducted in an outpatient setting that allows them to remain in the community. Outpatient specialists could also provide follow-up services to veterans who have completed their rehabilitation and have now returned home. Outpatient specialists, when used effectively, could reduce veterans' lengths of stay in inpatient settings and, thus, shorten waiting times for admission. This type of outpatient care could implement effective managed care techniques and provide a full continuum of care services to blinded veterans.

While outpatient specialists offer VA a means to enhance care for blinded veterans, they need special cross-training and increased supervision to meet the full spectrum of veterans' needs. Blind rehabilitation requires expertise in rehabilitation teaching and in orientation and mobility. Both types of skills require different certified training, although a few rehabilitation specialists have dual certification. Low-vision aids and devices represent another increasingly important area of expertise. Optimally, professionals who try to provide the full spectrum of services for their blind patients have some training in all these areas.

Blind rehabilitation is a special program in which VA has excelled beyond anything the private medical sector offers. And a blind rehabilitation program similar to that which VA provides is not likely to be included as a basic health benefit under any future reformation of the nation's health care system. Consequently, VA must plan to meet this need.

Recommendations

- Experiment with $5 million of funding earmarked in fiscal year 1995 to identify innovative and effective programs for blind rehabilitation.
- Add full-time VIST coordinators at the eight remaining medical centers with teams that lack them.

Cost

$500,000 for eight full-time VIST coordinators.

Education and Training

Education of health professionals is one of VA's four congressionally mandated missions. The VA medical care system is the nation's single largest medical professional educator. Annually, the VA system trains more than 100,000 students, in affiliation with almost all of the country's medical schools, all schools of dentistry and many nursing and allied health schools. While most of these graduates enter the private medical sector, many are recruited to VA staff.

The *Independent Budget* coauthors place great importance on the continued integrity of these affiliations. Each year, students in various health care disciplines rotate through more than 70,000 unfunded positions, and approximately 8,500 VA-funded medical resident positions are available for graduate medical education. During an average year, 35 percent of the nation's residents in training rotate through these billets. Conversely, VA medical centers, particularly the large tertiary care facilities, depend heavily on resident physicians for patient care. Not only do these affiliations improve patient care, through the years they have also been VHA's chief source of professional staff.

THE MUTUAL BENEFITS OF VA/ACADEMIC AFFILIATIONS

The mutual benefits to both affiliated partners have never meant more than they do today. Changes in health care delivery and the associated medical market dynamics challenge medical schools and their academic hospital centers no less than changes that affect the VA health care system. To adapt to the new health care environment, VA and its medical school affiliates must channel some of their talent and resources into

developing primary and long-term care, as their private-sector counterparts are doing. Managed care is also now prevalent in the private sector—experts estimate that capitated managed-care plans will eventually deliver at least 85 percent of health care in the United States. Academic medical centers and affiliated VA medical facilities will both be enmeshed in that competitive market.

Medical schools and their teaching hospitals are complex structures of tertiary care fragmented into high-cost academic departmental enclaves. Cost-competitive programs within these multidisciplinary "high-tech" centers can be difficult to achieve. Both structural and cultural problems must be overcome. Sensing that the future is going to belong to organizations that control the largest number of primary care physicians, many schools and academic medical centers across the country are restructuring to acquire primary care services and form integrated delivery systems. Even if they network successfully, the true test is whether they can compete on price.

Impeding academic medicine's ability to enhance its primary care capability is a protracted erosion of traditional sources of academic revenue. Congress continues to reduce Medicare appropriations for graduate medical education, and many payers, including the government, are reducing providers' payment rates. The private sector and the government are constraining the growth of research budgets. Medical schools cannot correct the problems, since tuition income has reached maximum levels and state legislatures are pressed for funds. Added to this is the likely prospect of reduced revenue from faculty practice plans as academic centers are forced to compete in the private medical market. A consensus is understandably building that academic medicine must have subsidized sources of support for education and research. In this environment, VA support for faculty salaries and resident stipends will be increasingly significant.

RESIDENT TRAINING PROGRAMS

Beyond 1995, graduate medical education (GME) could undergo significant alterations—changes that will profoundly affect VA. Congressional proposals and others' recommendations have addressed both the allocation and number of residents necessary to provide health care in the United States. One such proposal would limit the number of new residents. Some legislative proposals would also limit opportunities for specialty resident training, to create an equal ratio of primary care and specialty residents. The congressionally chartered Council on Graduate Medical Education and Physician Payment Review Commission each recommend that Congress direct federal Graduate Medical Education funds to those goals.

VA is responding to these trends and to the increasing need for VA primary care physicians as its care delivery system implements managed care. In July 1994, VA launched a multidisciplinary primary care training program (PRIME). The PRIME program provides grants to VA medical centers to support medical residents' and associated health professionals' training. Trainees work on interdisciplinary teams providing primary care to VA patients. VA's PRIME program supports primary care training for nurse practitioners and physician assistants and for residents in internal medicine and family practice. Forty-nine VA medical centers received the first round of grants to train 250 medical residents and 450 associated health professionals. In July 1995, 20 additional VA medical centers will receive grants totaling $20 million to train 370 residents and 600 associated health students. This innovative initiative has moved VA to the forefront of academically based primary care training; currently, 40 percent of VA resident positions are in primary care specialties.

Recommendation

Provide grants to five more medical centers for PRIME training program in fiscal year 1996.

Cost

$5 million.

RESIDENCIES AND FELLOWSHIPS IN HIGH-DEMAND SPECIALTIES

VA continues to need certain physician specialists as well as generalists. It must enhance resident training to meet its patient population's demonstrably high need for geriatrics, psychiatry, surgery (especially orthopedics and urology) and rehabilitation medicine. It must also augment the fellowship training program, which funds training for VA's future leaders in critical

102 VA medical areas, including substance abuse treatment, post-traumatic stress disorder treatment, female veterans health, ambulatory care, spinal cord medicine and geriatric neurology, psychiatry and dentistry.

The demand for geriatric services and VHA's requirement for geriatricians will grow as the veteran population ages. Veterans' median age will peak during the late 1990s, when two-thirds of all American men older than 65 will be veterans. VA's record and continued ability in providing graduate medical education in geriatric medicine are worthy of special note. In response to a growing need within the system, VA initiated post-graduate fellowship training in geriatrics in the late 1970s, independent of medical school affiliations. Through such organized efforts, VA has since expanded both knowledge in gerontology and the pool of personnel trained to care for older patients.

The output has also been an important resource for the larger health care community. As demand for training grew, many affiliated medical schools introduced geriatrics courses in their curricula and joined VA staffs to acquire board certification for the subspecialty of geriatric medicine. As a result, the private medical sector initiated residency programs, and VA converted its geriatric fellowships to residency programs—an important source of physicians who provide primary care to aging veterans.

Just as VA began to lead the nation a decade ago in training health care professionals in geriatrics, VHA now leads the nation in innovative approaches to incorporating high-quality ambulatory care education into medical residency training. Expanding VA's ability to provide education in areas such as ambulatory primary care will allow it to respond to the growing need for generalist physicians, while fellowships in other disciplines will help to satisfy the unique health care needs of veterans.

Recommendation

Provide funds to support residents and fellows in high-demand specialties.

Cost

$10 million.

THE TUITION REIMBURSEMENT PROGRAM

VA has successfully retained many registered nurses who attended school under this program, and the program is a positive recruitment tool. It is limited, however, to only nurses. VA must offer this type of program to other health professionals as well. We urge continued funding for at least 750 new participants, including employees in other health professions. This will require $1.5 million in funding.

Recommendation

Fund tuition reimbursement for nurses and expand the program to other health professions employees.

Cost

$1.5 million

SATELLITE TV PROGRAMMING

VHA increasingly uses its television network to provide field facilities with satellite television broadcasting on continuing education and management topics to approximately 50,000 employees annually. This live television programming uses a mix of in-house and contracted components. The IBVSOs support expansion of VHA's capacity to use satellite TV programming for the cost-effective and timely presentation of clinical training and management messages.

Recommendation

Provide funding for expanded satellite television educational programming, requiring 15 FTEEs.

Cost

$2 million

CAREER FIELD AND SERVICE CHIEF DEVELOPMENT

Although VA needs continued funding to ensure the professional growth of senior administrative and clinical chiefs, Congress denied the fiscal year 1992 request for specific funding. We repeat, as a high priority, a request of $10 million, which will provide 20,000 units of training.

Recommendation

Provide 20,000 units of training for service chiefs.

Cost

$10 million.

AIDS-RELATED TRAINING

VHA must continuously train health professionals who work with AIDS-infected veterans. This training gives caregivers the knowledge they need to manage this special class of patients properly and avoid the risk of contracting this fatal disease.

Recommendation

Provide funding for AIDS-related training.

Cost

$3 million.

Human Resources Development

To remain an important part of the future health care delivery system, VA must change from an inpatient-focused medical system to an outpatient-focused health care system. Current dynamics in the health care industry dictate that such change in VA orientation must occur sooner than later. This requires a dramatic shift of program emphasis and conversions in the medical care mission of facilities nationwide. VA's dedicated staff will have to shoulder much of the burden of short-term transitions that will, it is hoped, make VA a faster, friendlier and more flexible institution in responding to its patients' needs. To achieve this goal, VA must try to recruit more generalized physicians and midlevel professionals to supplement those already on staff.

NURSES

Nurses are a critical component of the VA clinical staff and account for almost 45 percent of its direct care workforce. Their services are invaluable to the system; VA has made commendable efforts in improving its nursing supply by adjusting pay scales and otherwise enhancing benefits. While nurses still have concerns about salary compression and pay retention, they have won a large victory in the enactment of the *Nurse Pay Act of 1990* and its subsequent amendments.

Nurses—especially advanced practice nurses—are critical to enhancing primary care. Nurse practitioners are capable, under supervision, of delivering much primary and preventive care, thereby supplementing physician services. Because of increasing demand, general practitioners will be scarce in the medical labor market in the short term. It therefore makes economic sense for VA to recruit nurse practitioners to complement its general practitioner services.

Recommendations

- Continue to monitor the implementation of amendments to the *Nurse Pay Act* and problems in salary compression and pay retention.
- Recruit nurse practitioners to supplement primary and preventive VA providers.

Cost

None (VA needs authorization to increase staff ceiling; balancing services toward primary care may free some other staff positions).

PHYSICIANS

VA relies on several sources for its physicians. First, it hires its own physicians. VA physicians, like nurses, have won better salaries and benefits in recent years. These achievements, plus opportunities for research and frequent interactions with academia, have given VA a more competitive recruitment tool.

Second, VA enjoys support from academic affiliations. Medical students, interns and residents receive training in VA medical centers. Since the 1940s, the VA/academic affiliates partnership has successfully provided academic affiliates education and research opportunities and brought to VA physicians-in-training who provide inexpensive, high-quality services to supplement VA's physician workforce.

Third, VA issues contracts with private-sector physicians. Providing medical malpractice insurance for these physicians while they are practicing in VA is a major expense for VA, yet it is necessary to recruit successfully such specialty personnel as neurosurgeons, orthopedic surgeons, radiologists, anesthesiologists and psychiatrists. Congress needs to extend to contract physicians, practicing in VA facilities, the same legal protection that VA physicians receive; this will enhance VA's ability to recruit contract providers. Such protection will not leave veterans without a legal forum for tort claims. Benefits accrue to VA and the veteran patient. Extending this protection reduces the expensive tendency toward defensive medicine and can also save millions of dollars on the costs of malpractice insurance VA must now pay for covering con-

104 tract physicians. With more successful contract arrangements, veterans can have more ready access to the services they need.

VA must monitor closely its interactions with the academic affiliates to ensure that the partnership that has successfully existed for so long can continue. As VA converts missions and restructures facilities and services, it must continue to enjoy the support of its medical community. VA's restructuring may involve recruitment of different types of physicians. VA will certainly need more generalists as it becomes increasingly involved in primary and preventive care. VA undoubtedly will need to offer retraining to certain physician specialists, whose expertise exceeds system needs and who are anxious to qualify as generalist physicians. Such training requires an average curriculum of one year. Ideally, VA could offer retraining as a physician recruitment tool.

Recommendations

- Extend tort claim protection to VA-contract physicians when treating VA patients.
- Reprogram staff requirements to emphasize primary and preventive care needs.
- Offer generalist "retraining" to specialists as a recruitment tool.

Cost

Primary care training for physician specialists included in education and training initiatives for PRIME program.

DENTISTS

Every dental school in the United States is affiliated with at least one VA medical center. Currently, several dental schools are pursuing consortia arrangements with VA medical centers to give veterans access to services at a dental school clinic or university hospital that might not be available at a VA medical center.

Demonstration projects would provide incentives to develop consortia—such as allocation of new residency positions that VA and affiliated dental schools would share. Such residency support would improve care and enhance opportunities for VA dental research. Such support is critical to training primary care dentists—those with a generalized focus who can provide a broad array of services to veterans and function within the primary health care team.

Recommendations

- Continue to strengthen VA-dental school affiliations and seek opportunities for sharing resources and facilities with dental schools.
- Provide 50 dental residency stipends.

Cost

$1.25 million for 50 dental residency stipends.

PHYSICIAN ASSISTANTS (PAS)

VA is the nation's largest employer of physician assistants (PAs); it employs some 1,000 of the nation's 21,000. PAs are trained to provide much of the care physicians traditionally performed, including triage and diagnostic work. They may write certain prescriptions under a physician's supervision. They also provide administrative support. VA utilizes PAs to comply with Accreditation Council for Graduate Medical Education (ACGME) standards. Generally, VA and other providers increasingly view PAs, like nurses, as appropriate and cost-effective alternative care staffing to complement physician staff.

Unfortunately, VA has neglected its physician assistant workforce. Congress enacted pay grades and certification criteria for VA's physician assistants in 1978, but has not amended them since. As competition for alternative care sources grows, VA's problems with PA recruitment and retention are increasingly evident. There has been a 16 percent turnover in the last two to three years, and the vacancy rate has climbed from between 2 and 3 percent to between 8 and 9 percent in the same period.

Recommendation

Take steps to ameliorate retention problems and to improve recruitment of physician assistants by implementing more acceptable pay.

Cost

Requires new legislation to amend PA pay grades.

Information Resources Management

The IBVSOs' recommendations regarding information resources management are based on an appreciation of the strength and flexibility of the information systems VHA has developed over the last decade. The decentralized hospital computer program (DHCP) is firmly established as VA medical centers' information base. The DHCP's user-designed, modular approach has enabled innovative staff throughout VA to install flexible, cost-effective information systems. Ongoing development of new clinical modules and DHCP's extension via the Hybrid Open Systems Technology (HOST) to include off-the-shelf software provide a solid basis for continuous improvement.

No technology is expanding as rapidly as information technology, and VHA must continually upgrade its systems to keep up with changes in medical practice, health care delivery systems and health care financing. The emerging themes of the evolution of health care in the 1990s—telemedicine, video-imaging, managed care, outcomes measurements, cost-containment and quality evaluation—will drive demand for information. VHA can build on its strong foundation in clinical information systems to develop the integrated, patient- based systems it needs to provide efficient, high-quality health care for veterans.

VA needs new types of information support for preventive care and care in alternative settings. It also needs data-driven decision support processes, both in the clinical and management areas. Front-line health care professionals must have clinical decision support that is patient-specific and that includes information on preventive services, health care reminders (which flag individuals who periodically need certain types of care), therapeutic options and costs.

VA must establish an information network that positions VA medical centers for success in the post-health-care-reform arena. This network must serve VHA's patient care, educational, research and DOD contingency missions by allowing appropriate sharing of patient record and multimedia information among VA medical centers, private care providers and billing institutions. This network must have a future growth path and serve current needs. VA managers cannot make informed treatment, quality and business practice decisions without an adequate information network. 105

Currently, VHA spends about 2 percent of its budget on information, while the private sector typically spends 4 percent. Steady growth of the DHCP calls for more Information Resources Management (IRM) staff at the facility level. New information system functions will require more staff to maintain new programs, train hospital staff, and install and maintain computing equipment. As medical centers add more clinical modules, uninterrupted IRM support becomes critical to round-the-clock patient care. Productivity at VA's information service centers (ISCs) has driven the DHCP's steady expansion. Facility directors must budget sufficient resources to their IRM departments, to fully utilize available tools.

As VHA reorganizes to give local network and facility directors more flexibility to adapt to local needs and opportunities, it must centrally establish and monitor information collection and reporting standards to ensure veterans of consistent service nationwide. VHA patients must be able to use all VA facilities with the certainty that their records are available and current, wherever they go. Yet with local flexibility goes local responsibility. State-of-the-art information systems, therefore, are essential to the re-focused corporate culture that follows decentralization.

In the short term, medical information resources management should focus on developing VHA's telecommunications infrastructure. Integrated service networks imply integrated information systems, which depend on telecommunication systems to move data and information. VHA cannot implement the Automated Patient Record, an essential tool for efficient patient management in a managed-care network, without a high-capacity telecommunications network. To keep up with advances in medical computer applications, all VA facilities need fiber optics cabling. Most VA hospitals have installed fiber optics to provide the wider bandwidths necessary to support digital image transmission. VA should install this capability in all new construction and major renovations.

Congress should support VA efforts to modernize its basic, 15-year-old technology, upgrade its networking capability, and provide adequate support

106 infrastructure at VA medical centers. VA should invest in VA medical centers' infrastructure to provide adequate IRM support that enables the Department to compete in the health care market. VA should upgrade networking capability at VA medical centers so that they can exchange patient data with other VA medical facilities and private care providers. VA should upgrade the basic technology at VA medical centers, to include workstations that implement decision support tools.

Recommendation

VA should invest in its medical system's information infrastructure, adding $100 million annually during fiscal years 1996 through 2000.

Cost

$100 million in FY 1996.

There is broad consensus on the goals for VHA information systems development. While progress depends on adequate funding, dollars are not the only resource necessary; people—skilled programmers and technicians—are a critical resource. In the last year, VHA has been unable to take advantage of available private-sector funding for information systems development and support because of FTEE ceilings. VA cannot spend funds designated for special projects, whether funding comes from congressional appropriation, transfer from other government agencies, or contributions from veterans' service organizations, because it cannot hire and train qualified personnel quickly or terminate them when projects are completed. Congress should authorize the establishment of a nonprofit foundation, modeled on the nonprofit VA research merit foundations Congress established in the late 1980s, to provide a mechanism for applying non-appropriated funds to develop and market software.

The research foundations, located at major VA medical centers, attract and spend more than $40 million in non-appropriated funding to support VA research and collateral patient care operations. Like the VA research foundations, an "information services" foundation would be subject to the Inspector General's review, annual audits, IRS regulations and applicable state laws. Such a foundation would give VHA information services managers flexibility to add additional manpower when funding for special projects becomes available and to release those people when the work is done. The foundations should also develop new applications for VA information systems and Congress should allow them to market these applications.

Recommendation

Congress should authorize the establishment of a nonprofit VA information services foundation, to facilitate the application of non-appropriated funding to VA information systems development and to market VA information system technology, thereby generating non-appropriated resources for VA information resources development.

Pharmacy Initiatives

In fiscal year 1994, VA spent more than $881 million on pharmaceuticals. VA's 229 pharmacies filled more than 62 million outpatient prescriptions for veterans; this represents a 9.5 percent increase over the fiscal year 1993 outpatient workload. VA mailed almost 60 percent (or 36 million) of these prescriptions—a 10 percent increase over the fiscal year 1993 mail prescription workload. Many of the prescriptions mailed (more than 7 percent) contained more than a one-month supply. Counting these multi-month prescriptions, VA's fiscal year 1994 workload actually increased 24 percent over fiscal year 1993 levels.

VA has also completed implementation of the pharmaceutical unit dose distribution system, a long-time *Independent Budget* objective. Unit dose distribution is now the practice standard for inpatient VA medical care.

VA is also securing access to its pharmaceutical supply. Inventory control processes using barcodes and dispensing accountability will manage access to controlled substances within pharmacies and patient care wards. In FY 1995, VHA will also begin to implement an inpatient automated inventory of controlled substances and documentation of medication administration with hand-held radiofrequency devices that interface with the facility's computer system.

A recent GAO report stated that VA could save as much as $34 million annually by reducing the number of mail service pharmacies and modernizing remaining

ones. VA is making some progress in implementing improvements. It has selected six pilot sites to implement the Consolidated Mail Outpatient Pharmacy; three of these sites have already begun operation. VA will evaluate productivity and quality improvements before it selects more sites. The *Independent Budget* supports VHA's plan to consolidate its pharmacies.

Recommendations

- Complete consolidation of VA mail service pharmacies.
- Complete improvements in inventory control for controlled substances.

Cost

No additional funding recommended

Equipment

Funding to eliminate the equipment backlog is one of VA's most critical needs. VA currently estimates the backlog at about $870 million. VA has pledged to fund retirement of this backlog through a 10 percent annual reduction of the backlog VA estimates at the end of the year. Congress's inconsistent and inadequate "add-ons" to reduce the backlog, however, do not fully address VA needs.

The *Independent Budget* addresses equipment funding in several places, reflecting VA's own budgeting practices. Recommendations for the facility activations account include funding for "new" capital equipment, for example. The IBVSOs, however, recommend eliminating the equipment backlog through a funding initiative. Setting priorities for equipment purchases should reflect the health care environment's new orientation toward primary and preventive health care services and more collaborative service delivery. VA must critically assess high- tech, high-cost equipment needs to determine how they will improve VA health care. VA must balance these incentives for creating a system less centered on tertiary care, with its need to be "state of the art" to compete effectively. We suggest that VA re-evaluate its equipment purchase priorities, keeping in mind the emerging trends in the health care environment, and create a list for public scrutiny of the backlog and its cost. We continue to suggest an annual increment to retire the $870 million backlog within five years.

Recommendation

Retire a newly established equipment backlog priority list within the next five fiscal years.

Cost

Add $173.8 million annually in fiscal years 1996 through 2000.

Non-Recurring Maintenance

The non-recurring maintenance and repair backlog still stands at approximately $800 million, according to VA. This backlog reduces VA hospital directors' ability to maintain their physical plant. The inability to deal appropriately with infrastructure alienates VA users and potential users and jeopardizes patient safety and quality of care. It also promotes a negative image of VA. Incidents such as broken elevators trapping patients and failure to meet JCAHO safety standards are legend at VA medical centers, counteracting all the system's positive outcomes. The physical plant will eventually need repairs, modernization, beautification and amenities, including paint, wallpaper and window treatments, comparable to private-sector facilities. VA must maintain its plant or risk patients' safety, staff morale and the system's image

VHA plans to fund non-recurring maintenance for a 5 percent reduction in the backlog annually. The *Independent Budget* authors suggest an annual increment to retire the $800 million backlog within five years. This amounts to $161 million annually during fiscal years 1996 through 2000.

Recommendation

Retire the non-recurring maintenance backlog within the next five fiscal years.

Cost

$161 million annually in fiscal years 1996 through 2000.

Medical Care Cost Recovery

In the nine years since the Medical Care Cost Recovery program's authorization, VA has significantly improved its third-party payment collections for treatment of non-service-related disorders in VA. This funding is substantial and growing. VA projects that, in fiscal year 1995, it will be able to collect $668 million. Still, VA officials suggest that this funding

108 reflects only a portion (approximately 80 percent) of the full collection potential under current authority.

The veterans' community continues to believe that this funding, collected from veterans for their care, should remain in VA. Congress must identify new sources of VA funding, since VA's access to increasingly limited discretionary funds does not appear to be improving. Allowing VA to retain funding it is already authorized to collect encourages VA collection efforts. It also allows the VA medical care system to shift some costs of its care onto other payers. VA could redirect collections for non-service-related care to provide unanticipated care for veterans without insurance. This mirrors a common private-sector practice that VA has not had the opportunity to exploit.

VA has additional opportunities to enhance its sources of revenue. It treats many higher-income veterans who are eligible for Medicare. VA should be able to receive Medicare reimbursement for veterans in its lowest eligibility category, to cover the costs of their care. Medicare provides such reimbursement to private-sector providers if higher-income veterans choose to receive services there and VA can provide a fuller health service spectrum to veterans for less than Medicare would realize in the private sector. Congress should not view this funding as duplicative, since VA is only funded to meet the needs of veterans in the highest eligibility categories. The Secretary must determine whether VA has the space and resources to treat higher-income veterans. VA is not currently authorized to collect Medicare funds, but the *Independent Budget* reasserts, as we have in past years, that Congress should grant VA this authority.

Because VA now provides care to higher-income veterans on a space- and resources-available basis, many of these veterans are denied care. If these higher-income veterans could cover their care costs and VA could collect and retain their payments from any source—Medicare, third-party payers or copayments—rather than denying their care, veterans and VA would benefit. Veterans would have new-found access to needed care, and VA would enjoy a new funding source, which might buffer the system from funding shortfalls it experiences.

In the same regard, opportunities could exist for VA to provide care to veterans' adult dependents. If Congress authorized treatment of dependents who have third-party coverage (at the discretion of the local hospital administrator), VA could provide care to more patients at no additional federal cost. Veterans and their families would also enjoy the convenience of sharing the same care provider, which would increase veterans' loyalty to the system as the external health care community is offering competitive choices. Options for dependent coverage could be particularly attractive to veterans in rural areas where VA is the community's sole provider.

The IBVSOs are not relieving Congress of the responsibility to appropriately fund VA medical care. Even in these fiscally austere times, Congress must give top priority to delivery of health care to veterans who have earned it through service to their country. Rather, facing the reality that discretionary funding is becoming increasingly limited, we are seizing opportunities to treat more individuals at no additional cost to the system.

Treating veterans' dependents also benefits the system. It makes VA more competitive in local markets, because it allows families to use the same care provider. It diversifies VA's patient mix, which benefits veterans by allowing clinicians to practice their skills and thus maintain program quality. It brings in appropriate workloads to justify VA programs, particularly women's health, that might otherwise be more cost-effectively provided on a contract basis. Granting VA new authorities to collect funds allows it to increase workload, competitiveness, quality, veterans' access to care and revenues—a winning proposition for all involved.

Recommendations

- Authorize VA to retain all payments collected from veterans' insurers for the treatment of non-service-related disorders.
- Authorize subvention of Medicare funds for higher-income veterans.
- Authorize VA to collect and retain all funds from all external payers, including Medicare, private insurers and veterans' copayments, for treatment of higher-income veterans without appropriation offsets.

- Authorize VA to treat veterans' dependents, at the dependent's expense and the discretion of the local hospital director and to the extent that veterans' access to care is enhanced.
- Authorize VA to collect and retain all funds from all external payers, including Medicare, private insurers and veterans' copayments, for treatment of veterans' dependents without appropriation offsets.

Cost

Requires budget authority of $2.9 billion (please see Appendix A for details).

Medical and Prosthetic Research

Total research funding continued to plummet as a percentage of overall Medical Care dollars. The Office of Management and Budget routinely rejected even moderate increases the Department proposed in annual budget negotiations. Research managers had to defend their programs against the lingering unfounded perception that research is a "luxury" in a VA strapped for dollars, instead of being vital to maintain a high-quality health care system for veterans.

In the FY 1994 appropriation, Congress attempted to "stem the tide" by raising funding by $20 million to $252 million. FY 1995 budget pressures, however, forced appropriators to straightline research funding once again at that same amount. The FY 1995 level was $76 million below the current services mark ($328 million) that the *Independent Budget* set for that year. The *Independent Budget* research recommendations are based upon the recommendations of a blue ribbon commission appointed by President Ronald Reagan to determine clear goals for VA research and set parameters to achieve those goals. The commission recognized that VA research had been sorely underfunded. It recommended a sizeable increase in research funding, to a base of $280 million for FY 1992. The initial Reagan Administration Commission recommendation for that year was $53 million higher than the actual appropriation. Despite annual adjustments by the Congress each year, appropriations have never been close to the $280 million recommended by the Reagan Administration blue ribbon commission. When the *Independent Budget* raised the commission's initial recommendation each year to reflect increasing costs and inflation for FY 1993, FY 1994 and FY 1995, the gap has only widened.

Deteriorating research budgets have shaken the research community's confidence in VA as a stable resource that combines clinical practice and high-quality investigation.

TABLE 17

Comparison of VA Budget And Blue Ribbon Research Commission Recommendations

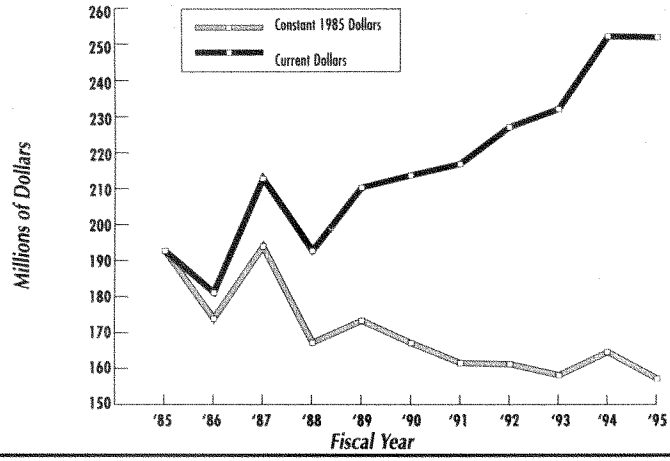
Fiscal Year 1992	
Recommendation-Blue Ribbon Commission	$280 million
Actual Appropriation	$227 million
Shortfall	($53 million)
Fiscal Year 1993	
Independent Budget Recommendation	$303 million
Actual Appropriation	$232 million
Shortfall	($71 million)
Fiscal Year 1994	
Independent Budget Recommendation	$317 million
Actual Appropriation	$252 million
Shortfall	($65 million)
Fiscal Year 1995	
Independent Budget Recommendation	$328 million
Actual Appropriation	$252 million
Shortfall	($76 million)

Severe budget pressures on overall VA health care funding have taken their toll on research. Deteriorating research budgets have shaken the research community's confidence in VA as a stable resource that combines clinical practice and high-quality investigation. This demoralization has seriously undermined the two primary objectives of the research program: award-winning clinical research in VA's 171 medical centers; and, its ability to attract and retain health care professionals of the highest calibre to care for the veteran patient.

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CHART 10

VA Medical and Prosthetic Research Appropriated Funding FY 1985 to FY 1995



The Program and Its Challenges

VA research activities are divided into three divisions: Medical Research, Rehabilitation Research and Development, and Health Services Research. Rehabilitation research and health services research are the smaller of the three entities and yet have received moderate increases over the past ten years. The major shortfalls have occurred in the Medical Research account, which forms the core of VA research operations.

As shown in Chart 10 "Appropriated Funding FY 1985-1995," the ten-year trend based on FY 1985 constant dollars shows a net loss in total VA research purchasing power. The medical research account shows a minuscule 14 percent increase in 1995 dollars, but actually suffered a 29 percent loss after adjusting for inflation from 1985 constant dollar levels. The number of funded medical research programs fell by 20 percent (from 1,948 to 1,577 programs) between 1990 to 1995 alone.

TABLE 18

VA Research and Development Appropriations 1985-1994

Dollars in Thousands

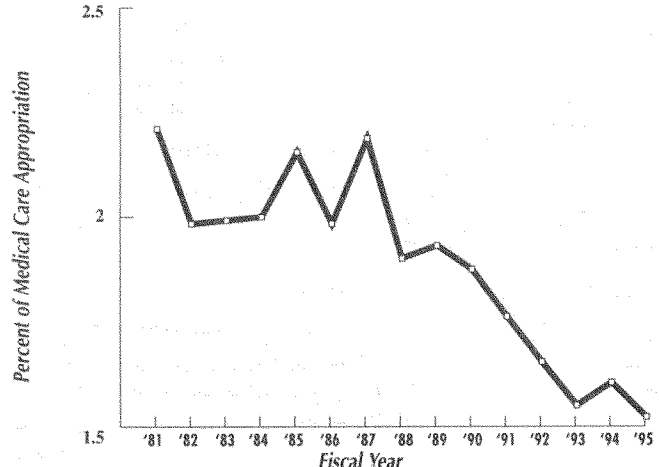
	1985	1990	1995	1985-1995 % Change
Total	$192,695	$213,652	$251,743	31%
Medical Research	$170,983	$182,734	$194,300	14%
Rehabilitation Research and Development (RR&D)	$ 15,277	$ 21,664	$ 25,475	67%
Health Services Research and Development (HSR&D)	$ 6,435	$ 9,254	$ 31,968	397%

VA/DOD Cooperative Research Funding

This deterioration has occurred despite additional appropriations up to $30 million per year to support VA research through the Department of Defense

CHART 11

Appropriated Medical and Prosthetic Research as a Percentage of the Medical Care Budget



Source: Budget of the U.S. Government

research and development account. Each year, the VA/DOD Cooperative Research program faces an uncertain political future. Initiated by Representative G.V. (Sonny) Montgomery (D-MS), the fund requires separate authorization and appropriation actions in the House and Senate and separate battles each following year to save it from being rescinded. The VA/DOD funding for FY 1996 could face its most serious challenge yet from a Congress determined to cut overall spending yet raise defense spending at the same time. Losing the VA/DOD account this way in 1996 would eliminate at least 130 research programs.

The Value of VA Research

Research is a major component of the VA health care system. Opportunities to conduct research with direct clinical application in VA, the nation's largest federal health care provider, attract hundreds of the nation's most qualified physicians to the system each year. Successful VA research grant applicants must commit themselves to serving five-eighths to full time in VA medical facilities, using their expertise and professional experience for the direct benefit of the veteran patient. Of equal importance, award-winning VA clinical research gives veterans access to the most innovative technologies and treatments available today on the most cost-effective basis imaginable.

VA Research: Facing a Changing National Health Care System

Despite the failure of sweeping national health care reforms in 1994, federal, state and private health systems are scrambling to reinvent themselves. Pressures of skyrocketing health care costs and shrinking access are forcing changes in health care delivery unheard of ten years ago. VA too will have to reduce costs to compete effectively. But it should not do so at the expense of its primary missions. Specialized services, such as spinal cord injury medicine, advanced rehabilitation and prosthetics, are at the core of VA's responsibility to meet veterans' unique needs. VA's substantial contribution to health professionals education

112 and its research base are also specialized missions. They render the system a unique player, and not just another competitor, in the nation's health care enterprise.

Serious erosion has already undermined research contributions to VA medicine (see Chart 11). In 1981, the VA research appropriation was just over 2.2 percent of the total health care budget.

> Specialized missions such as research give VA a unique niche to advance the quality of its medicine and overall health care for veterans.

In FY 1995 that percentage fell to 1.6 percent. By comparison, corresponding private sector medical systems strive to allocate 5 percent of medical care costs to research to maintain a competitive standard. Yet, the call to manage care and restrain costs forces many health systems, including some health maintenance organizations, to discount research and medical education altogether. With the drive to decentralize and streamline its operations, Congress and VA should not succumb to the allure of "bottom-line" medicine. It should recognize that specialized missions such as research give VA a unique niche to advance the quality of its medicine and overall health care for veterans.

Why Is VA Research Unique?

Historically, VA research constitutes one of the Department's most distinguished chapters. The contributions VA research has made to medical knowledge and the health and welfare of the American people have returned many times over the public's original investment. Contrary to a common misperception, VA research does not duplicate the National Institutes of Health mission product. On the other hand, a great deal of NIH research is conducted at VA. VA research is clinically based and derived directly from the veterans' health problems. While only 25 percent of NIH funded researchers are clinicians, more than 80 percent of VA researchers see VA patients daily. The other 20 percent of the research force are generally Ph.D.'s who support direct patient care.

VA RESEARCH ACCOMPLISHMENTS

In over 50 years, VA research has won two Nobel Prizes, claimed victory over tuberculosis, and pioneered transplant technology and nationally recognized breakthroughs in prosthetic technology, rehabilitation science and health systems innovation. Among other research accomplishments, VA is well known for having achieved the following:

- Development of the cardiac pacemaker and the nuclear-powered cardiac pacemaker;
- Development of the CAT scan;
- Development of magnetic resonance imaging (MRI);
- Development of radio-immune assay techniques (Nobel Prize);
- Development of the nicotine patch;
- Discovery of carcinogenic viruses;
- Development of the "smart" wheelchair, robotic limbs and the laser cane for the blind;
- Discovery of peptides manufactured in the hypophysis that control body functions (Nobel Prize).

SCOPE OF CURRENT RESEARCH

VA award-winning research targets specific diseases and disabilities prevalent in the veteran population. Highlights of current scientific investigation include the following:

Arthritic Diseases

VA treats more than 37,000 veterans each year for symptoms related to the musculoskeletal system. VA sponsors a wide variety of biomedical, health services and rehabilitation research to address such disorders. In total, 171 projects are funded with $6.9 million, and another 189 investigators work on projects without funding.

Cardiology

In 1993, 118,391 veterans received treatment in VA medical centers for various forms of heart disease. More than 70 million Americans have cardiovascular diseases. In total, $39.4 million funds 955 VA investigators conducting cardiology studies, and another 1,356 VA investigators are working on cardiology research projects without current funding.

Diabetes

Diabetes affects 13 million Americans and costs $23 billion annually. The most common form of diabetes occurs in older adults. The population older than 65 will grow from 31 million in 1995 to over 60 million by the year 2025. In total, $14 million funds 325 VA investigators pursuing diabetes studies. Another 294 VA investigators are working on diabetes-related research projects without current funding.

Aging

Research in aging is difficult to define, because aging is not a disease but rather a stage of life. There are currently 7 million veterans aged 65 years or older. That number will swell to more than 9 million by the year 2000. The effects of aging are inherent in research on any disease group VA considers. More than 150 individual-investigator-initiated research projects on aging are currently underway by VA investigators, in addition to VA's unique Geriatric Research, Education, and Clinical Centers (GRECCs), which are funded separately.

Alcohol Abuse

The cost to society of alcohol abuse is estimated to be above $100 billion annually. In total, 1,261 projects are funded with $21.7 million, and another 339 investigators work on projects without funding. VA has also established three special centers to study problems related to alcohol abuse.

The size and uniform management structure of the VA system present major opportunities for research to conduct broad-based clinical trials and cooperative studies. The unique nature of the system provides an exceptional health research platform to assist the nation in finding ways to curb runaway health care costs and improve the quality of care.

The Myth of Extramural Funding

Opponents of adequate funding for VA research complain that increased research appropriations would strain already finite health program budgets. They theorize that VA research does not actually suffer when the VA research line item stagnates or falls, pointing to the considerable extramural funding VA research attracts from other federal agencies and private sources. Indeed, in FY 1992, VA researchers obtained $250 million from the National Institutes of Health, other federal agencies and the private sector. Extramural funding rose to $271 million in FY 1994. The VA Non-Profit Research Foundations should attract more than $40 million in private-sector funding to support research in FY 1995.

Those research dollars, however, would not have come to VA if researchers had not already been eligible for and receiving VA research dollars and work at VA. Increases in extramural funding have barely kept pace with research inflation rates, while VA research opportunities continue to drop. Although NIH budgets have doubled over the past ten years, the percentage of VA researchers conducting NIH-funded research in VA medical centers has declined since 1991. Extramural funding can never compensate for the core VA funding needed to keep a VA research program alive. Shrinking VA opportunities encourage researchers with NIH funding to take their research, their research dollars and the services they provide to veterans elsewhere.

Challenges for the Future

Recommendations

Establish New "Blue Ribbon" Research Commission: Upcoming major changes in VA management, structure and eligibility should require that VA conduct a new overview of all its research capabilities and missions similar to the previous blue ribbon commission mandate. The national trends toward primary care, systems analysis, outcomes research and health care guideline development should provide VA exciting opportunities to expand its significant contribution to health care in these and many other areas. A new commission should prescribe a mission for VA research that will complement the changing nature of VA health care, changing veterans needs and medical science's changing expectations. Importantly, the new commission, like its predecessor, must identify the resources needed to accomplish its recommendations.

Until the new commission's recommendations are available, the *Independent Budget* recommends an incremental approach to FY 1996 funding to eliminate the current disparity between actual appropriations and the previous blue ribbon commission's recommenda-

114 tions. As described above, FY 1995 funding, which was $252 million, was $76 million below the FY 1994 inflation-adjusted blue ribbon commission recommendation of $328 million. Based on our adjustment criteria from previous years, the FY 1996 *Independent Budget* recommendation will rise to a current services level of $336.6 million. Even if that shortfall could be overcome in a one-year appropriation increase, VA would be hard-pressed to expend those additional dollars efficiently on currently available quality research programs.

The *Independent Budget* recommends that the FY 1996 research budget level be achieved in three increments. The first installment, which Congress should appropriate for FY 1996, should include an increase of $38.2 million, raising overall current services research funding to $290.2 million. The second and third installments, each $23.2 million, should raise total current services funding to $313.4 million in FY 1997 and to $336.6 million, the ultimate goal, in FY 1998. The three-year incremental increase approach should also allow the Secretary of Veterans Affairs and the Under Secretary for Health the time to appoint and receive the recommendations of the new commission on research. It would give VA time to gauge the new research advisory commission's program analysis and recommendations on how VA research should best realign itself to satisfy the needs of a reorganized VA health care system—and, what that will cost.

In addition, the *Independent Budget* recommends funding as follows for research initiatives as shown in Table 19 to address special needs within the veteran population.

TABLE 19

Research Initiatives for Veterans' Special Needs

Aging Initiatives	$5 million
Women's Issues	$4 million
Spinal Cord Medicine	$1 million
Persian Gulf Syndrome	$10 million
Total	**$20 million**

With the $20 million for additional targeted research, the total *Independent Budget* recommendation for FY 1996 is $310 million, $58 million higher than the FY 1995 level.

Medical Research

Opportunities to pursue medical research have never been greater, especially in molecular biomedicine. VA medical research has vast application to the full spectrum of contemporary basic science and clinical investigation. The *Independent Budget* recommends $234 million for FY 1996, an increase of $40 million over the FY 1995 level.

Rehabilitation Research

Rehabilitation research applies advances in engineering, computer science and material technologies to create new devices and techniques that help severely injured or disabled veterans maintain their independence and mobility. The *Independent Budget* recommends $34.5 million for Rehabilitation Research in FY 1996, a $9 million increase over FY 1995.

Health Services Research

Health services research is directed toward improving the VA health care delivery system's effectiveness and efficiency. It includes outcomes research and the evaluation of patient management and health care delivery systems. Reorganization and realignment of the VA health care system in light of major restructuring in national, state and private health systems will provide great opportunity for VA to maximize its health services research capability. The primary goal for this research should be the development of practice guidelines, parameters and outcomes, to maximize efficiency and quality within a changing VA health care system. The *Independent Budget* recommends $49 million for Health Services Research and Development in FY 1996, a $9 million increase over FY 1995 levels.

TABLE 20

Medical and Prosthetic Research

Independent Budget Recommended Appropriation

FY 1995 Current Services Level	**$328,583,000**
FY 1996	
Payroll Related Increases	
Retirement Programs	(92,000)
Annualization of 1995 Pay Raise	556,000
Annualization of 1995 Federal Employee Health Benefit Program	107,100
Pay Raise 1996	1,906,016
Federal Employee Health Benefit Program 1996	256,000
Within Grade Pay 1996	305,000
Inflation	4,991,000
Total Appropriation to be Achieved in 3 Increments in FY 1996, 1997 and 1998	**$336,602,000**
FY 1995 Congressional Appropriation	**252,000,000**
FY 1996 Incremental Funding Recommended	**38,200,000**
FY 1996 Recommended Current Services Level	**$290,200,000**
Special Initiatives	20,000,000
FY 1996 Recommended Appropriation	**$310,200,000**
FY 1997 Recommended Current Services Level	**$313,400,000**
FY 1998 Recommended Current Services Level	**$336,600,000**

Medical Administration and Miscellaneous Operating Expenses (MAMOE)

The Medical Administration and Miscellaneous Operating Expenses (MAMOE) appropriation supports a current Central Office FTEE level of 804. This appropriation supports clinical and administrative services within VA Central Office (VACO). The largest of these is the recently reorganized Office of the Associate Chief Medical Director for Construction Management, which is currently authorized an FTEE level of 249. Represented within MAMOE are all hospital-based services; ambulatory care services; environmental medicine and public health services; rehabilitation and prosthetic services; nursing, medical research and education programs; and such administrative services as medical information resources, management support and the medical care cost-recovery program. Within MAMOE are also legislative activities, public affairs, external relations, sharing and emergency preparedness planning.

MAMOE's wide-ranging functions cover the management spectrum from policy development to operational issues and oversight, including quality assurance and credentialing. This diverse spectrum of activities and responsibilities has yielded both praise and criticism for those whose salaries this appropriation pays.

The MAMOE appropriation has decreased dramatically over the past decade, while, at the same time, Congress has charged it with managing a broad array of new program initiatives. Between FY 1982 and FY 1992, VHA staffing in Central Office declined from a high of 866 FTEEs to 531 FTEEs, for a reduction of almost 40 percent. During this same period, resources for such activities as travel for oversight purposes, training, education, contracts, consultants and equipment decreased. Yet, with the addition of a fourth major mission (to provide contingency support to the Department of Defense) and the addition of major programs in support of AIDS and the homeless, demands upon MAMOE have increased. VHA studies also identified 13 existing functional areas as having increased management and oversight needs. The programs identified were blind rehabilitation, resource planning, the medical inspector, prosthetics, quality management, supervision of house staff, credentialing and privileging, field operations, management evaluation, technology assessment, patient satisfaction and consumerism, sharing analysis and total quality management.

The IBVSOs commend the Office of Construction Management's innovative leadership for its far-reaching and thorough analysis of the management and budgetary problems facing the Veterans Health Administration. This office's reorganization is a major step toward achieving the customer focus and responsiveness a competitive health care system requires. Potential benefits of this reorganization are the creation of interdisciplinary teams that will comprise a single contact for major construction projects, the establishment of a single manager for the Veter-

116 ans Benefits Administration and National Cemetery System major construction projects, the elimination of two levels of middle management, the creation of a quality support office to ensure quality management and a renewed organization-wide commitment to customer service.

The Office of Construction Management serves VA's Central Office well as a model for streamlining processes and increasing operational efficiency. While certain areas within Central Office remain understaffed, some areas need to be more efficient, to allow the Under Secretary to redirect resources to areas of great need. For example, VA would profit from allowing functional areas to collaborate in creating policy to benefit veterans. Staff concerned with creating policy for a specialized service, such as blind rehabilitation, might work together as a team rather than working through quality management, clinical affairs, administration and other programs that generally monitor blind rehabilitation programs. This would also allow Central Office to eliminate duplicative areas and communicate better between functional areas of expertise.

VA's leadership is currently reviewing several plans for decentralizing management and creating a real leadership role for VHA. The IBVSOs have reviewed many of the proposals and believe that many have merit. Over the years, the IBVSOs have supported increased staffing for MAMOE. We still believe that the responsibilities MAMOE shoulders—which include managing a headquarters responsible for a $16 billion budget and more than 200,000 employees located in more than 400 health care delivery sites—merit adequate staff and resources. This year, therefore, we recommend that Congress adjust funding for inflation and other uncontrollables and allow MAMOE's staffing and resources to stay constant in the next fiscal year. During this time, the Secretary and the new Under Secretary should continue to evaluate proposals for decentralizing many MAMOE functions and redefining remaining roles from those of operations management to those of leadership, emphasizing policy formulation and strategic development.

The MAMOE appropriation has decreased dramatically over the past decade, while, at the same time, Congress has charged it with managing a broad array of new program initiatives.

Our recommendation does not express any loss of faith in VACO, but rather supports our view that staff should refocus its talents and leadership abilities within a transitional time, in which leadership is evaluating major changes in VA's structure and management. The IBVSOs believe that VACO will have an even more critical role in a decentralized management plan for health care administration. Rather than concentrating its efforts on detailed operations, staff will be able to lead the system and ensure that it meets the broad criteria set forth for successful operations. The IBVSOs foresee a strong, but altered, role for VA's Central Office Health Administration staff in the future.

Indeed, VACO's leadership will also be critical as VA prepares for its role in the emerging health care environment. VA must anticipate changes that will take place in the states and private sector, rather than react to changes that have already occurred. This will require an in-depth knowledge of veterans' needs and continual re-evaluation of how the VA system should act in veterans' best interests. The *Independent Budget* has consistently supported adequate staffing in the MAMOE account and continues to do so. This reflects our attitude that change can be resource- and personnel-intensive in the short term and VA must properly manage it to ensure the desired outcomes of efficient management and high-quality patient care.

We also anticipate that the VA health care system will undergo major changes as it moves from a predominantly hospital-based system to a managed-care system that emphasizes service delivery in an ambulatory setting. For these reasons, the IBVSOs support an FY 1996 funding level of $72.3 million and a FTEE level of 804, as Table 21 shows. We believe that this is the minimum level from which VA can manage and effect changes necessary to transform the system.

The IBVSOs support VHA's operational reorganization into veterans' integrated service networks

(VISNs), in the hope that such a realignment will achieve the laudable goals of field empowerment, resource and management flexibility, service consolidation and patient care excellence. Such a change to the current system, however, will present management and organizational challenges to VACO that require an adequate staff and MAMOE budget.

The IBVSOs believe that VACO will have an even more critical role in a decentralized management plan for health care administration.

TABLE 21

Medical Administration and Miscellaneous Operating Expenses (MAMOE)

Independent Budget Recommended Appropriation

FY 1995 Current Services Level	**$69,808,000**
FY 1996	
Payroll Related Increases	
Retirement Programs	329,000
Annualization of 1995 Pay Raise	527,000
Annualization of 1995 Federal Employee Health Benefit Program	24,000
Pay Raise 1996	618,000
Federal Employee Health Benefit Program 1996	58,000
Inflation	979,000
FY 1996 Current Services Level	**$72,343,000**
FY 1996 Recommended Appropriation	**$72,343,000**

Recommendations

The IBVSOs support FY 1996 funding of $72.3 million and an FTEE level of 804 to ensure that MAMOE can provide the policy, planning, operational guidance and oversight that effect VHA's successful transformation in the uncertain health care environment.

The *Independent Budget* recommends that VA review and implement portions of the recent work group recommendations that Deters, Thibault, Farsetta and others made regarding VACO's appropriate role within VHA's management structure. Significant changes in the health care environment burden VACO further in the short run and could force significant changes in its relationship to the field. It is important to the success of the veterans' health care system that Central Office components be functionally and organizationally responsive to the needs of not only those it manages but, more importantly, of those veterans it serves.

Education Loan Repayment Program

Since the 96th Congress authorized it, the Health Professions Education Assistance Program (HPEAP) has offered grants covering tuition and monthly stipends to nursing, occupational and physical therapy and nurse anesthesia students. In exchange, those who receive grants must offer VA "payback" employment for two years at a VA medical center with insufficient personnel. While HPEAP has served as a valuable recruitment and retention tool, it is somewhat difficult to administer, since VA must select, fund and monitor students throughout their academic careers. VA has not used HPEAP to recruit physicians.

Beginning in 1992, Congress has annually proposed a VA Loan Repayment Program, which it believes would be a more effective recruitment tool. Under this program, VA could recruit health professionals in critical specialty areas, promising that, for each year they worked for VA, VA would repay some of their educational loans. The current bill would limit loan repayment to $4,000 annually and cap total reimbursement at $12,000. Although VA could recruit physician assistants or nurse practitioners with this amount of funding, Congress would have to authorize higher dollar limits to make the program an effective physician recruitment tool. The average medical student debt at graduation is currently $80,000, and many private-sector managed care systems offer loan repayment to recruit primary care physicians.

Recommendation

Authorize the VA Educational Loan Repayment Program to replace the Health Professionals Educational Assistance Program.

Cost

$20 million.

Construction Programs

Three things are to be looked to in a building: that it stand on the right spot; that it be securely founded; that it be successfully executed.

Johann Wolfgang von Goethe, Elective Affinities

Overview

Most VA construction activities are funded through the Major Construction appropriation, which finances projects costing $3 million or more, or the Minor Construction appropriation, which pays for smaller projects. A third appropriation finances the Parking Garage Revolving Fund. Veterans Health Administration construction needs account for most expenditures within all three appropriations.

Grants for the Construction of State Extended Care Facilities, Grants for Construction of State Veterans Cemeteries and Grants to the Republic of the Philippines are also construction program accounts.

VA Management Initiatives

In FY 1993, VA reorganized its Construction Program and assigned it to the Veterans Health Administration. It created an Associate Chief Medical Director (AsCMD) for Construction Management (CM) and assigned some functions to the Associate Chief Medical Directors for Operations and Resource Management. In FY 1994, VA again reorganized the Construction Management program to streamline operations and promote a customer service philosophy. This latest organizational change created a multidisciplinary team approach to manage major construction projects. There are now four teams managing VA construction projects, and a fifth team is charged with meeting VBA and National Cemetery System needs. Construction Management has significantly streamlined its organization, reducing staffing by 21 percent, from 314 full-time employee equivalents (FTEEs) to 249 FTEEs. It did not reduce staff, however, in the functions assigned to Operations and Resource Management.

The Office of Construction Management, which currently supervises construction projects worth $3.6 billion, has recently begun to decentralize authority and focus on serving its customers in the field. Central to embracing this philosophy is developing a total quality project concept that emphasizes "partnering," a system DOD and the Corps of Engineers use to coordinate work more effectively between field and CM staff, architectural and engineering firms, and construction contractors. CM is also delegating more of its construction efforts to field managers and staff. The

IBVSOs support these changes, which have been favorably noted in the Thibault Report on Central Office *reorganization* and closely mirror initiatives contained in the Vice President's National Performance Review.

CM has authorized medical facility directors to lease up to 10,000 square feet of space, costing up to $300,000 (the maximum legal delegation), to meet outpatient clinic needs. The IBVSOs applaud such efforts. Expedited lease acquisition provides facility directors greater flexibility and control in meeting their patients' needs for accessible ambulatory care. Leasing space during initial site inspection, rather than delaying the process through a formal *Solicitation* for Offers, also grants VA facility directors more flexibility in responding expediently to local market conditions. This is particularly important in states that are currently implementing health care reforms and that may offer veterans cost-competitive alternatives to care from more accessible community providers. Central Office is hesitant, however, to grant facilities much autonomy and plans to revisit the issue.

The Enhanced-Use Leasing Program is a promising program that encourages the private sector to fund needed VA infrastructure by developing compatible non-VA activities on VA property. This program allows VA to meet facility and service needs that it cannot accommodate within its budget priorities. For example, in FY 1994, CM was able to secure a managed care clinical, research and education center to be built on the grounds of the Minneapolis VA medical center by a private health maintenance organization. The HMO will join the medical center in managed care research and educational activities and other sharing agreements for VA specialized medical resources. The IBVSOs strongly support extending legislative authority for this program, which is due to expire at the end of FY 1995.

Efforts are underway to implement a seamless timeline from facility design to construction. VA used to begin preliminary facility planning and design with minimal funding and then had to wait for additional funds before proceeding with the final design. This practice ensured increased costs due to construction delays.

A new process, expedited project delivery, enables the design team to work without interruption throughout the design process.

A new process, Expedited Project Delivery, was implemented in the FY 1995 budget request and enables the design team to work without interruption throughout the design process. This will reportedly reduce the time required to develop major construction projects by two years. Medical administration executives consider most facilities that require more than five years from design to *move-in* to be obsolete on activation. To the extent that VA can reduce the design to move-in timeline to five years or less, it will save funds and better serve veterans.

Congress's intermittent funding of projects also delays VA construction. The IBVSOs believe that, once Congress authorizes a major project, VA should receive multi-year budget authority for the project's total cost, to preclude delays. Congress should also guarantee activation funds for staff and equipment once the project is complete.

The IBVSOs realize that future appropriations will remain constrained. Consequently, prudent use of available funds is paramount. We strongly urge VA to continue to adopt private-sector business practices in operating its construction programs. VA major construction projects take longer to complete and are far more expensive than comparable private-sector projects. VA should utilize competitive bidding, which decreases design and construction costs, and other innovations, such as partially shifting the accountability for cost overruns to the builder. While the IBVSOs realize that VA's building costs are comparable to the private sector's, VA design still adds a great deal of cost to major construction projects. Much of the added design cost is due to design delays, but VA must continue to streamline its design process to eliminate duplicative project review and approval. It could then direct cost savings to other VA functions.

Additional Management Improvements Needed

At VA's request, the National Institute of Building Sciences (NIBS) performed a review of the CM program. Several issues in *VA Cost and Standards Study*,

Phase II, June 17, 1993, bear emphasis. The IBVSOs believe VA staff or the NIBS leadership should conduct additional studies:

- Construction Management's reorganization is imperfect. Planning functions that were delegated to Resource Management in the reorganization should be returned to CM. CM and Resource Management often reach contradictory decisions on projects, equipment or budget issues. Resource Management sets policies that have a direct impact on construction costs, but only CM is held accountable for cost. Returning some Resource Management elements to CM would allow better coordination of the two offices' functions and allow further staff reductions by eliminating overlap.

- VA designs to the highest level of architecture and engineering. For example, VA designs require that all rooms be accessible to people with disabilities. This standard far exceeds the *Americans with Disabilities Act* (ADA) guidelines for general purpose hospitals and long-term care facilities. Under ADA, only rehabilitation facilities have such stringent codes. VA could realize cost savings by applying the appropriate ADA guidelines to its facilities or by setting a higher standard only when a facility's users need it.

  VA also applies natural hazard mitigation standards differently than the private health sector does. The latter designs and builds for protection of life. VA designs for continued operational capability—a much more costly venture. VA has developed its own seismic standards; whenever a state has higher standards, VA uses those. Risk zone values are revised as the U.S. Geological Survey (USGS) performs its ongoing analyses across the country. Risk factors are based on estimated horizontal ground acceleration and range from .02g to .60g. With all the system requirements for accessible, attractive facilities that allow for enhancement of critical services (discussed further later), the IBVSOs question the high priority CM places on seismic corrections. In addition to the seismic value, VA should better coordinate planning and code application.

  For example, Memphis is identified as a high priority for seismic correction. This is problematic for two reasons. First, in light of the West Coast's history of earthquakes, it is conceivable that other sites are more vulnerable than Memphis to seismic activity. Second, Tennessee is one of the states to which the Department of Health and Human Services has granted a waiver to test models for Medicaid expansion and other reforms. The plan, TennCare, makes other providers financially accessible to some veterans currently using VA medical care. VA estimated that up to 11.6 percent (or 25,000) of the 216,000 veterans using VA medical facilities in the state might choose the TennCare plan. While the total effect the availability of Tenncare may have on VA health care utilization is not yet clear, VA should consider such a factor in determining the need for replacement beds. The development and implementation into policy of proposals to reduce VA's design and construction standards is necessary to lower costs and improve quality. 121

- VA's hospital building system (VAHBS) has been criticized as cost-additive for years. NIBS could not reach a definitive answer in its 1993 evaluation but cast some doubt on the planning and design process. VAHBS has been most severely reproached for its extensive use of interstitial space, which adds to initial cost.

  The IBVSOs concur that an outside group, under the leadership of NIBS, should validate the cost-effectiveness of VAHBS. An external authority should compare the system to DOD's integrated building system, Kaiser-Permanente's zone system and other appropriate methodologies.

  The IBVSOs also believe the VAHBS study should arrive at a life cycle for such facilities as hospitals, nursing homes, clinics and administrative offices (VBA). Establishing life cycles for major delivery components allows VA to avoid the appearance of building for 100 years.

  A study should also further identify those services appropriately "in an envelope" using interstitial space and those services not requiring it. Flexible space and interstitial space may provide

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cost-effective means to keep up with radical changes in health care delivery over the next 25 years. Designs must be flexible to respond to future needs and technological advances. Services using interstitial space, however, should have reasonable expectations for long-term expansion and be able to clearly justify additional costs.

Perhaps the most difficult problem VA construction activities face is coordinating mission and program planning for facilities.

The Dilemma of Fiscal Year 1996

An urgent need exists to develop a strategic plan for VA's delivery system that corresponds to state and private-sector health care reforms. Perhaps the most difficult problem VA construction activities face is coordinating mission and program planning for facilities. The Office of Construction Policy realizes that the facility development program (FDP), which focuses on individual facilities, is obsolete and plans to use networks to assess system needs. By using a network, rather than a facility, as the unit of analysis, VA can examine a catchment area's demand and assess how well the area's facilities meet their aggregate needs. VA can then capitalize on opportunities for internetwork sharing and share resources to the Department's and its patients' best advantage.

Chicago's four area facilities comprise the only VA network that has thus far used this planning approach. The Chicago Area Network Facility Plan capitalizes on the strengths of each facility within the catchment area. The plan's goal is to assign patient workloads to appropriate care settings within the network, expand access for veterans and allow facilities to consolidate resources to reduce costs.

Chicago planned its network to allow its patients maximum access to primary care providers who can coordinate veterans' health care services. All hospital directors remain mangers of their facility and participate in a management council that oversees and makes decisions, including those regarding resource allocations, for the network. The management council also includes chiefs of staff, a representative of the academic affiliates and a VSO representative. One position oversees ambulatory care operations for the network, and the plan identifies off-campus ambulatory care clinics.

This planning model will certainly not work for every facility—Chicago facilities have the advantage of being near one another. The Chicago facilities and the Office of Construction Policy should be commended, however, for their efforts to collaborate in serving veteran patients through an integrated delivery system. This cooperation is an example of the integration of strategic and facility planning that the IBVSOs believe must occur across the VA delivery system.

In light of public- and private-sector health care reforms now taking place, the facility sizing model (also known as the bed sizing model) that VA currently uses requires adjustment. It puts historical weight on inpatient services, although evidence suggests that inpatient care is not the high priority for competitive health care organizations that it once was. Non-VA hospitals and managed care organizations are reducing bed occupancy to an average of 66 percent nationwide, reducing staff by 20 to 24 percent and moving to more outpatient activity; yet VA continues to emphasize hospital inpatient care in construction priorities. Even activities intended to increase veteran patients' access, such as sharing, still emphasize creating inpatient beds, rather than clinic access. In developing the *Independent Budget* the coauthors assume that VA will be able to provide care in the most appropriate setting. This will require VA to enhance capabilities in some areas, such as primary, preventive and long-term care, and possibly reduce it in others.

VA should revise its planning models and guidelines to account for veteran demographics. Current and future populations' needs should determine system priorities and the resource allocation. To determine the need for outreach and community clinics, VA must review distance and travel time from home to care site for its veteran patients. A two-hour driving time criterion is inconsistent with the thirty-minute criterion on some state health reform proposals and the private

sector established. Ultimately, these reforms and VA eligibility expansion will facilitate a more realistic approach to setting priorities for the system's future construction projects.

VA should emphasize the care of special populations: those with spinal cord dysfunction; PTSD and other psycho-social problems; blind veterans; and nursing home residents. Where current and future populations are declining, the strategic and facility development plans must include alternatives to provide needed care in different settings or organizations. The IBVSOs recommend that VA begin revisions to strategic planning models and FDPs now and complete them as soon as possible.

VA must shift the emphasis of its construction program from "bricks and mortar" construction to expanding primary care access, improving the infrastructure to make facilities more modern and attractive, and increasing long-term care capacity

Priorities for the Fiscal Year 1996 Budget

Because VA has committed its limited construction funds to building or replacing hospitals, construction funds will not be available for outpatient care, infrastructure improvements and other needs until FY 1998. The IBVSOs believe that VA must shift the emphasis of its construction program from "bricks and mortar" construction to expanding primary care access, improving the infrastructure to make facilities more modern and attractive, and increasing long-term care capacity in both non-institutional and institutional settings. The need for enhanced outpatient and extended care facilities and infrastructure improvements far outweighs the need for additional hospital beds.

VA can expand access to primary and preventive care by leasing, through sharing agreements or by contracting out for these services. In some cases, where a smaller veteran user population is located far from a VA facility, VA will have to contract with local providers to make care accessible to those veterans at a reasonable cost. VA must ensure that these providers meet or exceed VA performance standards and have information systems that can directly interface with VA's. Wherever possible, VA should maintain operational control over local clinics, to maintain its identity as a provider for veterans and maximize veterans' access to system providers who can best meet veterans' special health care needs. Although the IBVSOs support alternative routes to creating points of entry into the system, *we do not support wide-scale efforts to mainstream the system.*

VA's prompt expansion of its ambulatory care program is a crucial initiative, given its reduced need for inpatient beds. To be competitive, VHA must substitute more appropriate care in ambulatory care settings for inpatient care. VA currently operates 357 outpatient clinics. It must open more, however, in areas that are more accessible to veterans. Making VA care more geographically accessible is key to VA's success in recruiting new patients and retaining current users. VHA must begin extensive primary care outreach through more remote and satellite clinics during this fiscal year and in FY 1997. It should place some primary care clinics contiguous to or within veterans' outreach centers (or vet centers). Expanding leasing authority is an essential, immediate need if VHA is to reconfigure its delivery system expeditiously. In the future, if VA decides there is a renewed need for inpatient beds, the IBVSOs urge it to use leasing, sharing agreements and contracted services as they provide quicker, inexpensive alternatives to new construction.

To continue to make its unique contributions to the U.S. health care delivery system, VA must provide services in accessible, attractive and modern care venues. VA targeted infrastructure needs, such as ensuring patient privacy with telephones for each patient room and private and semi-private bathrooms, as necessary improvements that will allow VA to compete with other care providers. The IBVSOs believe this is commendable, but population need and facility mission must determine priorities for system remodeling. Not all facilities have the same need for patient privatization, so it should not be a high, fixed priority systemwide. Since some facilities prioritize funding

124 differently, however, VA should allow flexibility in determining individual VA medical centers' and service areas' needs.

The growing population of aging veterans merits rapid expansion of VA long-term care alternatives. VA must increase access to community and home-based alternatives for long-term care and nursing home bed availability. VA should make some institutional long-term care available by converting inpatient hospital beds to nursing home care beds. Remodeling hospital beds to nursing home care beds is less expensive than new nursing home construction.

Independent Budget Funding Recommendations for FY 1996

Major Construction

The *Independent Budget* recommends a $490 million Major Construction appropriation for FY 1996, as Table 22 shows. Less funding in FY 1996 would be catastrophic, given the extended replacement cycle for facilities, rapidly changing clinical requirements and the existing plant's age.

Most of the *Independent Budget* recommendation is for leases for outpatient clinics and nursing homes. In these uncertain times, the *Independent Budget* coauthors believe that leasing is preferable to new construction. Leasing offers an affordable, expedient and flexible solution to the immediate need for VA capacity in the outpatient and nursing home venues. The *Independent Budget* funding recommendation accommodates the annual cost of leasing three nursing homes. It also accommodates annual leasing costs for approximately 100 outpatient clinics. Funding for leased clinics complements other *Independent Budget* recommendations to enhance ambulatory care. VA must also increase its in-house capacity and offer VA care in remote community settings such as vet centers.

Replacement and modernization costs also comprise a significant portion of the Major Construction budget. The *Independent Budget* coauthors believe that VA should consider acquisition and conversion projects as alternatives to new construction. Facilities available for acquisition offer VA an opportunity to realize substantial savings and activate beds more quickly than a "ground-up" construction project would. VA is, in fact, doing this in some places. When VA acquires facilities, it needs funds to make them accessible to people with disabilities and to improve infrastructure. The IBVSOs recommend that established priorities dictate selected replacement and modernization projects that provide natural hazard mitigation and modernize and upgrade the physical plant. Those priorities should carefully assess veterans' needs and the probable effect of changes in local health care markets to the need for facilities mission conversions.

The *Independent Budget* coauthors recommend that some new construction complement leasing and bed conversions, to increase available VA-operated beds for nursing home care. Indeed, the aging veteran population necessitates making more nursing home beds available through the 1990s. The *Independent Budget* Major Construction budget includes funding

TABLE 22

Construction Programs

Independent Budget Recommended Appropriation

FY 1996 Major Construction	
Medical Care Program	
Replacement and Modernization	257,406,000
Nursing Home Care	40,000,000
Leases for Nursing Homes	12,000,000
Domiciliary Care	10,000,000
Leases for Outpatient Care Clinics	100,000,000
National Cemetery	16,000,000
Other	54,600,000
TOTAL MAJOR CONSTRUCTION	**$490,006,000**
FY 1996 Minor Construction	
Medical Care Program	
General Fund	250,000,000
Nursing Home Care	1,800,000
National Cemetery	18,000,000
TOTAL MINOR CONSTRUCTION	**$269,800,000**
FY 1996 Parking Garage Revolving Fund	**$1,500,000**
FY 1996 Grants for State Extended Care Facilities	**$180,000,000**
FY 1996 Grants for Construction of State Veterans Cemeteries	**$6,000,000**
FY 1996 Grants to the Republic of the Philippines	**$500,000**
TOTAL FY 1996 CONSTRUCTION PROGRAMS	**$947,806,000**

for four new nursing homes. In the immediate future, VA must enter two new enhanced-use leases for nursing home beds. This effort, however, will alleviate only some of the actual need for nursing home beds. VA must continue to pursue the IBVSO strategy for making nursing home beds available to veterans.

The *Independent Budget* Major Construction budget also recommends funding for two new VA domiciliaries. Domiciliaries offer shelter and often some social services for aging, mentally ill and homeless veterans and those with substance abuse disorders. The growing prevalence of these problems in society should compel VA to provide humane care through an enhanced in-house domiciliary capacity.

The *Independent Budget* Major Construction proposal includes $16 million to acquire land for national cemeteries in states that have no available grave sites. The IBVSOs recommend that VA construct two new national cemeteries annually until the National Cemetery System meets previously stated goals of one open cemetery in each state.

Minor Construction

The FY 1996 *Independent Budget* recommends a $269.8 million appropriation for Minor Construction, which funds smaller facility construction projects. As Table 1 on page xxvi shows, the *Independent Budget*'s FY 1996 recommendation significantly exceeds the FY 1995 appropriation. The increment requested reflects the IBVSOs' growing concern about VA facilities' urgent need for update and repair. Most VA facilities were constructed during the 1950s, and updating and repair needs are increasing rapidly. Earlier appropriations have fallen far short of addressing these needs. Needs for repairs, beautification, installment of amenities (such as phone lines) and mission conversions should be system-wide priorities, especially if VA medical centers compete with private-sector providers. Of the total Minor Construction appropriation, $250 million should be allocated to these types of projects. Within this allocation, VA should select residential sites to purchase for compensated work therapy programs. The need for compensated work therapy programs is addressed in the "Medical Care" section on pages 93-4.

VA should use $1.8 million of the Minor Construction fund to convert unused and unneeded hospital beds to nursing home care. NIBS found that remodeling hospital beds to nursing home beds was less expensive than new construction. Accordingly, the *Independent Budget* coauthors emphasize conversion as the principal means to make nursing home care available to veterans. The IBVSOs recommend that VA convert the beds it planned for in FY 1995 and convert twelve 30-bed wards in FY 1996. While this strategy represents a tremendous conversion rate, it is the only way VA can keep pace with the demands of the aging veterans' community.

The FY 1996 *Independent Budget* recommends $18 million for existing National Cemetery System construction projects.

Parking Garage Revolving Fund

The FY 1996 *Independent Budget* recommends a $1.5 million allocation to this fund, which finances VA facility parking garage construction and operation. Reasonable parking access is essential to patient care. If VA is to compete, veterans need access to available parking within reasonable distances from medical facilities. Eventually, parking garage revenues should pay for new projects. Because only a few revenue-producing projects currently exist, VA needs limited new appropriations. Future funding requirements should diminish.

VA should also promote private-sector construction of parking garages through the Enhanced-Use Leasing program. Enhanced-use agreements would allow VA to provide accessible parking to its patients and their families without having to undertake the investment building such facilities entails. The IBVSOs encourage VA to investigate further utilization of this program to build parking garages where needed.

Grants for the Construction of State Extended Care Facilities

The state home program greatly enhances VA's extended care workload capacity. This appropriation provides grants to help states acquire or construct state domiciliary and nursing homes for veterans. It also provides grants to assist in expanding, remodeling or

126 altering existing facilities, including state home hospital facilities.

The Grants to State Extended Care Facilities are mutually beneficial to the states and VA. States benefit by receiving federal money to add nursing home capacity for state residents who have dual eligibility for VA and state programs such as Medicaid. Under these grants, states are responsible for at least 35 percent of nursing home construction costs. States pay at least 50 percent of treatment costs, which are reimbursed on a *per diem* basis; VA pays a portion of the *per diem* cost. States may also retain some of veterans' Social Security income to cover their shares of operating costs.

Congress should encourage and fund Grants for the Construction of State Extended Care Facilities wherever states will participate. For FY 1996, the *Independent Budget* recommends a $180 million appropriation for these grants. This appropriation will fund all state applications for state home programs.

Grants for the Construction of State Veterans' Cemeteries

This program makes grants to states to help them establish or improve state-owned veterans' cemeteries. VA anticipates that it will need $6 million to fund program requirements in FY 1996.

Grants to the Republic of the Philippines

Grants to the Republic of the Philippines help to replace and upgrade medical equipment and rehabilitate physical plants and facilities. The Veterans' Memorial Medical Center at Manila provides care to U.S. veterans. The facility is now more than 40 years old, so replacement and rehabilitation are major needs. The IBVSOs recommend a grant of $500,000 for FY 1996.

Investment Fund

In previous sections of the document, the IBVSOs have referred to the need for an investment fund, as the *American Health Security Act* identified. If the Veterans Health Administration is to operate in the emerging health care environment, retaining its patient base as well as attracting new patients to the system who pay for care through third-party reimbursements, then VA must provide services in accessible, attractive and modern care venues. The Clinton Administration's investment fund, as the *American Health Security Act* proposed it, would have significantly augmented Minor Construction funding for modernization and infrastructure improvement projects. VA has many old, unattractive facilities. It also lacks amenities commonly found in the private sector, such as telephones in patient rooms and private or semi-private bathrooms. VA spending priorities for this fund were to specifically focus on redressing these problems.

Congress's failure to enact this legislation denied VA the investment fund it desperately needs to correct its infrastructure deficiencies. Correcting these critical deficiencies would have enabled VA to compete with other health care providers in local markets. The IBVSOs still support additional funding for infrastructure improvement. Such funding is essential to enable VA to participate in the new health care environment under state and market-driven health care reform. While the *Independent Budget* does not propose a specific investment fund, resource needs for infrastructure enhancement are outlined in the *Independent Budget*'s Medical Care section and in the above recommendations for the Major and Minor Construction accounts.

Appendix A

BUDGET EXPLANATORY NOTES

Medical Care

1. The Congressional appropriation to the Medical Care account for FY 1995.
2. Increased cost (over FY 1995) to VA in retirement programs, including the Federal Employment Retirement System and Social Security.
3. Amount necessary to annualize the pay raise implemented in January 1995. The pay raise for federal employees was 1.6%. Whereas the 1995 pay raise applied to only nine months of FY 1995, the amount here covers the rest of the calendar year which falls in FY 1996 (or the remaining three months).
4. The amount necessary to annualize the increase in health benefits cost increases that became effective January 1995.
5. Estimated cost of a 2.2-percent pay raise effective January 1996 for the remaining nine months of FY 1996.
6. Estimated longevity/performance increases for FY 1996.
7. Estimated increase in health benefits effective January 1996
8. Estimated increase for one additional workday in FY 1996.
9. Other personnel costs include stipends and compensation programs.
10. Estimated cost of inflation for items excluding personnel and some contract services.
11. Personnel, equipment and other costs related to new or remodeled facilities activities through FY 1995. Already adjusted to include amounts obligated in FY 1995 for equipment and other capital purchases that will not recur in FY 1996.
12. Estimated increased cost of rental property.
13. Increased cost of state nursing home care for veterans, including funds to reimburse state homes at one-third of the cost they recognize for veterans' care as agreed by VA.
14. Increased cost of state home hospital care for veterans, including funds to reimburse state homes at one-third of the cost they recognize for veterans' care as agreed by VA.
15. Increased cost of state home domiciliary care for veterans, including funds to reimburse state homes at one-third of the cost they recognize for veterans' care as agreed by VA.
16. Increased cost of community nursing home care for veterans.
17. Increased cost of contract hospital care for veterans.
18. Total of items 1 through 17 which allow VA to provide the same level of care in FY 1996 as occurred in FY 1995.

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19. Estimated costs associated with needed outpatient workload expansion including adding 50 dedicated full-time employees as women veterans coordinators and staff clinics at 50 vet centers.

20. Cost of essential improvements to the VA extended care programs, including funds for expanded nursing home workloads ($97 million) and domiciliary care workloads ($52 million) and, expanding programs such as: hospital-based home care ($82 million); adult day health care ($12 million); geriatric evaluation and management units; geriatric research, education and clinical centers ($28 million); respite hospice and, community residential programs ($5 million).

21. Increase in bio-psycho-social programs—such as program alternatives for chronically mentally ill patients, substance abuse programs and, post-traumatic stress disorder.

22. Funds to expand homeless programs including veterans' industries to develop their independent living skills.

23. Amount necessary to expand blinded veterans outpatient programs to reduce waiting times for inpatient care.

24. Amount necessary to activate one new spinal cord outpatient clinic and increase funding for the Independent Living Fund.

25. Increased funding for additional prosthetics program personnel.

26. Additional required funding for education and training programs including Resident Training ($10 million); the Tuition Reimbursement Program ($1.5 million); Satellite TV Programming ($2 million); Career Field and Service Chief Development ($10 million); AIDS Related Training ($3 million); Primary Care Training Program ($5 million); and, Dental Residency Stipends ($1.25 million).

27. Funds required to incrementally provide $500 million for a comprehensive overhaul of the VA medical system's information resources management system.

28. Additional requirement to incrementally eliminate a critical $870-million backlog in VA medical equipment replacement over five years.

29. Funds required to incrementally eliminate $805-million backlog of non-recurring maintenance and repair needs specified by VA over five years.

30. Personnel and equipment funds needed to activate 100 leased clinics.

31. Personnel and equipment funds needed to activate two leased nursing homes IBVSOs recommend to manage increased veteran demand for long-term institutional care.

32. The *Independent Budget* recommended appropriation to provide for an acceptable level of service to veterans in FY 1996.

33. Funding that, under enhanced authority, VA could collect for care of higher-income veterans who are eligible for Medicare. The IBVSOs propose that Congress allow VA to retain this funding without offsetting appropriation.

34. The collection and retention (under IBVSO proposed budget authorities) of all funds VA could collect from third-party payers for the treatment of non-service-related problems for mandatory veterans. VA must be able to retain these funds without offset to Congressional appropriations.

35. Under new authorization, funding that VA could collect and retain without offset from new veterans and veterans' dependents who gain access to the system under local initiative.

36. Estimated funding that can be diverted from hospital inpatient to outpatient and nursing home settings under eligibility reform.

37. Estimated funding required in nursing homes to provide care diverted from hospital inpatient settings under eligibility reform.

38. Personnel and equipment funds needed to activate one leased nursing home to manage increased workload diverted from hospital inpatient care under eligibility reform.

39. Estimated funding required in outpatient settings to provide care diverted from hospital inpatient settings under eligibility reform.

40. Net effect on VA medical care funding from workload shifts allowed by reforming eligibility (outlined in Items 36 through 39).

41. All the funding the *Independent Budget* coauthors recommend that Congress authorize for VA medical care programs in FY 1996. (Total of items 32,33, 34, 35 and 40).

Independent Budget
Recommended Medical Care Appropriation and Budget Authority

FY 1995 Current Services Level		**$16,232,756,000**	→#1
FY 1996			
Payroll Related Increases			
Retirement Programs		83,343,000	→#2
Annualization of 1995 Pay Raise		51,492,000	→#3
Annualization of 1995 Federal Employee Health Benefit Program		6,216,000	→#4
Pay Raise 1996		164,995,000	→#5
Within Grade Pay 1996		76,367,000	→#6
Federal Employee Health Benefit Program 1996		16,154,000	→#7
Workday Change		37,755,000	→#8
Other Personnel Costs		50,000,000	→#9
Inflation		547,959,000	→#10
Facility Activations (Including Capital Investments)		200,000,000	→#11
Property Rental		6,039,000	→#12
Adjustments for Rate Changes			
State Nursing Homes		80,660,000	→#13
State Home Hospitals		2,561,000	→#14
State Home Domiciliaries		10,405,000	→#15
Community Nursing Homes		27,247,000	→#16
Contract Hospitals		14,449,000	→#17
FY 1996 Current Services Level		**$17,608,398,000**	→#18
Additional Initiatives 1996			
Outpatient Workload Increase		335,530,000	→#19
Extended Care Programs Increase		274,668,000	→#20
Bio-Psycho-Social Programs		16,500,000	→#21
Homeless Initiatives		20,000,000	→#22
Blinded Veterans Programs		500,000	→#23
Spinal Cord Medicine Programs		500,000	→#24
Prosthetics Programs		7,700,000	→#25
Education and Training		32,750,000	→#26
Decentralized Hospital Computer Program		100,000,000	→#27
Equipment Backlog		173,782,000	→#28
Non-Recurring Repair and Maintenance Backlog		160,719,000	→#29
Facility Activations for Leased Clinics		35,000,000	→#30
Facility Activations for Leased Nursing Homes		5,250,000	→#31
FY 1996 Recommended Appropriation		**$18,771,297,000**	→#32
Authorization for Medicare Reimbursement for Higher Income Veterans		$133,677,000	→#33
Retention of Full Collection of Third Party Reimbursements		$800,000,000	→#34
Authorization to Retain Payments from Dependents and New Veteran Users		$2,006,828,000	→#35
Reform of Access Criteria			
Shift Inpatient to More Appropriate Outpatient or Nursing Home Care	(2,856,492,265)		→#36
Additional Workload Shifted from Inpatient Venues to Nursing Home	68,541,525		→#37
Facility Activations for One Additional 120-Bed Leased NH	2,625,000		→#38
Additional Workload Shifted from Inpatient Venues to Outpatient Care	637,504,968		→#39
Subtotal for Initiative		($2,147,720,772)	→#40*
Total Budget Authority Recommended		**$19,564,081,000**	→#41
Discretionary Funding Required from Congress Under New Budget Authorities		**$16,623,576,228**	

*The exact impact of shifting workload could vary due to a number of factors.

130 Medical and Prosthetic Research

1. Funds required in FY 1995 to maintain the service level as (1) FY 1985 in Medical Research; (2) FY 1988 in Rehabilitation Research; (3) FY 1989 in Health Services Research & Development.
2. Increased cost (over FY 1995) to VA in retirement programs, including the Federal Employment Retirement System and Social Security.
3. Amount necessary to annualize the pay raise implemented in January 1995. The pay raise for federal employees was 1.6%. Whereas the 1995 pay raise applied to only nine months of FY 1995, the amount here covers the rest of the calendar year which falls in FY 1996 (or the remaining three months).
4. The amount necessary to annualize the increase in health benefits cost increases that became effective January 1995.
5. Estimated cost of a 2.2-percent pay raise effective January 1996 for the remaining nine months of FY 1996.
6. Estimated increase in health benefits effective January 1996
7. Estimated longevity/performance increases for FY 1996.
8. Estimated cost of inflation for items excluding personnel, using the biomedical research and development price index projected by DHHS (5.01% in FY 1996).
9. Total of items 1 through 8. In the current fiscal environment, the IBVSOs propose that Congress add incrementally to the FY 1995 appropriation to establish a baseline budget for each of the next three fiscal years.. Because of the immediate need for increased research funding the first increment to the FY 1996 budget would be $38.2 million; the second and third increments would be $23.2 million each.
10. The Congressional appropriation to the Medical and Prosthetic Research account for FY 1995.

Medical and Prosthetic Research

Independent Budget Recommended Appropriation

FY 1995 Current Services Level	**$328,583,000 →#1**
FY 1996	
Payroll Related Increases Retirement Programs	(92,000) →#2
Annualization of 1995 Pay Raise	556,000 →#3
Annualization of 1995 Federal Employee Health Benefit Program	107,100 →#4
Pay Raise 1996	1,906,016 →#5
Federal Employee Health Benefit Program 1996	256,000 →#6
Within Grade Pay 1996	305,000 →#7
Inflation	4,991,000 →#8
Total Appropriation to be Achieved in Three Increments in FY 1996, 1997 and 1998	**$336,602,000 →#9**
FY 1995 Congressional Appropriation	**252,000,000→#10**
FY 1996 Incremental Funding Recommended	**38,200,000→#11**
FY 1996 Recommended Current Services Level	**$290,200,000→#12**
Special Initiatives	20,000,000→#13
FY 1996 Recommended Appropriation	**$310,200,000 →#14**
FY 1997 Recommended Current Services Level	**$313,400,000→#15**
FY 1998 Recommended Current Services Level	**$336,600,000→#16**

11. Funding increment the IBVSOs recommend to create a baseline budget for FY 1996.
12. Amount VA needs in FY 1996 to reach the targeted funding level for FY 1998.
13. Additional funding recommended for research in Alzheimer's; heart disease and other disorders disproportionately experienced in elderly populations ($5 million); in reproductive organ cancers disproportionately experienced by women veterans ($4 million); in spinal cord medicine ($1 million); and, for Persian Gulf Syndrome ($10 million).
14. The *Independent Budget* recommended appropriation to provide an acceptable level of VA research in FY 1996.
15. Baseline funding required for VA research programs in FY 1997.
16. Baseline funding required for VA research programs in FY 1998.

Medical Administration and Miscellaneous Operating Expenses (MAMOE)

1. The Congressional appropriation to the Medical Administration and Miscellaneous Operating Expenses account for FY 1995.
2. Increased cost (over FY 1995) to VA in retirement programs, including the Federal Employment Retirement System and Social Security.
3. Amount necessary to annualize the pay raise implemented in January 1995. The pay raise for federal employees was 1.6%. Whereas the 1995 pay raise applied to only nine months of FY 1995, the amount here covers the rest of the calendar year which falls in FY 1996 (or the remaining three months).
4. The amount necessary to annualize the increase in health benefits cost increases that became effective January 1995.
5. Estimated cost of a 2.2-percent pay raise effective January 1996 for the remaining nine months of FY 1996.
6. Estimated increase in health benefits effective January 1996
7. Estimated cost of inflation for items excluding personnel.
8. Total of items 1 through 7 that allow VA to provide the same level of care in FY 1996 as occurred in FY 1995.
9. The *Independent Budget* recommended appropriation to provide an acceptable level of service to veterans in FY 1996.

Medical Administration and Miscellaneous Operating Expenses (MAMOE)

Independent Budget Recommended Appropriation

FY 1995 Current Services Level	**$69,808,000**	→#1
FY 1996		
Payroll Related Increases		
Retirement Programs	329,000	→#2
Annualization of 1995 Pay Raise	527,000	→#3
Annualization of 1995 Federal Employee Health Benefit Program	24,000	→#4
Pay Raise 1996	618,000	→#5
Federal Employee Health Benefit Program 1996	58,000	→#6
Inflation	979,000	→#7
FY 1996 Current Services Level	**$72,343,000**	→#8
FY 1996 Recommended Appropriation	**$72,343,000**	→#9

Construction Programs

1. Replacement and Modernization costs for completing all initiated VA projects within the next two fiscal years. The IBVSOs place priorities for any new projects on development of the primary and preventive care capacities and long-term care.
2. Projected cost for construction of four new nursing home care bed units.
3. Projected cost of 3 new leases for VA-operated nursing homes.
4. Projected cost of building or converting two existing facilities to domiciliaries for veterans.
5. Projected cost of leases for 100 VA-operated outpatient care clinics.
6. Projected costs of acquiring and preparing land for the National Cemetery System.
7. Projected costs to complete all other Major Construction projects within FY 1996.
8. Total appropriation to adequately provide for the Major Construction needs of VA in FY 1996.
9. Projected costs of Medical Care Program General Fund include projects for repairs, beautifications, mission conversions and installation of amenities as needed. Sites for compensated work therapy should also be purchased from these funds.
10. Projected costs for Nursing Home Care includes funding to convert 360 hospital beds (or approximately twelve 30-bed wards) to nursing home care beds.

132 11. Projected costs of necessary National Cemetery Minor Construction projects.

12. Total appropriation to adequately provide for the Minor Construction needs of VA in FY 1996.

13. Total appropriation to adequately provide for the Parking Garage Revolving Fund needs of VA in FY 1996.

14. Total appropriation necessary to satisfy all pending grants received from states to build or augment state veterans extended care facilities.

15. Total appropriation necessary to construct three new state veterans cemeteries.

16. The usual annual appropriation made for maintenance needs of the VA Medical Center in Manila in the Philippines.

17. The *Independent Budget* recommended appropriation to undertake critical VA construction programs in FY 1996.

Construction Programs

Independent Budget Recommended Appropriation

FY 1996 Major Construction	
Medical Care Program	
Replacement and Modernization	257,406,000 →#1
Nursing Home Care	40,000,000 →#2
Leases for Nursing Homes	12,000,000 →#3
Domiciliary Care	10,000,000 →#4
Leases for Outpatient Care Clinics	100,000,000 →#5
National Cemetery	16,000,000 →#6
Other	54,600,000 →#7
TOTAL MAJOR CONSTRUCTION	**$490,006,000 →#8**
FY 1996 Minor Construction	
Medical Care Program	
General Fund	250,000,000 →#9
Nursing Home Care	1,800,000→#10
National Cemetery	18,000,000→#11
TOTAL MINOR CONSTRUCTION	**$269,800,000→#12**
FY 1996 Parking Garage Revolving Fund	**$1,500,000→#13**
FY 1996 Grants for State Extended Care Facilities	**$180,000,000→#14**
FY 1996 Grants for Construction of State Veterans Cemeteries	**$6,000,000→#15**
FY 1996 Grants to the Republic of the Philippines	**$500,000→#16**
TOTAL FY 1996 CONSTRUCTION PROGRAMS	**$947,806,000→#17**

Appendix B

ENTITLEMENT AND ELIGIBILITY CRITERIA FOR DEPARTMENT OF VETERANS AFFAIRS MEDICAL CARE BENEFITS

Unfortunately, confusion is considerable regarding, first, the definition of a veteran eligible for benefits under programs the Department of Veterans Affairs (VA) administers, and, second, the criteria for participation in various levels of VA health care delivery. Eligibility differs for hospital care, outpatient care and long-term care. It also differs according to the veteran's status. Thus, many practical problems exist in the planning and delivery of veterans' health care for veterans themselves, for VA administrators and for budget officials in the executive and legislative branches. Were eligibility further clarified and rationalized, it would greatly facilitate the delivery of medical services.

It should be noted that "entitlement" refers to conditions for which provision of care is mandatory. "Eligibility" refers to situations where VA may provide medical care, under certain conditions, pending availability of space and other resources.

Definition of a Veteran

According to *38 CFR §3.1 (d)* a veteran is "a person who served in the *active* military, naval, or air service and who was discharged or released under conditions other than dishonorable."

Qualifications for Access to VA Health Care

Current laws governing eligibility for VA health care services are the product of Congressional action and compromise, reflecting the historic U.S. emphasis on service-connected disability and low income as the principal criteria entitling veterans to treatment. Until recently, all veterans have been divided into three groups (Categories A, B and C) in determining eligibility for hospitalization in VA medical centers. Recent changes in the law, however, have collapsed the three categories into two: Category A and all other veterans.

Means Test Categories relate to the *Veteran's Health Care Amendments Act of 1986* (*Public Law 99-272*), effective July 1, 1986. The intent of the law is to ensure that veterans with service-connected disabilities and other special groups of veterans, as well as those with low income, are provided VA medical care, albeit under differing conditions. The law established an eligibility assessment procedure (means test) based on income for determining whether a non-service-connected disabled veteran qualifies for Category A or for the "all other" classification. Service-connected disabled and exempt veterans do not undergo the income-based eligibility assessment.

Listed next are the criteria for inpatient (hospital) and outpatient care, nursing home care, beneficiary travel and certain other benefits.

134 Hospital Inpatient Care

Category A

1. The Secretary of VA is *required* to provide hospital care to
   a. veterans with service-connected disabilities;
   b. veterans who were discharged from the military for disabilities that were incurred or aggravated in the line of duty;
   c. former prisoners of war;
   d. veterans who are in receipt of disability compensation under the auspices of 38 USC 1151;
   e. veterans exposed to a toxic substance or ionizing radiation;
   f. veterans who are in receipt of non-service-connected disability pension benefits;
   g. veterans of the Mexican border period or World War I; and
   h. non-service-connected veterans whose income does not exceed the means test cap (the limit in January 1995 is $20,469 for a veteran or $24,565 for a veteran with one dependent; each additional dependent adds $1368 to the cap).
2. For purposes of determining eligibility for non-service-connected medical care, income will be assessed on the same basis as that used for determining eligibility for non-service-connected pension benefits. The income limits for medical care purposes are increased effective January 1 of each year by the same percentage as non-service-connected pension rates.
3. The VA health care system treats some 900,000 inpatients per year, representing about 1 million discharges; some 97 percent are in Category A.

All Other Categories

1. Veterans outside the Category A net continue to be eligible for inpatient care as space and resources permit, but they must pay a part of the cost for inpatient, outpatient and nursing home care. Currently, the veteran is charged the lesser of the following: the cost of care received, or $716 for the first 90 days of care (or part thereof) during any 365-day period. For each succeeding 90 days of care (or part thereof), the veteran is required to pay either the cost of hospital care received or one-half the amount of the inpatient deductible ($358)—whichever is less. For each 90 days of care in a nursing home, the veteran is required to pay the lesser of either the cost of furnishing care or the inpatient deductible ($716). There is a $10 per diem charge for each hospital inpatient day and a $5 per diem charge for each nursing home inpatient day.
2. The Secretary is authorized to recover from health insurers the reasonable costs of care furnished in department facilities to insured veterans who have no service-connected disability and to insured, service-connected veterans for the cost of treating a non-service-connected condition.
3. Public Law 99-272 repealed the provision of law allowing veterans 65 years of age or older to receive care in VA medical facilities regardless of income.

Outpatient Care

1. The Secretary shall furnish on an ambulatory or outpatient basis such medical services, other than dental services, as the Secretary determines are needed, to
   a. any veteran for service-connected disability;
   b. any veteran with a service-connected disability rating 50 percent or more for any disability;
   c. any veteran disabled as a result of VA treatment or vocational rehabilitation.

d. any veteran with a non-service-connected disability that is held to be aggravating a service-connected disability.

2. The Secretary *shall* furnish outpatient or ambulatory medical services that are reasonably necessary in preparation, or to obviate the need, for hospital admissions or as a follow-up to hospital care for a period not to exceed 12 months for any disability to

   a. any veteran with a service-connected disability rating of 30 or 40 percent; and

   b. any veteran whose annual income does not exceed the maximum annual rate of non-service-connected pension payable to a veteran in need of aid and attendance (currently $12,855 for a single veteran and $15,345 for a veteran with one dependent) for any disability.

3. The Secretary *may* furnish on an ambulatory or outpatient basis medical services that the Secretary determines are needed to

   a. former prisoners of war;

   b. veterans of the Mexican border period or World War I whose annual income exceeds the maximum annual rate of pension;

   c. veterans in a VA-approved vocational rehabilitation program;

   d. veterans in receipt of increased pension or compensation based on the need for regular aid and attendance or by reason of being permanently housebound.

4. The Secretary *may* furnish outpatient or ambulatory medical services that are reasonably necessary in preparation, or to obviate the need, for hospital admissions or as a follow-up to hospital care for a period not to exceed 12 months for any disability to

   a. any veteran who has a service-connected disability rating of less than 30 percent;

   b. veterans exposed to toxic substances in Vietnam or to ionizing radiation during atmospheric detonation of a nuclear device, or who were exposed to ionizing radiation following the detonation of such devices in Japan during World War II; 135

   c. "Category A" veterans whose income exceeds the maximum rate of pension after a determination of inability to defray necessary expenses.

A payment is required of non-Category A veterans seeking non-service-connected, outpatient treatment. For each visit, the payment is 20 percent of the estimated nationwide average cost of the department's outpatient visits during the current fiscal year (currently $39), but it is not to exceed, during any 90-day period, the amount of the current inpatient payment ($716).

Miscellaneous

1. Certain veterans are eligible for dental services, prosthetic appliances and home health care services, in addition to medical treatment.

2. The Secretary *may* provide VA skilled or intermediate-type nursing care and related medical care in state or private nursing homes for convalescents or persons who are not in need of hospital care.

3. The Secretary *may* furnish needed domiciliary care to any veteran whose annual income does not exceed the maximum annual rate of pension payable to a veteran in need of aid and attendance or to any veteran whom the Secretary determines has no adequate means of support.

4. The Secretary has authority to provide fee-basis care outside of the United States for service-connected disabilities, related to service in the U.S. military forces, to citizens of the Republic of the Philippines or Canada or elsewhere, as determined by the Secretary.

Beneficiary Travel

1. During any fiscal year in which the secretary exercises the authority to make beneficiary travel payments, payments *shall* be made for travel in

136 connection with examinations, care, or treatment (e.g., hospital, nursing home, domiciliary or outpatient treatment) for which the veteran is eligible to

a. veterans for scheduled compensation and pension medical examinations;

b. veterans for service-connected disabilities;

c. veterans with service-connected disabilities rating of 30 percent or more for treatment of any non-service-connected disabilities;

d. veterans in receipt of non-service-connected pension;

e. veterans whose annual incomes do not exceed the maximum annual rate applicable to the non-service-connected pension program;

f. veterans for whom ambulance transportation, wheelchair van transportation or other special modes of transportation are medically indicated, when the Secretary determines that these veterans are unable to bear the cost of such transportation (no deductible applies); and

g. veterans whom the Secretary determines are unable to defray the expenses of travel or such other persons as determined by regulation.

2. Eligible veterans will be responsible for the first $6 of the cost of travel to receive VA medical care. For eligible veterans whose medical conditions warrant frequent visits, $18 is the maximum monthly amount for which the veterans will be responsible.

Some material in the preceding section was excerpted from:

U.S. House of Representatives, One Hundred First Congress, Committee on Veterans' Affairs, *Eligibility Criteria for Department of Veterans Affairs Medical Care Benefits*, January 30, 1989; updated for FY 1996.

Appendix C

MAJOR ISSUES TO BE ADDRESSED IN THE FY 1996 *INDEPENDENT BUDGET*

(presented to the Office of Management and Budget, October 28, 1994)

Medical Programs

Veterans cannot and must not be condemned to receive care in a second-rate system while other health care providers undergo a revolution in their care delivery. VA must act immediately to improve its management and delivery systems. Congress and the Administration must work together to authorize the funding, amend legislation that impedes VA's delivery of high-quality care, and curtail its micro-management functions to allow this to occur.

- *Changes in national and state health care legislation, as well as changes in the organization and delivery of health care in the private sector, will transform VA's medical program whether or not initiatives in these sectors specifically address VA.* VA must respond proactively to the revolution in health care delivery these entities are creating. VA must provide patient-centered care with an emphasis on improving the quality and integrity of its specialized services—VA's premier product line.

- *The VA medical system will continue to deteriorate without adequate funding.* Congress must take a rational and predictable approach to funding VA's medical care system. VA must have an open enrollment system for the beneficiaries it treats. VA must also specify the content of its benefits packages for those enrolled—mandatory veterans and other users—and know the costs of delivering these packages to veterans. To ensure that such funds are made available for entitled veterans, they should come from mandatory spending accounts. This will guarantee that VA will be able to deliver the health care services to which its enrolled beneficiaries are entitled.

- *VA needs investment funds to turn its service delivery around, emphasizing new delivery styles and better access to health care services for its enrollees.* Congress must appropriate adequate funding to VA that its officials can use to implement priority projects. VA's health planning documents indicate that they are aware that VA must develop accessible primary and preventive care sites and otherwise improve the infrastructure to compete under any health care reform scenario. VA is also aware that institutional and non-institutional long-term care settings must also continue to be developed to meet the needs of the aging veteran population. Congress and the Administration should indicate broad parameters for how such funds should be used and then allow VA officials to invest dollars as needed. The veterans' service organizations were supportive of the Veterans Affairs portion of the Administration's health care reform proposal largely because it provided the much-needed investment funds to put VA in a better position to compete.

- *VA must be given the authority to collect and retain funding from external sources.* Specifically, VA should be allowed to charge third-party payers and Medicare for services rendered to non-mandatory veterans. VA should also be able to "market" services once all veteran demand is satisfied—VA already has successful sharing programs with many federal, academic and community providers and should pursue sales of services to other providers, to

138 allow better access to both veterans and the local communities in which VA medical facilities exist.

- *Congress must liberate VA from its restrictive and antiquated entitlement criteria.* VA's practice patterns are held hostage to complex and antiquated eligibility criteria. While the rest of the nation's health care providers are turning to preventive and primary care delivered in ambulatory settings to control costs and improve access and quality, VA providers are restricted from doing the same for many VA beneficiaries. Nonservice-connected "mandatory" veterans are not entitled to VA outpatient care except under limited conditions. Instead, they are forced to wait until their conditions worsen and they must be hospitalized for care. Because these veterans comprise more than half of the veterans the system serves, VA cannot appropriately redirect its resources to provide these services to the remaining veterans. Currently, non-mandatory catastrophically injured or ill veterans must "spend-down" their resources, impoverishing themselves and their dependents, to access free VA health care. Rather than allowing this impoverishment to occur, Congress should entitle these veterans to the same medical care services mandatory veterans are able to receive at the onset of catastrophic injury or illness. This allows VA to provide the veteran with a comprehensive array of services and allows veterans and their families better resource bases from which to rebuild lives after rehabilitation or recovery.

- *Congress must ensure that each beneficiary VA serves is assured access to a basic package of services.* Veterans should be entitled to a comprehensive package of services to be provided in the most appropriate settings. VA beneficiaries must continue to receive all of the services for which they are eligible under Title 38, U.S.C., and they should receive no fewer benefits through VA medical centers than residents receive in the states in which VA medical facilities operate, as states continue to undertake health care reform.

- *VA medical centers must have the authority and flexibility to respond to changes in the environments in which they operate.* The radical change occurring in the private sector in health care delivery is outpacing VA's ability to respond, largely because of VA's entrenched bureaucracy. VA medical centers must be allowed to "partner" with other providers in their area. They must offer at least the level of benefits offered to Medicaid beneficiaries or other state residents through a "basic benefits" package. They must also meet or exceed the standards other providers in the state must meet in the areas of quality, price, performance and accessibility. VA managers at the local level must have authority to operate in the facility's environment, to ensure that these standards are upheld and that individuals served by the facility are treated appropriately. Once authority is granted, VA managers must be held accountable for maintaining standards and be removed if performance is unacceptable.

- *VA should have authority to interact more closely with community and federal providers, to maximize its resources and make resources optimally available to VA beneficiaries.* VA already has broad authority for sharing resources. Its sharing program allows medical facilities to share high-cost specialized resources with communities and academic affiliates. It also shares resources and, in some cases, enters into joint ventures to share facilities with the Department of Defense. VA must have the authority to pursue sharing even more aggressively. For example, it could seek out opportunities to offer its specialized services to external providers as a contractor, enter into joint ventures with academic or community providers to develop satellite primary care clinics, or contract for underdeveloped VA services, such as primary care. Congress and VA Central Office should allow local managers to make contracting decisions consistent with a centrally approved mission assignment.

- *VA must emphasize its specialized services—spinal cord injury medicine, geriatrics, long-term care services, readjustment counseling, environmental medicine, all types of rehabilitation services, prosthetics and sensory aids and mental health services—as the centerpiece of its health care delivery system.* These are the services the VA medical system was created to deliver. Efforts to

create "mini health maintenance organizations" within the VA without highlighting special services are likely to fail. The private sector has far more experience with marketing, finance and other expertise associated with managed care delivery. It also has more resources on hand to compete in this arena. For VA to succeed, it must distinguish itself from other, better established organizations. VA can do this by promoting its specialized services, for which it has developed expert and, in some instances, unique programs for care delivery, as the focal point of its health care delivery efforts. To bolster this campaign, VA should also highlight the research and medical education that fortify these programs.

- *VA is the ideal test-site for the creation of practice parameters, particularly for its specialized services.* As the nation moves to develop more consistency in its clinical decision making, the VA medical care system should be at the forefront of such efforts. VA clinicians and researchers have responsibility for treating a large number of individuals who need specialized services, such as prosthetics and orthotics, spinal cord injury medicine and post-traumatic stress disorder treatment. Incidence of such conditions in the general population is low, thus making VA a particularly suitable site for the development and implementation of these types of protocols.

- *VA must fulfill its Congressionally assigned missions as researcher, educator and contingency provider of health care in times of national emergency.* The nature of these missions preserves the character and distinctiveness of the VA medical program and enhances the quality of patient care. VA's role in academic medicine is mutually beneficial to VA and to the medical community. VA benefits through the arrangement by having a reliable inflow of clinical providers who are supervised by some of the nation's premier professors of medicine, who in turn help to maintain the integrity of medical care delivered. The medical community benefits by having access to a teaching venue and research facilities where it can explore clinical issues of interest to veterans and the nation.

Construction Programs

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VA must shift the emphasis of its construction program from "bricks and mortar" construction to expansion of primary care access, improvement of the infrastructure to make facilities more modern and attractive, and thus more competitive, and expansion of long-term care capacity in both non-institutional and institutional settings.

- *Making VA care geographically accessible is key to VA's success in retaining and recruiting new patients.* If the Veterans Health Administration is to successfully compete for an expanded universe of patients, especially those who will pay for their care through third-party reimbursement, then VA must provide services both these new recruits and VA's current users need in accessible, attractive and modern care venues.

- *Expansion of VA ambulatory care is crucial.* While VA has an increasingly reduced need for inpatient beds, it must place greater emphasis on developing its ambulatory care program. VA currently operates 357 outpatient clinics. If it is to be comparable to the private sector, however, VA will have to increase its number of outpatient clinics, locating them in areas where they are accessible to veterans.

- *VA can expand access to primary and preventive care by leasing, through sharing agreements, or by contracting out for these services.* Although, in some cases, VA will have to contract with local providers to make care accessible to veterans at a reasonable cost, VA must ensure that these providers meet or exceed VA performance standards and have information systems that can directly interface with VA's. Wherever possible, VA should maintain operational control over local clinics to ensure that VA is able to maintain its identity as a provider for veterans and maximize veterans' exposure to system providers who can best meet veterans' special health care needs. Although the VSOs are supportive of exploring alternative routes to creating points of entry into the system, we do not support wide-scale efforts to mainstream the system.

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- *The aging of the veteran population merits rapid expansion of VA long-term care alternatives.* The Veterans Health Administration needs to care for the growing population of aging veterans by increasing access to community and home-based alternatives for long-term care and increasing the number of nursing home beds to meet the needs of the aging veteran population. VA should make some institutional long-term care available by converting inpatient hospital beds to nursing home care beds. Remodeling hospital beds to nursing home beds is less expensive than new nursing home construction.

- *Congress's unsteady appropriation of construction funding and costs associated with construction cause problems in the timeliness and expense of major VA projects.* Congress intermittently funds these projects, which causes delays in construction and, thus, adds to taxpayer expense. Once Congress authorizes a project, VA should receive a multi-year budget authority for the total cost of the project, to ensure that it does not have to delay construction. Similarly, when Congress authorizes a major project, it should guarantee that activation funds for staff and equipment will be available once the project is complete.

- *VA must continue to adopt private-sector business practices to operate its construction program.* By and large, VA's major construction projects still take too much time and are far more expensive than comparable private-sector projects. Competitive bidding in the construction industry is bringing down private-sector construction costs for both designing and building facilities. Other innovations shift accountability for cost overruns, at least partially, to the builders. Many of these innovations need to be further instituted in VA.

Benefits Programs

VA has made little improvement on the delivery of entitled benefits to veterans. Huge backlogs of claims for compensation and pension exist and the appeals process is unreasonably lengthy. Veterans cannot access the direct benefits, like vocational rehabilitation VA provides, on which they may rely to be re-oriented to productive occupation. Demand for services from the National Cemetery System is growing, while resources, including open burial space, are dwindling. Staffing, equipment and funding must better match VA's benefits administration needs.

- *Reasonable timeliness standards must be applied to the administration of benefits and services.* Veterans' entitlement and their timely and accurate delivery are inseparable. Only a minimum timeliness standard for adjudicating benefits claims and providing vocational rehabilitation services will ensure veterans of the adequate delivery of their entitled benefits.

- *Mandatory spending accounts should fund appropriations for administering veterans' entitled benefits.* Adequate funding will allow the Veterans Benefits Administration to recruit and retain a sufficient number of well-trained employees to ensure timely claims adjudication by creating a rational system of measures that establishes a workforce mindful of and in concert with established workloads. In short, VA should realistically assess its employment needs based on reasonable timeliness standards.

- *Relatively small investments in automated data processing systems for benefits administration would allow VA to meet reasonable timeliness standards.* VA officials have stated that purchase of reliable computer hardware would allow veterans' benefits administrators to significantly reduce its claims backlog.

- *The National Cemetery System should be maintained as a system of shrines available to veterans in sites proximate to their homes.* Adequate staff and equipment must keep pace with increasing demand for services.

Appendix D

STATE AND TERRITORIAL HEALTH CARE REFORMS

State or Territory	Comprehensive Reform Plan	Employer Mandate	Health Insurance Purchasing Cooperatives/ Managed Competition	Major Medicaid Reforms	Insurance Market Reforms	Creation of Basic or Standard Benefit Packages	Creation of Medical High-Risk Pools	Medical Savings Accounts
ALABAMA	NO	NO	NO	NO	NO	YES	NO	NO
ALASKA	NO	NO	NO	NO	YES	YES	YES	YES
ARIZONA	NO	NO	YES	YES	YES	YES	NO	NO
ARKANSAS	NO	NO	NO	NO	YES	NO	NO	NO
CALIFORNIA	NO	NO	YES	YES	YES	NO	YES	NO
COLORADO	NO	NO	YES	NO	YES	YES	YES	YES
CONNECTICUT	NO	NO	NO	NO	YES	YES	YES	NO
DELAWARE	NO	NO	NO	NO	YES	YES	NO	NO
DISTRICT OF COLUMBIA	NO	NO	NO	NO	YES	NO	NO	NO
FLORIDA	YES	NO	YES	NO	YES	YES	YES	NO
GEORGIA	NO	NO	NO	NO	NO	YES	YES	NO
HAWAII	YES	YES	YES	YES	NO	YES	NO	NO
IDAHO	NO	NO	NO	NO	YES	YES	NO	YES
ILLINOIS	NO	NO	NO	NO	YES	YES	YES	YES
INDIANA	NO	NO	NO	NO	YES	NO	YES	NO
IOWA	NO	NO	YES	NO	YES	YES	YES	NO
KANSAS	NO	NO	YES	NO	YES	YES	YES	NO
KENTUCKY	NO	NO	YES	YES	YES	YES	NO	NO
LOUISIANA	NO	NO	NO	NO	YES	YES	YES	NO
MAINE	NO	NO	NO	NO	YES	YES	NO	NO
MARYLAND	NO	NO	NO	YES	YES	YES	NO	NO
MASSACHUSETTS	YES	YES 1996*	YES	YES	YES	NO	NO	NO
MICHIGAN	NO	NO	NO	NO	NO	NO	NO	YES
MINNESOTA	YES	NO	YES	NO	YES	YES	YES	NO
MISSISSIPPI	NO	NO	NO	NO	YES	YES	YES	YES
MISSOURI	NO	NO	NO	NO	YES	YES	YES	YES
MONTANA	NO	NO	NO	NO	YES	YES	YES	NO
NEBRASKA	NO	NO	NO	NO	YES	YES	YES	NO
NEVADA	NO	NO	NO	NO	NO	NO	NO	NO
NEW HAMPSHIRE	NO	NO	NO	NO	YES	NO	NO	NO

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State or Territory	Comprehensive Reform Plan	Employer Mandate	Health Insurance Purchasing Cooperatives/ Managed Competition	Major Medicaid Reforms	Insurance Market Reforms	Creation of Basic or Standard Benefit Packages	Creation of Medical High-Risk Pools	Medical Savings Accounts
NEW JERSEY	NO	NO	NO	NO	YES	YES	NO	NO
NEW MEXICO	NO	NO	YES	NO	YES	YES	YES	N
NEW YORK	NO	NO	NO	YES	YES	NO	NO	NO
NORTH CAROLINA	NO	NO	YES	NO	YES	YES	NO	NO
NORTH DAKOTA	NO	NO	NO	NO	YES	NO	YES	NO
OHIO	NO	NO	YES	NO	YES	NO	NO	NO
OKLAHOMA	NO	NO	NO	YES	YES	YES	NO	NO
OREGON	YES	YES 1997-98**	NO	YES	YES	YES	YES	NO
PENNSYLVANIA	NO	NO	NO	NO	NO	NO	NO	NO
PUERTO RICO	YES	NO	YES	NO	YES	NO	NO	NO
RHODE ISLAND	NO	NO	NO	YES	YES	YES	NO	NO
SOUTH CAROLINA	NO	NO	YES	YES	YES	YES	YES	NO
SOUTH DAKOTA	NO	NO	YES	NO	YES	NO	YES	YES
TENNESSEE	NO	NO	NO	YES	YES	YES	YES	NO
TEXAS	NO	NO	YES	NO	YES	YES	YES	NO
UTAH	NO	NO	NO	YES	YES	NO	YES	NO
VERMONT	NO	NO	YES	NO	YES	YES	NO	NO
VIRGINIA	NO	NO	NO	NO	YES	YES	NO	NO
WASHINGTON	YES	YES 1995-99**	YES	YES	YES	YES	YES	NO
WEST VIRGINIA	NO	NO	NO	NO	YES	NO	NO	NO
WISCONSIN	NO	NO	NO	NO	YES	YES	YES	NO
WYOMING	NO	NO	NO	NO	YES	NO	YES	NO

* Massachusetts' employer mandate is scheduled to take effect in 1996. However, repeal of the mandate is a distinct possibility

**Oregon and Washington's employer mandates need federal waiver exemptions from the *Employee Retirement Income Security Act* (ERISA). In both states, however, repeal of the mandates is a distinct possibility.

Appendix E

GLOSSARY

A

ADC *(Average Daily Census)*
Average number of patients cared for per day during the reporting period.

ADHC *(Adult Day Health Care)*
A program that provides medical, rehabilitative, social, recreational and health education services to veterans in a congregate setting during normal working hours.

ACGME *(Accreditation Council of Graduate Medical Education)*
An organization whose responsibilities include establishing standards for teaching hospitals' treatment of medical residents.

AHA (American Hospital Association)

ALOS (Average Length of Stay)
Number of inpatient days for discharged patients divided by total number of discharges; equivalent to the average number of days for an inpatient episode of care.

Ambulatory Care
Medical treatment provided without an overnight hospital stay, including some forms of surgery, non-emergency examination, diagnosis and treatment of medical conditions, and laboratory and other diagnostic testing. Synonymous with outpatient care.

AMVETS *(American Veterans of WW II, Korea, and Vietnam)*
A veterans' service organization and coauthor of the Independent Budget.

B

Basic Benefit Package
A list of specific services covered under an insurance contract. Also, services determined to meet minimum requirements for medically necessary care authorized under specific legislation. See also: *Uniform Benefit Package*.

Bio-Psycho-Social Programs
Mental health programs that consider biological, psychological and social causes of mental illness.

C

C&P *(Compensation and Pensions)*
The organizational component of the Veterans Benefits Administration that processes veterans' claims and administers payments for compensation and pension benefits.

Capital Facilities Inventory
A system the VSOs recommend to maintain a current information base, which would enable VHA to determine major construction project needs.

Capitation
A fixed amount paid per person to cover services over a period of time; a fixed, per capita payment.

Care Maps
Elaborate critical pathways that show the relationship of interventions to immediate outcomes over a set period of time.

Carry-over Authority
The authority granted to a federal agency that enables it to retain residual appropriated funds from one fiscal year to the next; reduces unnecessary spending of funds at the end of a fiscal year.

Catastrophic Disability
A disability that requires costly treatment; one that is catastrophic to the patient's or family's finances.

Category A Veterans
Service-disabled veterans, ex-POWs, Veterans of World War I or earlier conflicts, veterans exposed to ionizing radiation and Agent Orange, VA pension recipients, veterans with Medicaid and other low-income veterans. Category A veterans are entitled to the provision of hospital and some forms of outpatient care. Also referred to as *Mandatory* or *Core Group* veterans. See Appendix B.

Civilian Health and Medical Program of the Uniformed Services *(CHAMPUS)*
A federal health benefits program that pays for medical care delivered by civilian providers to retirees and dependents of active and retired members of the uniformed services. The Department of Defense *(DOD)* administers the program.

CIARDS *(Central Intelligence Agency (CIA) Retirement and Disability System)*

CIRO *(Chief Information Resources Officer)*
Veterans benefits official responsible for departmental information resources management activities.

Clinical Practice Guidelines
Standards developed to assist practitioner and patient decisions about appropriate care in specific clinical circumstances.

CMD *(Chief Medical Director)*
Former title of head of the Veterans Health Administration *(VHA)* (now the Department of Veterans Affairs Under Secretary for Health).

COLA *(Cost of Living Adjustment)*
Increase in benefits to compensate for rise in the cost of living due to inflation; usually provided on a yearly basis.

Compensation
The appropriation account that provides for compensation payments to service-connected disabled veterans and their survivors.

Critical Paths
Clinical management tools that organize, sequence and time the major interventions of nursing staff, physicians and other hospital departments for a particular case type or condition.

CVA *(The United States Court of Veterans Appeals)*
An Article I court, established under *P.L. 100-687*, with exclusive jurisdiction to review final Board of Veterans' Appeals *(BVA)* decisions.

CRC *(Community Residential Care Program)*
Provides residential care to veterans who do not require hospital or nursing home care but who cannot live independently; the veteran pays the cost of this care.

CSRS *(Civil Service Retirement System)*

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D

DAV *(Disabled American Veterans)*
A veterans' service organization and coauthor of the *Independent Budget*.

DHHS *(Department of Health and Human Services)*

DIC *(Dependency and Indemnity Compensation)*
Paid to the surviving spouses or children of service persons or veterans whose deaths occurred while on active duty or as a result of service-connected disabilities.

Discharge Rate
The ratio of the number of inpatients treated to the client population base; usually expressed as a rate of inpatients per 1,000 veterans.

DOD *(Department of Defense)*

E

Eligibility
Eligibility criteria are categorized by service-connected status, income levels and other factors; eligible veterans may receive VA health services if space and resources are available. Service-connected veterans are eligible for the full spectrum of VA medical care services; see Appendix B or Table 6 for entitlement and eligibility criteria.

Enhanced Use
A leasing agreement in which unoccupied or underoccupied VA facilities lease space to external parties for activities that will benefit VA.

Entitlement
An unequivocal, statutory commitment by Congress to provide a specific benefit, such as health care, to certain populations who meet the eligibility criteria established by law. VA is required to provide benefits to veterans who are entitled to programs under Veterans Benefits Administration criteria and inpatient and some forms of outpatient care to veterans entitled to VA medical care system treatment.

F

FDPP *(Facility Development Planning Program)*
A component of the current Medical Care Resource Management Program VHA uses to identify current and projected facility needs at individual medical centers.

FERS *(Federal Employees Retirement System)*

FTE *(Full-time Employee)*

FTEE *(Full-time Employee Equivalent)*

G

GAO *(General Accounting Office)*

GEM *(Geriatric Evaluation and Management Unit)*
Units at VA medical centers that assess elderly patients' medical, functional, psychological and environmental conditions.

GIF *(Guaranty and Indemnity Fund)*
The fund's principal objective is to encourage and facilitate extension of favorable credit terms by private lenders to veterans for the purchase, construction or improvement of homes for veterans and their families. Authorized by the *Veterans Benefits Amendments Act of 1989*, this fund finances all operations of the Loan Guaranty Program for loans closed on or after January 1, 1990, except manufactured home loans guaranteed under *38 U.S.C. Sec. 1812*, loans guaranteed under *section 1811(g)*, and most administrative costs.

GOE *(General Operating Expenses)*
The appropriation account for the administration of nonmedical benefits and support functions; includes the Veterans Benefits Administration, the National Cemetery System and general administration activities.

GRECC *(Geriatric Research, Education and Clinical Center)*
VA centers that advance geriatric and gerontological research, education and clinical achievements and their integration into the VA health care system.

H

HBHC *(Hospital-Based Home Care)*
Programs that allow the early discharge of chronically ill veterans to their own homes.

HCMI *(Homeless Chronically Mentally Ill Veterans Program)*
A VA outreach program that identifies and serves homeless, chronically mentally ill veterans.

HLGP *(Home Loan Guaranty Program)*
Provides housing credit assistance to eligible veterans and military personnel.

Hospice Program
Provides inpatient palliative care for terminally ill patients.

HPSAP *(Health Professional Scholarship Assistance Programs)*
Provides physician, nurse, physical therapist and other health professions scholarships.

HCVA *(House Committee on Veterans Affairs)*

I

IBVSOs (Independent Budget *Veterans' Service Organizations*)
Veterans' service organization coauthors of the *Independent Budget*, including AMVETS, Disabled American Veterans, Paralyzed Veterans of America and Veterans of Foreign Wars of the United States.

Incremental Reform
Describes various step-by-step approaches to health care reform that utilize modest changes to the current health care system to increase access to health care services and coverage. Examples include prohibiting pre-existing condition exclusions in health insurance, malpractice tort reforms, community-rating and increasing the tax-deductibility of health care coverage for the self-employed.

Inpatient Services
Those services that require patient admission to a health care facility.

Insurance Reform
Incremental reforms aimed at limiting restrictions on pre-existing conditions, allowing portability of insurance for individuals changing jobs and guaranteeing policy renewability (except for reasonable cause, such as nonpayment of premiums).

Intermediate Care
A medical bed section in a VA hospital that serves as a reservoir for patients with intensive care needs or chronic illness.

Investment Fund
A fund the *American Health Security Act* originally proposed; would have provided VA with $3.3 billion dollars incrementally over three years for modernization and infrastructure improvement.

IRM *(Information Resources Management)*
An entity responsible for managing the system's or department's databases and computer resources. Also may refer to a strategy based on the principle that information is a resource that should be managed from the highest level of an organization.

J

JCAHO *(Joint Commission on Accreditation of Health Care Organizations)*
Provides criteria and surveys hospitals for accreditation, which affirms that an organization has met standards associated with quality health care delivery. VA voluntarily complies with JCAHO standards.

L

LGRF *(Loan Guaranty Revolving Fund)*
Funds the non-administrative expenses incident to the management and sale of properties acquired when program borrowers fail to make their payments on VA-guaranteed or -insured loans. Revenue is derived principally from the sale of homes for cash, the sale of loans and collection of a funding fee.

Long-term Care
Non-acute care services that require more than 30 days of treatment.

M

Major Construction
VA construction projects costing $3 million or more; also refers to the appropriation account that funds such projects.

MAMOE *(Medical Administration and Miscellaneous Operating Expenses)*
The appropriation account that provides for the administration of all VA medical programs.

Managed Care
A system of health care delivery that manages the utilization and cost of services and measures performance. The goal is a system that delivers value by giving people access to quality, cost-effective health care.

MCCR *(Medical Care Cost Recovery)*
Program to collect veteran copayments and reimbursable costs from third-party insurers for medication and health care services.

Medical Savings Account *(MSA)*
Pre-tax income accounts for health care costs. This arrangement gives consumers a financial incentive to control their own health care costs. MSAs combine a high-deductible health insurance policy with an individual savings account. The health insurance policy provides insurance protection for large medical bills, while the savings account provides a source of funds to pay small medical expenses out-of-pocket.

Medicaid
A medical assistance program funded by the federal and state governments. Under federal regulations provided by the Health Care Financing Administration *(HCFA)*, each state administers Medicaid benefits to "categorically needy" individuals, who receive public assistance because they are poor, aged, blind or disabled. States may also provide Medicaid services to the "medically needy," who have incomes too high to be considered "categorically needy" yet are still unable to afford health care coverage.

Medicare
A program administered by the Health Care Financing Administration; pays certain hospital and medical expenses for those who qualify, primarily those over age 65 and disabled individuals. Benefits are provided regardless of income level. The program is government-subsidized and government-operated. Medicare Part A, Hospital Insurance (HI), provides for inpatient hospital services and post-hospital care. Part B, Supplemental Medical Insurance (SMI), pays for medically necessary doctors' services and other services and supplies Part A does not cover. Enrollment in Part B is voluntary and available for a small premium.

Minor Construction
VA construction projects costing less than $3 million; also refers to the appropriation account that funds such projects.

N

NCS *(National Cemetery System)*
The VA agency responsible for managing the national cemetery system and for interring and providing related services for deceased veterans, active duty members of the Armed Forces and their eligible dependents.

Non-Service-Connected *(NSC)* Patients
Veteran patients who do not have a military service-related injury or illness.

NSLI *(National Service Life Insurance)*
Trust fund started in 1940 as the financing mechanism for World War II insurance. Closed to new issues in 1951. Income is derived from premiums, interest on investments and transfers from Veterans Insurance and Indemnities appropriation.

O

OASDI *(Old Age, Survivors and Disability Insurance Benefits)*
The Social Security cash benefit program.

OBRA *(Omnibus Budget Reconciliation Act of 1990)*
An act to meet 1995 deficit reduction targets.

OBRA '93 *(Omnibus Budget Reconciliation Act of 1993)*
An act to meet 1999 deficit reduction targets.

Occupancy Rate
Ratio of average daily census to the average number of beds in a reporting period.

OMB *(Office of Management and Budget)*
The agency responsible to the executive branch for developing economic assumptions and agency budgets for the federal government in each fiscal year.

OSHA *(Occupational Safety and Health Administration)*

Outpatient Care:
See *Ambulatory Care*.

Outpatient Use Rate
Ratio of outpatient visits to the total veteran population.

Outpatient Visits
Visits by patients who are not lodged in the hospital while receiving medical, dental or other services. In the VA health care system, a visit may consist of one or more clinic stops. (Each test, examination, treatment or procedure rendered to an outpatient counts as one clinic stop.)

P

Pay-as-you-go *(PAYGO)*
Enforcement mechanism created by the *Budget Enforcement Act* that requires that any enacted legislation that either reduces revenues or increases mandatory spending above the baseline be offset by equal revenue increases or mandatory spending reductions. If a full offset is not enacted, then a pay-as-you-go sequester will be triggered. Also referred to as *PAYGO*.

P&SAS *(Prosthetics and Sensory Aids Service)*
The entity within VHA whose goal is the provision of prosthetic and orthotic appliances and sensory aids to veterans.

Pensions
The appropriation account that provides pension payments, subject to an income standard, to war-time veterans who are permanently and totally disabled from non-service-connected causes, and their survivors.

Pharmaceutical Unit Dose Program
A system that minimizes pharmacy costs by packaging and dispensing drugs in single-dose quantities.

Practice Parameters
Strategies for patient management developed to assist physicians in clinical decision making.

Also referred to as *Clinical Practice Guidelines*.

146 **Practice Standards**
Specified principles and procedures for which there is virtual unanimity regarding the health and economic consequences of intervention.

***Pro Se* Appeals**
Appellate cases in which the litigant is unrepresented by counsel.

PTSD *(Post-Traumatic Stress Disorder)*
A psychiatric condition caused by a traumatic experience, such as combat.

PVA *(Paralyzed Veterans of America)*
A veterans' service organization and coauthor of the *Independent Budget*.

Q

QMMP *(Quality Measurement and Management Project)*
The American Hospital Association's project established to design a system for monitoring quality assurance through outcome indices.

Quaternary Care
Intensive, high-cost therapy for major illness or injury, utilizing specialized professional teams.

R

RAM *(Resource Allocation Model)*
Formerly used system for distribution of resources in VA system based on diagnostic related groups (DRGs).

Rating Boards
A panel of benefits' claims adjudicators whose responsibilities include assigning disability ratings to veterans who claim service-connected disorders.

RB *(Readjustment Benefits)*
The appropriation account that provides payments for education and training, for eligible veterans and dependents, and as special assistance to veterans with disabilities.

Respite Care
Programs under which the elderly or people with disabilities are institutionalized periodically to allow a relief period for the patients' caregivers.

RO *(Regional Office)*
Benefits—An office in one of 58 geographical areas responsible for administering veterans' benefits.

Medical—An office in one of four geographical areas responsible for administering medical care benefits to veterans.

RPM *(Resource Planning and Management)*
Strategy formulated by the Veterans Health Administration to achieve comprehensive integration of strategic and operational planning, budgeting and operational management of the VA health care system.

S

SCVA *(Senate Committee on Veterans Affairs)*

SDVI *(Service-Disabled Veterans Insurance)*
The fund financing claim payments on non-participating policies issued to service-disabled veterans who served in the Armed Forces after April 25, 1951. The program provides insurance coverage for service-disabled veterans at standard rates. Claim payments exceed premium receipts each year. Funds are derived mainly from premiums and payments from the Veterans Insurance and Indemnities appropriation.

Secondary Care
Therapy for acute short-term illness or injury.

Sequestration
The cancellation of budgetary resources provided by discretionary appropriations or a direct spending law. A sequester will occur if a discretional spending limit is breached, if revenues are cut below or mandatory spending is increased above the baseline without offsetting changes to eliminate any impact on the deficit, or if the deficit maximum set for the year is exceeded.

Service-Connected Patient
A veteran with conditions resulting from illness or injuries sustained during military service.

SGLI *(Servicemen's Group Life Insurance)*

Sharing
Refers to federal agencies sharing health care services (usually high-cost or high-technology services) with community or private sector providers, or with other federal agencies. Sharing agreements have legislative authority.

Small Market Reform
Proposals that would institute practices that enable smaller firms to obtain insurance at competitive rates. Most proposals guarantee small groups access to insurance, restrict coverage cancellations because of high utilization, require insurers to cover all small groups (if they offer insurance to any), and stabilize premium rates.

SSA *(Social Security Administration)*
The governmental entity responsible for the administration of SSI (see below).

SSDVI *(Supplemental Service-Disabled Veterans Insurance)*

SSI *(Supplemental Security Income)*
Social Security counterpart to veterans' Pension Program.

Standard Benefit Package
A standard set of services covered under health insurance or a health plan. In the health reform process, consideration was given to mandating a minimum basic benefit package, which would permit purchasers to compare plans for cost and to prevent risk selection by the plans. See also: *Basic Benefit Package*.

Suppressed Demand
The difference between the expected workload of a given health care setting and the actual workload. Suppressed demand results from inadequate operating resources and is manifested by patient turnaways and unmet needs.

T

Tertiary Care
Definitive therapy for major illness or injury, utilizing specialized professional skills and techniques.

Third-Party Reimbursement
Payment for health care services by an interest other than the patient or provider, such as an insurance company or the government.

U

Uncompensated Care
Refers to hospital care provided for which the hospital receives no payment from a patient or insurer. It is the sum of a hospital's "bad debt" and the charity care it provides.

Under Secretary of Health
Title of head of the Veterans Health Administration *(VHA)* (formerly Chief Medical Director *(CMD)*); reports to the Secretary of the Department of Veterans Affairs.

Unmet Need
The difference between the health care needs of a population and the health care services actually delivered.

USGLIF *(U.S. Government Life Insurance)*
Trust fund started in 1919 as the financing mechanism for converting insurance issued under the *War Risk Insurance Act of September 2, 1914*, as amended. Closed to new issues in

April 1951. Income is derived from interest on investments and transfers from Veterans Insurance and Indemnities appropriation.

V

VA *(Department of Veterans Affairs)*
Formerly, Veterans Administration.

VACO *(Veterans Affairs Central Office)*
The headquarters for the operation of Department of Veterans Affairs programs; located in Washington, DC.

VAMC *(Veterans Affairs Medical Center)*
One of the 171 hospitals dedicated to administering veterans' health benefits.

VBA *(Veterans Benefits Administration)*
The Veterans Affairs component that administers the VA's non-medical benefits and services to veterans and their dependents (formerly VA's Department of Veterans Benefits).

Veterans' Industries
Programs devoted to enhancing impaired veterans' independent living skills.

VFW *(Veterans of Foreign Wars of the United States)*
A veterans' service organization and coauthor of the *Independent Budget*.

VGLI *(Veterans Group Life Insurance)*

VHA *(Veterans Health Administration)*
The VA agency responsible for delivering medical care; formerly, Veterans Health Service and Research Administration, and Department of Medicine and Surgery.

VI&I *(Veterans Insurance and Indemnities)*
The appropriation that provides payment for extra hazard costs to the National Service Life Insurance and United States Government Life Insurance; supplements the Service-Disabled Veterans Insurance Fund and provides direct payment to policyholders; also provides funds for expenses of the Veterans Mortgage Life Insurance Program.

VMLI *(Veterans Mortgage Life Insurance Program)*
A program funded by the Veterans Insurance and Indemnities appropriation. The program provides $40,000 in mortgage life insurance to individuals who have received a grant for specially adapted housing. Policies are issued at standard premium rates to individuals who are considered health risks.

VR&C *(Vocational Rehabilitation and Counseling)*
The component of the Veterans Benefits Administration that assists veterans who have service-connected disabilities.

VRI *(Veterans Reopened Insurance)*

VS *(Veterans Services)*
The component of the Veterans Benefits Administration that provides information, advice and assistance regarding benefits to veterans and their dependents and survivors.

VSLI *(Veterans Special Life Insurance)*

VSO *(Veterans' Service Organization)*
An organization advocating the rights of veterans.

Appendix F

Work Sheet For Comparison of Budget Recommendations
(in thousands)

	FY 1995 Appropriation	FY 1996 IB Current Services Level	FY 1996 IB Recommended Appropriation	FY 1996 IB Recommended Budget Authority	FY 1996 Administration	FY 1996 HCVA Recommended	FY 1996 SCVA Recommended	FY 1996 House App. Recommended	FY 1996 Senate App. Recommended	FY 1996 Conference Report
General Operating Expenses (GOE)										
General Operating Expenses	890,193	1,208,813	1,267,248	1,267,248						
Office of the Inspector General	31,815	32,591	32,591	32,591						
National Cemetery System	72,604	82,000	82,000	82,000						
Total General Operating Expenses	**$994,612**	**$1,323,404**	**$1,381,839**	**$1,381,839**						
Benefits Program										
Compensation, Pension, and Burial Benefits	17,626,892	17,661,972	17,661,972	17,661,972						
Readjustment Benefits	1,286,600	1,345,300	1,345,300	1,345,300						
Veterans Insurance & Indemnities	24,760	24,800	24,800	24,800						
Veterans' Job Training Fund	0	0	0	0						
Loan Guaranty Program Accounts	59,371	82,321	82,321	82,321						
Guaranty and Indemnity Program Account	572,321	582,207	582,207	582,207						
Direct and Other Loan Program Accounts	2,062	487	487	487						
Native American Veteran Housing Loan Program Account	218	455	455	455						
Total Benefits	**$19,572,224**	**$19,697,542**	**$19,697,542**	**$19,697,542**						
Medical Programs										
Medical Care	16,214,684	17,608,398	18,771,297	19,564,081						
Medical & Prosthetic Research	251,743	290,583	310,583	310,583						
Medical Admin and Miscellaneous Expenses	69,789	72,343	72,343	72,343						
Health Professionals Educational Assistance Program	10,386	0	0	20,000 *						
Total Medical Programs	**$16,546,602**	**$17,971,324**	**$19,154,223**	**$19,967,007**						
Construction Programs										
Construction, Major Projects	354,294	490,006	490,006	490,006						
Construction, Minor Projects	152,934	269,800	269,800	269,800						
Parking Garage Revolving Fund	16,300	1,500	1,500	1,500						
Grants for Construction of State Veteran Cemeteries	5,378	6,000	6,000	6,000						
Grants for Construction of State Extended Care Facilities	47,397	180,000	180,000	180,000						
Grants to the Republic of the Philippines	500	500	500	500						
Total Construction Programs	**$576,803**	**$947,806**	**$947,806**	**$947,806**						
Total VA Programs	**$37,690,241**	**$39,940,076**	**$41,181,410**	**$41,994,194**						

*Authorizes Educational Loan Repayment program to replace the Health Professionals Educational Assistance Program



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STATEMENT OF

LARRY D. RHEA

DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS

BEFORE THE

COMMITTEE ON VETERANS AFFAIRS

U. S. HOUSE OF REPRESENTATIVES

ON

DEPARTMENT OF VETERANS AFFAIRS

FISCAL YEAR 1996 BUDGET

FEBRUARY 24, 1995

Chartered by the United States Congress

The Non Commissioned Officers Association of the USA (NCOA) appreciates the opportunity to comment on the Department of Veterans Affairs (DVA) Fiscal Year 1996 Budget. It is the Association's sincere hope that our comments will be beneficial to the distinguished Chairman and members as you undertake your work to mark the Administration's proposed budget for the DVA.

PREFACE

When NCOA appeared last year before this Committee to testify on the Fiscal Year 1995 DVA Budget, there was little doubt in the minds of most veterans and Members of Congress that last years proposal was so woefully deficient that current services could not have been maintained. In fact, by all assessments, the Administration's FY95 Budget for DVA failed to meet muster in every major account. Fortunately for veterans, the strong intervention by the members of the House Veterans Affairs Committee facilitated the restoring of a measure of fiscal sensibility to the current year budget.

An initial review of the FY96 DVA Budget could easily lead one to conclude that the Administration has heeded the message that Congress clearly sent last year regarding veterans programs and spending. The $39.5 billion total funding level for DVA in FY96 represents an increase of $1.3 billion above the $38.2 billion FY95 budget enacted by Congress. The Administration's FY 96 budget request is approximately $1.7 billion more than the Administration requested for veterans in their FY95 proposal.

On the sheer magnitude of the numbers Mr. Chairman, NCOA's initial reaction was that the DVA FY96 Budget was at last attempting to match the Administration's promises to uphold veteran's programs and benefits. NCOA's first reaction was that the budget was probably as good as veterans could hope for. On closer examination of the Administration's proposal however, NCOA has arrived at the same conclusion that the Distinguished Chairman has reached. It appears to this Association that the proposed budget represents a continuation of "business as usual." In NCOA's opinion, it is unfortunate that the Administration did not address some of the underlying hindrances that prevent VA from working smarter.

In this regard Mr. Chairman, NCOA will confine its comments on the budget to two principal areas of concern. The first area is the omission within the budget proposal to convey a strategic vision, particularly in the area of health care. Secondly, NCOA is deeply disappointed that the Administration is proposing to extend certain provisions of the Omnibus Budget Reconciliation Act (OBRA) of 1993 that markedly tarnished and devalued some veterans programs. It is for these two reasons primarily that NCOA urges the Committee to look closely at this budget both in terms of its longer impact and its outright unfairness to veterans particularly in the area of educational programs.

VETERANS HEALTH ADMINISTRATION (VHA)

The DVA budget contains a total request of $17 billion for veteran health care, a $747 million increase from the FY95 level. The VA believes that this level of funding, in concert with its reorganization and operations management improvements, will allow the Department to fulfill its anticipated health care obligation, including an additional expected 43,000 eligible veterans. NCOA is pleased that the budget supports an employment level of 201,254 employees in the VHA. The Association is also notes that the proposed budget fully funds construction of new hospitals in Brevard County, Florida, and at Travis Air Force Base in California, as well as three nursing homes.

As NCOA has stated previously, the Association believes that veteran health care must shift its emphasis from costly inpatient hospital care to outpatient and noninstitutional care settings. Unquestionably, this has been the general trend across the country for several years in combatting the rising cost of medical care while continuing to provide suitable patient care. NCOA does not believe that the FY96 DVA budget provides the priority needed in this area of veteran health care. While the DVA has made progress in shifting from inpatient to outpatient

care, NCOA is disappointed that this budget did not aggressively seek to further that effort.

In NCOA's opinion, the preeminent shortfall in the Administration's budget for the VHA is its omission, intentional or otherwise, to address the underlying cause of VA's inability to properly shift the treatment of patients to the most cost effective setting. Although the Department of Veterans Affairs has consistently acknowledged that reform of veteran health care eligibility rules is desperately needed, NCOA was hopeful that their FY96 Budget would address this area. In NCOA's view, it is most unfortunate and somewhat short sighted that the Department did not include in this budget their recommendations to do so.

The veteran issue of paramount importance to NCOA, and thereby the budgetary area of principal concern, is the delivery of quality health care services to eligible veterans. This is not an issue that magically appeared on the radar scope two years ago when the Administration introduced its plan to reform the entire national health care delivery system for all Americans. As many members of the House Committee on Veterans Affairs know, NCOA has been seeking fundamental change to the Veteran Health Administration for many years. As several members of the Committee also know, the 102nd Congress was very close to enacting improvements, particularly in the area of eligibility reform. The landscape changed, however, with the convening of the 103rd Congress and the introduction of the President's national health security plan.

In good faith, NCOA actively participated in the dialogue and debate on veteran health care throughout 1993 and 1994. The point that NCOA wishes to underscore in our testimony today is that the Veterans Health Administration remains in need of fundamental change. NCOA is disappointed that the Administration did not include in the FY96 VA Budget those basic eligibility changes that they had so actively sought for the past two years.

By DVA's own estimates, more than 40% of inpatient care is for "non-acute" reasons. While the savings to be realized is debatable in shifting this percentage of the total VA patient load to an alternative setting, NCOA believes there is little doubt that substantial savings would be realized. At a time when there is a national focus on making the federal government work smarter and cost less, NCOA believes the Administration has missed an obvious area that would do both while better serving the needs of veterans.

As stated earlier, NCOA is thankful that $17 billion is earmarked for veteran health care in FY96. NCOA is skeptical though that this increase of $747 million over FY95 will go very far toward improving overall veteran health care. The major portion of the $747 million increase will be consumed by employee salaries and, therefore, in NCOA's opinion, the FY96 Budget for veteran health care is essentially a "hold the line" proposition. Within this reality, NCOA believes it is absolutely crucial that the Committee address the area of eligibility reform not only for its potential impact on the FY96 Budget but also for its longer term impact on the future viability of the Veterans Health Administration.

OBRA EXTENDERS

NCOA is extremely dismayed that the Administration has proposed to extend the Montgomery G.I. Bill cost-of-living adjustment (COLA) at 50% through the year 2000, two years beyond the limitation imposed by OBRA 93. Such an action could be accepted more easily if the remainder of the President's federal budget followed a similar pattern. But as you know Mr. Chairman that is not the case. Veterans cannot help but conclude that once again veterans educational assistance is being targeted in favor of non-veteran educational program. It is deeply troubling that the President can see fit to increase Americorps spending by $300 million (a 25% increase) yet finds it necessary to continue to cut the meager educational benefit of veterans.

For many years Mr. Chairman, NCOA has consistently voiced its concern regarding the value of veterans education assistance. By any comparison, today's program is considerably less valuable than the comparative benefit of programs that preceded the MGIB. In arguing this point, NCOA actively supported indexing the benefit and the Association was pleased that Congress saw the necessity of protecting veteran educational assistance against future erosion.

Nonetheless, Mr. Chairman, two central points are unarguable. First, indexing does little to extend comparative equity with the programs of earlier eras. Secondly, when indexing is frozen or held to one-half the intended increase, the value of the MGIB and the comparative equity is further eroded.

During last years events commemorating the fiftieth anniversary of the first veterans educational bill, the worth of the original program and in the subsequent programs that have followed was made clear and celebrated. Fifty years of history also make it clear that the value of such programs must be maintained. Not only is the attractiveness of veteran educational assistance as a post-service benefit wearing extremely thin, the attractiveness of the benefit as a recruiting and retention incentive is becoming more and more a non-factor. NCOA believes it is incumbent upon the Committee to very carefully consider the full ramifications of the Administrations proposal to further extend the provisions of OBRA 93 that pertain to the MGIB benefit. Further, as a matter of fairness in comparison with other provisions of the Administration's budget, NCOA believes that the Administration's proposal should be outright rejected.

INDEPENDENT BUDGET

As an endorser of the Independent Budget of Veterans Organizations, NCOA urges the Committee of carefully consider the recommendations contained therein that relate to other areas of the VA Budget that NCOA did not comment on in this statement. NCOA believes that the work of the four principal veterans organizations involved is worthy of the Committee's serious review and consideration.

CONCLUSION

NCOA is grateful that the Administration's proposal includes increases in the areas of construction and research and a $22 million increase for the Veterans Benefits Administration. The Association is also pleased that a $50 million increase has been provided to address the critical area of equipment backlog as well as providing a 3.1% COLA to compensation beneficiaries.

In NCOA's opinion, two areas of the DVA FY96 Budget need stringent review and analysis; namely, the budget's failure to address eligibility reform and the proposal to extend the provisions of OBRA 93 relating to the MGIB. Eligibility reform is needed now and MGIB benefits cannot endure further erosion.

Thank you.

STATEMENT OF CARROLL L. WILLIAMS, DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
FEBRUARY 24, 1995

Mr. Chairman and Members of the Committee:

The American Legion appreciates the opportunity to present its views on the Administration's proposed budget for programs and operations of the Department of Veterans Affairs (VA) for Fiscal Year (FY) 1996.

For FY 1996, proposed funding to operate VA programs and services is $39.5 billion. The proposal represents an increase of $1.3 billion over the FY 1995 budget estimate. The proposal provides for selective programs and functions as follows:

FISCAL YEAR 1996
DEPARTMENT OF VETERANS AFFAIRS BUDGET PROPOSAL

($ in millions)	Proposed FY 1996	American Legion Recommendation
Medical Care	$16.962	$19.6
Medical Research	$257	$290
Construction	$788	$750
State Home Grants Program	$ 43	$ 75
National Cemetery System	$75.3	$ 78
Veterans Benefits Administration (GOE)	$694	$785

MEDICAL CARE

The appropriation requested for Medical Care in FY 1996 represents a net increase of $747 million over the FY 1995 enacted level. This net gain is attained from new medical care program funding of $1.1 billion, which includes increases for payroll, inflation, facility activations, increased workload, equipment, supplies and services; minus $335 million and 3,429 FTE positions for various management efficiency improvements.

Proposed management efficiency improvements include:

-- Replacing the current regional structure with a new field management and operations structure under the Veterans Integrated Service Network (VISN) concept in which geographic areas will function as business offices to improve the efficiency and effectiveness of VA health care delivery.

-- Decentralizing to reduce administrative layers not producing value added service.

-- Marketing the services of certain national programs to interested VA medical centers thereby making the programs self-sustaining.

-- Reducing "management layers" by eliminating unnecessary positions and integrating the administrative functions of certain groups of medical centers.

-- Consolidating/realigning medical center services and integrating services of medical centers that are geographically close and have complementary missions.

-- Utilizing available community services that are less expensive than current cost.

-- Enhancing the shift of care from historical inpatient based services to increased reliance on ambulatory care.

The FY 1996 budget proposal will permit VA to initiate the following program enhancements:

-- increase in number of veterans seeking care: Increases of $108.3 million and 1,509 FTE positions will provide 436 more inpatient episodes and 400,000 more outpatient visits.

-- Reduce Equipment Backlog: $50 million.

-- State Home Programs: Increase of $8.2 million.

-- Facility Activations (replacement and modernization): Net increases of $208.4 million and 2,129 FTE positions.

The President's FY 1996 budget provides for various medical care programs as follows:

-- AIDS care and treatment proposes a funding level of $306.8 million, an increase of $15.2 million. By September 30, 1994, 22,190 cases of AIDS had been reported by VA medical centers.

-- Beneficiary Travel proposes an increase of $2.1 million to an annual funding level of $100.9 million.

-- Capital Investment: Proposes an increase of $78.3 million for a total FY 1996 budget of $888.6 million for maintenance and repair and replacement equipment funding.

-- Geriatric and Extended Care: Receives an increase of $170.4 million for a total of $2.2 billion. Institutional programs in this

classification includes nursing home care, domiciliary care, geriatric evaluation management, and respite care. Also included are various noninstitutional programs, including, hospital based home care, adult day health care, home health aide services, and community residential care. VA's Geriatric, Research, Education and Clinical Centers (GRECCs) proposes an increase of $1 million to an annual funding level of $24.2 million.

-- Homeless: Programs to assist homeless veterans are proposed to receive a funding increase of $1.5 million to an annual funding level of $77.5 million.

-- Post-Traumatic Stress Disorder (PTSD): Proposes an increase of $2.7 million for an FY 1996 funding level of $59 million. A new PTSD Evaluation and Treatment Program is proposed for establishment at VAMC Clarksburg, WV, for FY 1996.

-- Readjustment Counseling Service Vet Centers: The Vet Center program is proposed to receive an increase of $2 million for an annual funding level of $65 million.

-- Substance Abuse Treatment Program: VA operates specialized Substance Abuse Treatments programs at 165 medical centers. During FY 1993, 54,195 individual veterans were treated in specialized inpatient treatment programs. Within the outpatient components, there were over 2 million substance abuse clinic visits made by patients during FY 1993. A funding increase of $23.3 million is proposed for FY 1996, for an annual funding level of $587 million.

Mr. Chairman, The American Legion views the President's budget proposal for VA Medical Care for FY 1996 as a baseline for further congressional deliberations. The American Legion hardly thinks that an increase of 436 more inpatient episodes of care and 400,000 more outpatient visits, above FY 1995 planning levels, corresponds to the declaration that the budget will permit VA to provide quality health care to <u>all</u> eligible veterans expected to apply for care on a system-wide basis. The American Legion is uncertain what definition is employed for <u>all</u> eligible veterans in VA's budget proposal.

The American Legion questions whether VA will be able to achieve all of the targeted $335 million in savings under the pretext of management efficiency improvements in FY 1996. Further review of this

assertion is necessary. If the intended savings do not fully materialize in FY 1996, VA's operating budget could fall considerably short of necessary funds. Before this Committee sets its budget recommendations for VA medical care for FY 1996, a thorough review of VA's proposed management efficiency initiatives is required.

The American Legion believes additional resources are required to treat more deserving veterans on both an inpatient and outpatient basis. We continue to receive many letters from veterans who have been denied VA medical care (see the attached). Today, numerous VA facilities send a standard form letter to veterans seeking care, stating that due to budgetary and workload constraints, they cannot provide medical services to "Discretionary" category veterans so they can meet their obligations in providing care to all veterans in the "Mandatory" category. In this regard, VA is within their statutory and regulatory rights. However, the Legion has to question how VA will be able to provide care to all eligible veterans expected to apply for care in FY 1996, as they disallow care to many veterans today.

Mr. Chairman, the Veterans Health Administration, requires an in-depth reorganization of its field and Central Offices. The American Legion hopes this restructuring will form the template for subsequent eligibility reform, fiscal reform, and system reform, at the national and state level. While these changes will take time, we ask this Committee to ensure the integrity of the current VA health care system and to recommend to the Budget Committee adequate resources to carry VA through its transition.

Mr. Chairman, by now, all of the members of this Committee and your congressional colleagues should have received the proposal of The Partnership for Veterans Health Care Reform to reinvent the VA medical care system, entitled, Can You Ignore 27 Million Americans? These ten major Veterans Service Organizations (VSOs) believe this is an essential, realistic, and achievable proposal.

MEDICAL AND PROSTHETIC RESEARCH

In January 1990, the Secretary of Veterans Affairs established a 15-member VA Advisory Committee for Health Research Policy to review

VA research programs. The Committee had four specific charges: To determine if VA's research is appropriately balanced among subject areas; to determine the appropriate role of VA in providing medical and other services to veterans; to determine VA's role in research vis-a-vis the role of other agencies, such as the National Institutes of Health(NIH); and to assess the overall quality of VA research programs. **The Advisory Committee's report, issued in August 1991, found that VA's research program is of the highest quality and is entirely appropriate to its clinical mission.** Additionally, the Committee made specific funding and policy recommendations.

The Committee's main recommendations have still not been instituted within VA. Research funding remains inadequate. In fact, where officials in VA speak about protecting and improving the VA research program, it seems their actions do not coincide with the oratory. The Committee also recommended "The Secretary create a Health Research Advisory Council to oversee all aspects of research and to identify and prioritize those areas of investigation that hold the greatest promise of improving the VA's ability to prevent, diagnose, and treat veterans' medical problems." The Committee maintained that such a Council should include scientists from those pre-clinical, clinical, and other scientific disciplines that are relevant to VA health-related research. The Committee suggested the Council should review funding decisions, program priorities, and the balance across research areas and report such findings to the Secretary.

It is unfortunate that today, nearly four years since the issuance of the Committee's report, VA has not yet established the a Health Research Advisory Council, nor has annual VA research funding approached required levels. Persian Gulf veterans research efforts may have substantially improved through greater coordination and oversight by the proposed Health Research Advisory Council. **The American Legion strongly recommends the Secretary establish a Health Research Advisory Council, and the Council be empowered to oversee all aspects of VA's research programs, as recommended in the 1991 Blue Ribbon Research Committee report.**

From FY 1985 through FY 1995, in constant dollars, overall VA research program funding has decreased (18%), while medical service research funding decreased (29%). An analysis of active medical research programs from FY 1990 through FY 1995, shows a decrease from 2,188 projects to 1,812. The President's Medical and Prosthetic Research funding proposal for FY 1996 is $257 million, an increase of $5 million (2.1%) over FY 1995. It is the view of The American Legion that for FY 1994 and FY 1995, funding for VA research has not kept pace with inflation, and that the FY 1996 budget must reflect inflationary adjustments of four percent for each of those years, plus a real funding increase of approximately $16 million. It is time to stop the hemorrhaging and to restore VA research funding to an appropriate level. **Therefore, The American Legion recommends a VA Medical and Prosthetic Research appropriation of $290 million for FY 1996.**

CONSTRUCTION

The President's proposed FY 1996 construction budget of $742 million represents a fifty (50) percent increase in both major and minor projects. Approximately $514 million in major projects and $229 million in minor projects is proposed.

The American Legion views the proposed FY 1996 construction budget as essential to meeting the ongoing capital facility requirements of the nation's largest integrated health care system. **The American Legion believes the fifty percent increase in funding for both major and minor construction accounts is fully justified.**

The American Legion is disappointed that no proposal is included to fund the construction of a new national cemetery. Since 1987, two consultant studies concerning needed expansion of VA national cemeteries have recommended that VA undertake a consistent policy of adding new cemetery sites to its existing inventory of 114 national cemeteries (of which 56 are closed to new casketed burials). In recent years, VA has constructed one new national cemetery in San Joaquin, CA, and has identified up to four additional sites for further development. Gravesite development for a new cemetery in the vicinity of Seattle/Tacoma, WA was funded in FY 1995. VA has funded other pre-construction activities for new cemetery development in

Dallas, TX; Cleveland, OH; and Albany, NY. The American Legion is surprised that no new cemetery construction is proposed for funding in FY 1996, and respectfully ask the Committee to recommend funding for the construction of one new national cemetery each year through the end of the decade.

The American Legion believes VA must continue to accentuate its medical care program emphasis toward managed care and preventive health care services. While approximately $343 million of the proposed $513 million major project appropriation is targeted toward one replacement medical center and one new medical center, both of these projects are well justified. Additionally, other proposed major construction projects have been necessary for a considerable period.

The American Legion believes VA must increase the number of outpatient care access points within the system and is satisfied that progress (in the absence of an overall strategic health reform plan) is being made in this regard. Continued emphasis on improving access to outpatient care for eligible veterans is essential.

Major Construction projects included in the FY 1996 budget request include:

Location	Description
Travis, CA	VA/AF Joint Venture
Brevard City, FL	New Medical Center/NHC
Boston, MA	Ambulatory Care Addition
Reno, NV	Replace Bed Bldg/Amb Care
Lebanon, PA	Renovate Nursing Units
Marion, IL	Environmental Improvements
Marion, IN	Replace Psych Beds
Salisbury, NC	Environmental Improvements
Perry Point, MD	Renovate Psych Wards
Florida Nat Cem	Gravesite Development/Expansion

GRANTS FOR CONSTRUCTION OF STATE EXTENDED CARE FACILITIES

The grant program assists the States to acquire or construct State home facilities for furnishing domiciliary or nursing home care to veterans, and to expand, remodel or alter existing buildings for

furnishing domiciliary, nursing home, or hospital care to veterans in State homes.

By the early 1990s, the State Extended Care Grant Program had accumulated a shortage of millions of dollars in State grant applications exceeding annual appropriations. This deficit situation was essentially cleared-up by FY 1992, when the program received an appropriation of $85 million. Since FY 1993, the program has again accumulated a shortfall in funding. Today, approved grantapplications on-hand total $115 million. With a FY 1996 budget proposal of $41.5 million, the State Extended Care Facility Grant Program would maintain a funding deficit of $75 million.

Once again it appears that budget planners are being penny wise and pound foolish with regard to the State Extended Care Grant Program. With the increased aging of the overall veterans population, it would serve VA well to annually match the total amount of approved applications. The State Extended Care Grant program is an excellent complement to VA's institutional geriatric programs. By having the States willing to share the costs for aging veterans needs, less federal taxpayer dollars are required. **The American Legion urges an increase for this program in FY 1996 to the current funding level of approved applications. Also, we recommend that the annual appropriation level be directly tied to the total amount of approved State Home grant applications.**

NATIONAL CEMETERY SYSTEM

The National Cemetery System (NCS) requests $75.3 million and 1,340 FTE for FY 1996. This is an increase of $2,704,000 over FY 1995. The request reflects a projected 2.4 percent pay raise.

The American Legion believes the NCS continues to accomplish enhanced performance measures without adequate resources. The 25 FTE increase of FY 1995 has been fully absorbed by increasing workloads. As recently as FY 1990, NCS accomplished 60,500 interments and maintained 1.8 million gravesites. For FY 1996, interments at projected at 72,224 and gravesites maintained will be 2.147 million. Equipment funding remains deficient. All told, NCS requires additional resources and FTE for essential services.

An example of the budget shortfall is the recent policy decision with regard to the Calverton National Cemetery. Because of manpower and fiscal constraints, no longer will NCS personnel unload remains of the deceased from the hearse to the casket carriage to begin the committal service. This function beginning April 1, 1995, will be the sole responsibility of the funeral director. The Legion understands that the high interment workload at Calverton makes this policy imperative. We fear, however, that added funeral director responsibilities will only increase the family's funeral expense. In this case, and other potentially similar situations, additional NCS resources and personnel would help alleviate this predicament. **Therefore, The American Legion recommends an increase of $2.7 million above the President's proposed FY 1996 funding level and an increase of 30 FTE over current levels.**

VETERANS BENEFITS ADMINISTRATION

Proposed appropriations for all VA benefit programs in FY 1996 is $19.7 billion. This is an increase of $83.8 million over FY 1995 and reflects higher caseloads in a number of programs, as well as, changes in average benefit payments to veterans and other eligible beneficiaries. Under General Operating Expenses, requested staffing in the Veterans Benefits Administration (VBA) for administration and claims processing in FY 1996 will be 13,032 FTE which is a net decrease of 188 FTE over the FY 1995 staffing level. Total proposed appropriations will increase by approximately $18 million over the FY 1995 level.

Included in this request are several legislative proposals. There will be a 3.1 percent cost-of-living adjustment (COLA), effective December 1, 1995, for recipients of disability compensation and new law Dependency and Indemnity Compensation (DIC). However, recipients of old law DIC and GI Bill recipients will receive only one half the COLA rate. The COLA will be rounded down to the nearest dollar through FY 2000 for all beneficiaries. **The American Legion has long supported the annual adjustment in benefits as essential to maintaining the welfare of disabled veterans and their families. However, we believe the COLA should apply to all beneficiaries equally**

and we do not support those provisions which negatively impact on veterans benefits.

Legislation will be sought to extend VA's current authority to verify the eligibility for recipients of, and the applicants for, VA needs-based benefits using data obtained from the Internal Revenue Service and the Social Security Administration through FY 2001. The American Legion supports the proposed extension to ensure the continued fiscal integrity of VA's benefit programs.

In addition, proposed legislation would extend the current $90 a month VA pension limitation for recipients in Medicaid covered nursing homes through FY 2001. **The American Legion supports this measure as a means of ensuring that the nursing home care costs of veterans and surviving spouses are met by Medicaid and that the $90 a month in VA pension is available for their medical needs.**

Veterans Benefits Administration

The proposed staffing cut represents VBA's contribution to the mandated reduction in Federal employment, under the Administration's National Performance Review proposal. The decrease will be accomplished through reduced employment in Support Services activities - 100 FTE, the declining workload associated with the Credit Reform Act of 1990 - 23 FTE and the Omnibus Budget Reconciliation Action Act of 1990 (OBRA) - 12 FTE, and from cuts in the Cooperative Administrative Support Unit - 52 FTE.

Over the past dozen years, The American Legion has viewed with increasing concern the Agency's annual budget requests which were predicated upon what we viewed as unrealistic production and service goals, inadequate funding levels for regional office staffing, and flawed plans for computer modernization. In comparison to recent budget requests, VBA is projecting for FY 1996 continued improvements in both the quality and timeliness of its service to veterans and its other "customers." The data also takes into account increased claims activity based on additional benefits authorized for Persian Gulf War veterans and the success of the Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) as the armed forces continue to downsize.

VBA's optimistic projections appear to be supported by current fiscal year data indicating that the backlog of pending claims is, in fact, beginning to decline rather than continuing to grow, despite the fact of staff cuts in FY 1994 and in the current fiscal year. However, much of the increased productivity has resulted from the substantial use of overtime. The continued availability of overtime funding in FY 1996 will be important in providing management needed flexibility to maintain production levels as new procedures and computer modernization programs are implemented.

We believe current year data reflects the positive impact of a variety of VBA initiatives begun or completed within the last eighteen months, including Stage I of computer modernization. Many of these initiatives stem from the recommendations of the Secretary's Blue Ribbon Panel on Claims Adjudication. VBA is in the process of reorganizing adjudication activities within the regional offices, implementing programmatic changes, reinventing many of VA's business practices, continuing with the installation of new computer hardware and software and procurement of equipment and technology to replace the out-dated TARGET system, and providing enhanced training to field station personnel.

Staffing in the Compensation, Pension, and Education Service will remain at the FY 1995 level of 4,558 FTE. This will be supplemented by an additional $7.1 million in overtime. We believe a stable work force through the coming year together with current and planned VBA initiatives should enable the regional offices to handle an increased number of cases in a more effective and timely manner. Most of the expected increase in the regional offices' workload will be associated with claims by Vietnam Era veterans based on exposure to Agent Orange and Persian Gulf War veterans for undiagnosed illnesses. There will also be a number of claims filed as a result of the Supreme Court decision in Brown v. Gardner. In addition, the number of appeals filed at the regional offices is expected to remain in excess of 21,000 and the number of cases remanded by the Board of Veterans Appeals in FY 1996 will probably be in the neighborhood of 14,000 - 15,000, based on current estimates.

We believe VBA is at a critical juncture in terms of its ability to meet its responsibility of providing financial assistance benefits and services to the veterans of this nation in a timely and cost-effective manner. Congress must not be short-sighted and deny the support necessary to meet the goals which it has set for FY 1996. Anything less will, in our opinion, penalize veterans and their families by seriously undercutting the early progress in reducing the claims backlog and improved response time which has been achieved this fiscal year. It is, however, going to require a sustained effort by both VA and the Congress over a period of several fiscal years to bring the backlog under control and the response times down to a reasonable and fair level. Past budget constraints have prevented VBA from providing the level and quality of service veterans and their families expect and deserve.

Vocational Rehabilitation

The American Legion remains troubled by the apparent lack of concern for the situation that exists in the Vocational Rehabilitation and Counseling (VR&C) program for service connected disabled veterans.

In recent years due to repeated staffing cuts, it has been taking about two and a half months for a disabled veteran to be given an appointment for an initial evaluation to determine if he or she qualifies for vocational rehabilitation assistance. The stated goal is a waiting time of only 30 days. Following a veteran's placement in a program and while in training, the Vocational Rehabilitation Specialists (VRS) are not able to function effectively as case-managers due to an average workload of 256 veterans. The stated caseload goal, however, is 125. Those veterans who have completed their program of education or training and are seeking a job are being severely affected. They are now forced to wait between six (6) and seven (7) months for employment assistance services. Follow-up once they have found employment is also very problematic.

The budget request proposes a reduction of one FTE to 699 FTE. It projects the continued increase in demand for all types of services provided through the Vocational Rehabilitation Program. This in part is due to legislation which went into effect in 1994 reducing the

disability requirement for vocational rehabilitation eligibility from 20% to 10% as well as the success of the TAP/DTAP programs for individuals separating from the armed services. The net result will be a substantial increase in the numbers of veterans in each stage of the vocational rehabilitation process - evaluation and planning; rehabilitation or education services; employment services; and vocational/educational counseling.

This is one program area in VBA that has a critical need for additional staffing resources. **Therefore, The American Legion recommends a FY 1996 appropriation of $45 million and an additional 100 FTE for the effective operation of VA's Vocational Rehabilitation and Counseling program.**

Board of Veterans Appeals

The Department of Veterans Affairs has also been faced with a very real crisis at the Board of Veterans Appeals (BVA). Over the past two and a half years, the backlog of pending appeals has risen dramatically and the average response time was exceeding 800 days. In early 1994, the situation at the Board had deteriorated to point where personal hearings were temporarily suspended and records were no longer being transferred to the Board from the regional offices. Personal hearings were reinstituted this month.

The magnitude of the problem was evident in the fact that by the end of FY 1994, there were approximately 27,800 cases physically at the Board either in storage pending review or under active consideration by a Board section. In addition, approximately 19,300 certified appeals were being held in the regional offices due to the lack of storage space in Washington. It was still taking the Board almost 800 days to render a decision which in about fifty percent of the cases resulted in a remand back to the regional office.

Under the FY 1995 budget, staffing at the Board was increased by seven attorneys to a total of 449 FTE. In addition, Congress enacted legislation authorizing single member decisions as a means of increasing the Board's productivity, ALJ pay comparability which should enable the Board to maintain a stable and trained work force, provide for the adoption of performance evaluation standards for Board

members, as well as authorizing the pre-screening of appeals. The Chairman of the Board of Veterans Appeals has undertaken a major reorganization and realignment of the Board, including a variety of changes in its current operating procedures. The goal is to improve management and supervision, shift more resources to the decision-making process, and improve communication with the regional offices.

According to data for the first quarter of FY 1995, these initiatives are beginning to have a positive effect on the Board's productivity. The number of decisions for this period was substantially more than had been originally projected and has brought the Board's average response time down from about 748 days to 705 days. Maintenance of this level of production, at a minimum, is essential to the continued reduction of the massive backlog of pending appeals and the excessive response time.

The budget request for FY 1996 would provide for an additional 7 Board members and 20 more attorneys. As previously noted, the Board in FY 1995, with minimal additional resources, has implemented major changes in its operations and these efforts are beginning to show results. It is essential that the Board's recent achievements not be undercut and future improvements not be wasted or jeopardized in the name of fiscal austerity.

The American Legion believes very strongly that veterans should not have to wait years for a decision on their appeal. What is an unemployed disabled veteran with a family, who is appealing a denial of increased benefits, to do while the case sits in storage for months on end, or similarly a widow who has lost her veteran husband due to potentially service-related causes? Their frustration and hardship is heightened by the fact that approximately fifty percent of the Board's decisions are not final, but are time-consuming remands that can add a year or more to a claim.

In another important step, the Board is in the process of implementing a recommendation of the Secretary's Select Panel on Productivity Improvement for the Board of Veteran Appeals to provide more accurate information on the total amount of time involved at all stages of an appeal. Data developed through this initiative will

enable the Board, VA, and the Congress to have a clearer understanding of the appellate process and identify problem areas for corrective action.

HOME LOAN GUARANTY PROGRAM

Mr. Chairman, section 3726 of title 38, United States Code, prohibits the withholding of funds to which a veteran or eligible spouse is entitled without the written consent of the veteran or eligible spouse, or without a court order. This section of the law was enacted to prevent veterans from becoming victims of a VA practice of collecting on a loan for which the veteran was no longer responsible.

For example, if a veteran sells a property to another person, and the property was purchased using the VA home loan guaranty program, if the subsequent purchaser defaults on the loan and the property is sold for less than the value of the loan, the veteran, in some instances can be held responsible for the balance of the loan. In most cases where this has happened, the veteran is not at fault. Nevertheless, the VA moves to collect the debt by withholding money from tax returns or from VA benefit payments.

The American Legion opposes the proposed legislation to repeal section 3726 of title 38, United States Code. In our view, this is one more instance where the veteran is held responsible for the actions of a subsequent purchaser after selling a property in good faith. If the subsequent purchaser defaults on the loan, then VA should have the authority to collect the debt from the purchaser, not from the veteran. In many cases the VA buyer and seller is an active duty service member who sold the property after receiving orders to move to another duty station. It makes no sense to penalize these people for the actions of others which are totally out of their hands.

SUMMARY

Department of Veterans Affairs programs and services symbolize the gratitude of the American people for the sacrifices of the nation's veterans. The American Legion appreciates the Administration's effort to present a FY 1996 budget for VA programs and services which reflects an increase of $1.3 billion over the

current year estimate. The American Legion realizes that many individuals look at VA, and oftentimes see a large, impersonal bureaucracy, struggling to provide quality service to its veteran beneficiaries. The American people must be satisfied with the programs and services administered by VA. Taxpayers must have the assurance that VA health care benefits will be delivered in the highest quality manner at a competitive cost. The American Legion supports the concept that all benefits earned in the military service of this country must be delivered in the most efficient and effective manner possible.

The American Legion is dedicated to providing service to our nation's veterans and to its communities. The American Legion does not accept that VA is failing in its mission, but do believe, however, that the benefits and medical service programs of VA can be discharged in a more skillful and proficient manner. The FY 1996 VA budget request will help continue vital reforms already underway within the Veterans Benefits Administration and the Board of Veterans Affairs. Much more must and can be accomplished in the effective delivery of veterans benefit programs.

With regard to the VA medical care system, The American Legion is excited about current efforts to reinvent and reinvest in this vital national resource. Perceptions vary on how to proceed with this important task, although everyone agrees that VA needs to change. The Partnership for Veterans Health Care Reform's publication, Can You Ignore 27 Million Americans?, is a good blueprint. The American Legion has accepted the challenge to successfully reform VA's medical care system, and commits to work with the Congress and the Administration to find original solutions to VA's most pressing problems.

Mr. Chairman, that concludes our statement.

Attachment

DEPARTMENT OF VETERANS AFFAIRS
Outpatient Clinic
411 Dr. Martin Luther King Jr. Drive
Peoria IL 61605

January 5, 1995

In Reply Refer To: [redacted]

[redacted]

Dear [redacted],

This is in response to your recent application for [redacted] VA Care.

Eligibility for VA Hospital care and nursing home care is divided into two categories: "Mandatory and Discretionary". Veterans who meet the "Mandatory" category and must be provided hospital and/or nursing home care by the VA are those who are:

.... rated Service Connected
.... exposed to herbicides while serving in Viet Nam
.... exposure to ionizing radiation during atmospheric testing, or in the occupation of Hiroshima and Nagasaki
.... former Prisoners of War
.... veterans receiving VA Pension
.... veterans of the Mexican Border Period or World War I
.... veterans eligible for Medicaid
.... veterans requiring treatment for a condition related to their service in the Persian Gulf

Veterans placed in the "Discretionary" category are non-service connected veterans whose income exceeds established income criteria. Veterans in the "Discretionary" category may be provided treatment if they agree to make required co-payments and if space and resources are available.

Due to budgetary and workload constraints, it has become necessary for us to discontinue medical care to veterans in the "Discretionary" category to ensure we will be able to continue to meet our obligations in providing care to all veterans in the "Mandatory" category. After reviewing your application it has been determined that you fall into the "Discretionary" category and we would not be able to provide medical care at this time.

Sincerely,

[redacted]

Medical Administrative Officer

Attachment: VAF 4107

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

MAY 5 1995

The Honorable Bob Stump
Chairman, Committee on
Veterans' Affairs
House of Representatives
Washington, DC 20515

Dear Chairman Stump:

Enclosed are the responses for the record to the questions submitted in your letter dated March 3, 1995. The questions pertain to the Full Committee FY 1996 budget hearing held on February 24, 1995. Also included are responses to the other Committee member's questions.

Please let me know if we can be of further assistance.

Sincerely yours,

Jesse Brown

Enclosures

JB/KS

CONGRESSMAN STUMP

Construction Program-Reassessment

Question: 1. VFW testimony makes several points regarding VA construction practices that if changed would result in significant cost savings. These recommendations include the use of overly broad application of ADA construction standards, setting standards in excess of general purpose hospital requirements, questionable natural hazard mitigation construction practices that emphasize operational capability over preservation of life among others. In addition the Independent Budget urges greatly expanded leasing in lieu of major construction. In light of these criticisms, do you believe it is an appropriate time to reassess VA's construction program?

Answer: VA is continuously reassessing its construction program. Over the last two years, the Office of Construction Management (CM) has been engaged in a vigorous effort to reinvent itself and significantly improve service to its customers. In fiscal year (FY) 1994, CM effected a major realignment of the organization's structure and operating philosophy. These changes closely mirror initiatives contained in the Vice-President's National Performance Review. CM's customers, as well as outside organizations, have complemented these recent efforts.

VA is pursuing expanded leasing to acquire more primary care clinics to better serve the nation's veterans. However, VA has a vast infrastructure that also needs to be maintained. The last two budgets have emphasized patient environment, ambulatory care, and infrastructure projects. In order to become competitive in the health care environment, VA must upgrade its facilities. Particular emphasis has been placed on converting wards to no more than two beds per room and having private bathrooms for each room. This type of construction, as well as correcting infrastructure deficiencies, usually exceed the minor construction threshold. VA has a need to continue its construction programs for the foreseeable future.

CM will re-evaluate the construction practices noted in the VSO independent budget. CM has compared VA accessibility standards with ADAAG and UFAS. CM's Barrier Free Design Officer is actively working with the Architectural and Transportation Barriers Compliance Board as they merge the ADA accessibility guidelines with the current UFAS requirements. Revisions to the VA standards will be coordinated with ADAAG and made to serve our clients' needs in the most cost effective method possible. Hurricane Andrew and the recent earthquakes in California and Japan have created a need to re-evaluate national "private" as well as VA seismic and disaster standards. VA has a standing advisory committee of private sector seismic experts to advise VA on such matters. VA standards will be updated consistent with the national codes and standards. There is a Construction Policy Oversight Board Task Force to look at standards for administrative space.

Medical Care-Workload

Question: 2. The VA has projected an increase in its workload by 43,000 for FY 1996. Please explain how this number was derived? In actual count what was the number of veterans who became eligible for VA care in 1995 as a result of discharge from the service, disability, job loss or change in economic status. How many of these new veterans can be expected to use the VA in FY 1996? Which VAs will be impacted by this expected 43,000 increase?

Answer: Workload forecasts are prepared by the Veterans Health Administration's (VHA's) Boston Development Center and subsequently reviewed by VHA's line and staff offices.

The Boston Development Center forecasts future workload for each VA medical center in each of the Resource Planning and Management (RPM) system's 49 different patient classes (such as cardiovascular disease, stoke, and PTSD). Forecasts are accomplished using historical counts of unique patients by patient class and VA medical center for FY 1988 to the present. Forecasting methodologies that have a track record of accuracy are selected for each patient class. The accuracy of the forecast methodologies are reviewed annually and revised as needed. Workload changes that are anticipated because of construction are merged into the RPM forecast.

A display of estimated workload changes for FY 1995 to FY 1996 by VA medical center is provided as an attachment to this question.

The Defense Manpower Data Center. DoD, projects that 255,930 veterans will be discharged during 1995. VA's National Center for Veteran Analysis and Statistics estimates that approximately 127,450 (50 percent) of these veterans will be mandatory (Category A) veterans.

We estimate that annually approximately 400,000 veterans make their first health care contact with the VA. These 400,000 individuals are persons with no prior care in the VA within the prior 5 years. Some of them will be newly eligible veterans as described above, but others will be veterans who may have been eligible for a long time and are just now making contact with the VA for health care services. On the other hand, however, the number of veterans provided VA care in the previous year who will never be cared for again in the VA is almost as large as the group of new veteran patients. These are persons who have died, or who have acquired sufficient health care resources to pay for insurance, or who have become Medicare eligible and choose not to use the VA. The net change for 1996 is projected to be a net increase of 43,000 persons.

Veterans Benefits Administration Overtime

Question: 3. How much money is proposed for overtime at the Veterans Benefits Administration?

Answer: In 1996, overtime totaling $5.5 million is requested to continue to reduce the C&P backlog and to process OBRA and reimbursable workload.

Regional Office Claims Processing

Question: 4. How many FTEE are needed to reduce average initial compensation and pension claims processing time below 100 days?

Answer: Additional FTE will not immediately improve timeliness. If we hired new, unskilled employees in our adjudication divisions in 1996, it would require at least two years of training before these individuals could manage the range of duties expected of a fully-trained GS-9 adjudicator. Acquiring all the technical expertise we expect of our GS-12 rating specialists would require 3-4 years.

A sustained level of staffing and overtime, coupled with management and technological initiatives, is a more effective approach to improving timeliness. Over the last 6-8 months this combination has allowed us to reduce the backlog of pending C&P claims and to improve the timeliness for initial disability compensation and pension claims significantly. We believe that by the end of FY 1995, the processing time for initial pension claims will be very close to the 100-day mark. If Adjudication staffing for FY 1996 remains at the 1995 level (4,558 FTE), and if our planned management and technological initiatives (e.g., a

higher proportion of the decision-makers-especially in the rating area, the implementation of the first phases of the Veterans Service Network and the Claims Processing system) are implemented on schedule, by the end of 1996 the processing time for initial disability compensation claims should be down to 140 days. This is a substantial improvement over the 215-day average that prevailed in mid-1994. We anticipate this improvement will continue, and that by the end of FY 1998 the average initial compensation claim will be completed in 106 days.

Medical Office Leasing

Question: 5. VFW states that Central Office is having second thoughts about allowing medical facility directors authority to lease up to 10,000 square feet of space for outpatient needs. Has VA Central Office changed its mind on this decentralization of leasing authority and if so, why?

Answer: No, there are no plans to centralize this authority.

Question: 6. Looking at the census for VA facilities, all inpatient bed sections will be experiencing losses (medical beds -200. surgical beds -150, psychiatric -50, intermediate -100). The only areas experiencing growth are the nursing home and domiciliaries (nursing home + 718, domiciliary + 108 beds). Will these changes have any impacts upon the medical school affiliations? What is being done to realign the staffs to deal with losses in the inpatient area and growth in nursing homes and domiciliaries?

Answer: A decrease in patient census is not necessarily reflective of a comparable decreases in patient workload. During the last three years, FY 92, 93, and 94, patient census dropped approximately 6.7 percent while veteran population and patients treated experienced a decrease of 1.8 percent. Over the same period the number of unique patients grew by 2-5%, reflecting the ongoing shift to outpatient settings. This decrease in census is attributed to improved efficiencies in VHA's health care delivery such as reduced lengths of stay and greater utilization of ambulatory pre-admission screening and testing. With greater emphasis being placed on long-term care and primary care in the outpatient arena, facility directors have been made aware of the need to shift resources including staff, to the appropriate locations. This budget reflects an increase of 844 outpatient FTE and 1,001 nursing home FTE in 1996. These increases are offset by a decrease of 1,679 hospital FTE in 1996. While VA facilities are experiencing a decline in inpatient census, services are growing rapidly in the outpatient arena. The medical school affiliates are eager to have opportunities to teach in these settings and are planning for the transition of individual teaching programs and faculty with their local VAMCs. It should also be recognized that with VHA's move to primary care, VA's role in health education is significantly increased by participation in the training of primary care physicians which are in such great demand in the health care environment today.

MAMOE

Question: 7. The Medical Administration and Miscellaneous Operating Expenses Account (MAMOE) will be increased by $2.4 million, yet the FTE level will be decreased by 12. Please explain the effect of this reduction on the Under Secretary's planned reorganization.

Answer: MAMOE ceiling will be reduced from 802 FTEE to 790 FTE in the FY 1996 Budget. The reorganization proposed by the Under Secretary for Health will reconfigure and consolidate a number of offices, and the MAMOE ceiling will

have the flexibility to absorb this reduction without compromising the effectiveness of the new organization. The new organization will be focused on establishing policy, setting performance and quality measures, and representing VHA to its customers and stake holders. The Central Office staff will be less involved in operational decision making.

Research

Question: 8. The Research budget shows an increase of $5 million, yet the greatest reductions are in rehabilitation research, one of the VA's specialized program areas, and also in health services research. Please explain how these areas will be affected by the reductions.

Answer: We are requesting increased appropriations for both rehabilitation and health services research and these increases are greater proportionately than the increase for medical research. The decreases reflected in obligations are artifactual in that they result from such factors as carry over of prior year appropriations, as is possible with two-year appropriations.

Question: 9. Please explain the term direct research employment. Are these positions funded 100 percent by the VA? With the average FTE decreasing by 68 in the FY 1996 budget, which projects will be affected?

Answer: The table on page 3-8 (vol. 2 of VA FY 1996 Budget Submission) contains the terms, "direct FTE" and "reimbursable FTE". Direct FTE refers to research employees supported by research appropriation funds; reimbursable FTE refers to employees supported by funds transferred to VA from outside sources, such as other federal agencies, non-profit organizations, and pharmaceutical firms.

The decrease of 68 in direct FTE (shown in the same table) will result from a decrease of 60 research programs. These programs will be identified through a scientific peer review process.

Question: 10. What is the status of the $20 million research augmentation from the Department of Defense for this year and in FY 1996?

Answer: No funds for the cooperative VA/DoD medical research program for FY 1995 have been transferred to VA as of March 10, 1995. We expect that $13 million may be transferred shortly; the eventual transfer of the remainder is uncertain.

We do not know whether funding for this program will be appropriated for FY 1996.

Contracts

Question: 11. Contractual services in all accounts such as contract hospitalization, community nursing homes, and other contractual services have grown at a steady rate. The largest account is "other contractual services." Please describe what specifically is included in this account and what types of services VA buys under this account. What percentage of the budget figure of $1.1 billion is for contract personnel?

Answer: Based on page 2-45 of the budget submission, the major breakdown of Medical Care contractual services (object class 25) is as follows:

Category	(Dollars in thousands) 1994 Actual	1995 Estimate	1996 Estimate
Non-VA Programs	$797,515	$827,811	$875,975
Maintenance and Repair	188,232	204,823	211,188
Incentive and Therapy	6,970	7,270	7,737
Other Contractual Services	807,752	1,119,857	1,145,293
Total	1,800,469	2,159,761	2,240,190

In 1994, approximately $339.6 million of the total for other contractual services was obligated for personal services contracts including medical consultants/attendents ($11.2 million), house staff contracts ($193.5 million), scarce medical specialists ($85.4 million) and other personal services contracts ($49.5 million). These personal service contracts represent about 42 percent of the total for other contractual services. The balance of other contractual services, or $468.1 million, was obligated for contracts for performance of specified services. Examples of these contracts for services include Non-Recurring Maintenance contracts, architect and engineering services, various ADP services, services purchased from sharing partners, tuition and registration fees, etc. The above breakdown between personal service and other contracts is not precise and is based upon our best approximation of how VA sub-object codes should be classified.

Major Construction

Question: 12. The Major Construction Account for FY 1996 is $513,755 million. This represents an increase of $159 million over FY 1995. What are VA's top 20 Major Construction projects? In pre-heering questions, I raised concern over the Department's focus on bed based projects. Please describe the methodology which elevated the Brevard hospital construction project to number 2 on the FY 1996 submission?

Answer: The following chart reflects the top twenty major construction projects based on priority score from the inventory compiled and revalidated for use in the initial selection of projects to be considered for the FY 1996 Construction Budget. Only projects in the Secretary's top three priority categories (patient environment, ambulatory care, and infrastructure) were prioritized.

Location	Title	Priority Score
*Palo Alto, CA	Seis Upgrade, B-40 & 43	20.46
Travis, CA	VA/AF J/V, Travis AF Base	20.20
*Palo Alto, CA	Seismic Corrections, B-6	19.85
Atlanta, GA	Modernize Patient Wards	19.80
Lebanon, PA	Renovate Nursing Units	19.80
Marion, IN	Replace Psychiatric Beds	19.80
Marion, IL	Environmental Improvements	19.80
Salisbury, NC	Environmental Enhancements	19.80
**Ft. Howard, MD	Replacement Bed Building	19.80

*Indianapolis, IN	New Bed Tower	19.36
Reno, NV	Repl Bed Bldg/Ambul Care	19.29
*Palo Alto, CA	Seis Upgrade B-301, 137 & 329	19.23
*Palo Alto, CA	Seis Corrs, B-323 & 324	19.23
*Palo Alto, CA	Seis Corrs, B-303,222, 331	19.23
Perry Point, MD	Renovate Psychiatric Wards	19.14
*Waco, TX	Renov Bldgs 9 & 94 (F&S)	19.12
*Waco, TX	F&S Corrs, Bldgs 1 & 5	19.12
Long Beach, CA	Seismic Corrections	19.10
*Brooklyn, NY	Renovate 4 Wards	18.92
San Antonio, TX	Patient Privacy Corrections	18.70

*Not considered due to possible construction conflicts with ongoing construction projects
**Not considered due to possible mission change

Although projects are generally selected for inclusion in a budget based on priority score, some projects are chosen based on VA's participation in joint ventures with other government entities, the need to fill a sigificant gap in services to veterans (the Brevard County project), or other Departmental commitments.

The low score for Brevard results from the assignment of low program emphasis weights (PEWs) to new hospital projects. The highest PEWs are assigned to projects that improve access to care and the quality and safety of existing facilities. However, in the context of a large area with a large number of underserved veterans, such as Brevard's catchment area, the score does not accurately reflect veterans' health care needs. Therefore, we included the Brevard County project in our 1996 budget request because of the unique need of a growing veteran population in that area and to address long-standing needs for long-term psychiatry and nursing home care beds in the state of Florida.

State Approving Agencies

Question: 13. The budget seeks $13 million for the State Approving Agencies. How do they document their activities on behalf of the VA?

Answer: Each State Approving Agency (SAA) files the Quarterly Report of State Approving Agency Activities, a report whose format is prescribed by DVA and approved by OMB. The SAA describes the number of applications approved, denied, pending, and withdrawn. They also report supervisory visits, approval inspection visits, and visits at the request of DVA. They report deficiencies found and corrected and suspensions and withdrawals of approval. Vouchers submitted for reimbursement must be supported by visit reports and approval actions submitted to the VARO. The VARO Education Services Unit continually monitors SAA activity, particularly with reference to reimbursement.

Insurance

Question: 14. What would be the effect, if any, of allowing VGLI participants to elect conversion to commercial life insurance policies at any time during the 5 year term of the current VGLI policy?

Answer: Individuals insured in the VGLI program can convert their VGLI term coverage to permanent plans of insurance with any of the private insurance companies who participate in the program. Currently, the insureds can convert only at the end of each renewable 5-year VGLI

period. This proposal would allow them to convert at any time, not just the end of each 5-year period. This would be advantageous to insureds because conversion is less expensive the younger you are. Therefore, allowing them to convert at an earlier time would result in a lowering of their cost for the permanent plan policy. There would be no significant financial impact on the SGLI or VGLI programs.

Grants Programs for Construction of State Veterans Cemeteries

Question: 15. The Grants Program for the Construction of State Veterans Cemeteries provides aid to States in establishing State veterans cemeteries. It's a popular program and delivers a lot of "bang for the buck." The NCS request is over $4 million less than last year's level of $5.4 million. Is VA moving in the right direction on this program? Is $1 million an adequate level of funding to assist States in providing burial space for veterans in FY 1996?

Answer: Based upon known requirements, there will be approximately $5.2 million in prior year funding carried forward into 1996. With the additional $1.0 million requested, there will be a total of $6.2 million available for grants in 1996. Potential obligations exceed this amount by just under $1.0 million; however, experience shows that some of these projects will not materialize or will be delayed by the States until a later fiscal year. It is anticipated, therefore, that 1996 funding will be sufficient to fund all grants that are ready for obligation by the end of 1996, and that there will be no backlog of unfunded applications.

Care for Non-Indigent, Non-Service Connected Veterans

Question: 16. A letter written to the New York Times has raised many questions. The writer stated that her non-indigent, nonservice-connected husband was receiving nursing home care for Alzheimer's Disease and that she paid the VA approximately $6,000 a year for this care. An inquiry to the VA revealed that nearly 300 non-indigent, nonservice-connected patients were receiving similar services from the VA. I have been told that the demand for nursing home care is higher than the VA can meet, that service-connected veterans receive priority, and that waiting lists exist for service-connected veterans. Please explain the circumstances in which nonservice-connected veterans can receive care apparently ahead of service-connected veterans. Why is the VA charging only 13 percent of what it actually costs to care for these veterans considering the estimated cost is upwards of $45,000 per patient. The VA spends nearly $13 million on care for this group of non-indigent, nonservice-connected veterans. What is the current policy and what is being done to ensure that the service-connected veterans are given priority? Has the Department considered a change in the collection policy to reflect a more equitable reimbursement to the government?

Answer: At a particular facility, a nonservice-connected veteran in need of hospital based nursing home care can be admitted to a VA nursing home care unit when space and resources are available and an application for VA nursing home care from a service-connected veteran is not pending on a waiting list.

Service-connected veterans receive a higher criteria for placement in VA nursing home care units. The priorities for care follow:

a. Any veteran who has a service-connected disability and who requires nursing home care for any condition;

b. Any veteran whose discharge or release from the active military, naval, or air service was for a disability

incurred or aggravated in the line of duty and who requires nursing home care for any condition;

c. Any veteran who, but for a suspension pursuant to 38 U.S.C. §1151 would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for such care is provided for in the judgment or settlement described in such section and who requires nursing home care for any condition;

d. Any veteran who is a former prisoner of war and who requires nursing home care for any condition;

e. Any veteran who served in Vietnam during the Vietnam era and who may have been exposed to Agent Orange or other toxic substance and who needs care for a condition possibly related to such exposure, and to veterans who were exposed while on active duty to ionizing radiation from nuclear testing or participation in the American occupation of Hiroshima and Nagasaki following World War II and who are in need of nursing home care for a condition possibly related to such exposure;

f. Any veteran of the Spanish-American War, the Mexican Border Period, or World War I, for any condition that requires nursing home care; and

g. Any nonservice-connected veteran who is in receipt of VA pension or whose income is below the means test threshold amount.

h. Any nonservice-connected veteran eligible for VA hospital care whose income exceeds the means test income threshold amounts if the veteran agrees to pay the applicable copayments for the care rendered by VA.

It is possible to have a service-connected veteran on a waiting list at a facility which has a vacant bed, but the vacant bed does not meet the medical care level required by the service-connected veteran. In this case, a nonservice-connected veteran requiring the available level of care may be admitted. Most VA nursing home care units currently have waiting lists; however, there are a few units that do not.

Section 1710 of title 38, U.S. Code, establishes the means test based upon veterans' income and assets. Veterans whose income is above certain levels are required to make copayments for the care that they receive within VA facilities. Currently these copayments are:

a. Hospital Inpatient: The cost of care but not to exceed $716 the for first 90 days of care in any 365-day period. The copayment for the second, third and fourth 90 days of care is $358.

b. Nursing Home Patient: $716 for each 90 days of care received.

c. Outpatient: $39 for each outpatient visit.

In addition, Section 1710 further authorizes VA to seek reimbursement from veterans' insurance carriers for the cost of non-service-connected care provided to the veterans. Section 1729 of title 38 requires that VA assess a per diem copayment of $10 for inpatient care and $5 for nursing home care for care provided to these veterans.

The collections VA can make, and the copayments VA can charge, are established by law and can be changed only by Congressional action.

CONGRESSMAN MONTGOMERY

Telecommunications

Question: 1. Mr. Secretary, I understand you requested funds to address the serious problems veterans and their families face in trying to contact the VA by telephone. Tell us about your request and why it is needed.

Answer: VBA's VAATS initiative to address telecommunications deficiencies was intended to introduce the use of Computer Telephone Integrated (CTI) technology to VBA as our primary means of managing telephone traffic and providing the means for veterans to interact with VBA for information and services.

The telecommunications industry has made significant advances in telephone traffic management since deregulation. The tasks of receiving telephone calls from the veteran population and providing current information are no different for VBA than for private industry or other government agencies. The lack of funding over the past few years limited VBA's ability to take advantage of industry solutions which are readily available. In only a few cases has the Administration been able to upgrade its telephone systems to address the blocked call rate.

CTI is commonly used throughout the business community. The basic principle of the initiative, or CTI, is to extend the use of the veteran's telephone instrument to interact more effectively with VBA. Features such as recorded messaging, menu selections, and voice mail are the more widely available CTI features which would have the most direct impact on the blocked call rate. More advanced features such as interactive voice response systems will allow VBA to make changes to business processes and further reduce the need for telephone inquiries.

The percentage of blocked calls currently experienced by VBA is reflective of an outdated telephone system which limits the number of lines or calls to an office. The number of lines is controlled by the number of FTE available to answer telephone calls. The limitation in the FTE will not allow VBA to resolve the blocked call rate. The introduction of proven technology in telephone traffic management continues to be the only means available to VBA to resolve this problem and improve service to veterans.

The features mentioned above which impact on the blocked call rate include:

--automated call attendant - this function answers the phone, greets the caller, and provides a menu of options and routes the call based on the option selected by the caller.

--audio text - this function allows veteran clients to hear pre-recorded messages.

--voice mail - this function allows callers to leave messages to request forms, applications, and pamphlets.

One component of the initiative which we plan to pursue is the upgrading of individual regional office call handling systems. This is only an interim solution since it does not introduce the full benefits of CTI. The cost of modern telephone systems with desirable features varies dependent upon the number of lines needed to serve the population within the assigned station jurisdiction.

Guaranteed Home Loans

Question: 2a. Mr. Secretary, I am a little surprised that you are proposing that we repeal protections afforded veterans who lose their home that is guaranteed by a VA loan. (Current law provides that the United States may not

garnish benefits to satisfy a loan guaranty indebtedness.) Doesn't this mean that the veteran may be forced to pay a debt which he or she never had a chance to contest?

Answer: All borrowers under VA home loan programs receive clearly stated notice at closing of the possible consequences of default. We believe that an individual who has stopped paying his/her mortgage, but continues to live in the house, knows full well that foreclosure is about to occur because of the activities leading to that sale. Those activities usually include a VA appraiser's visit and at least minimal notice published in a local newspaper or posted on the property itself. Those borrowers who abandon the property have every reason to know that the lender and the Government will seek to mitigate their losses. In some states, borrowers have a right to redemption or loan reinstatement for a period of months following a foreclosure sale.

Should foreclosure result in the establishment of a debt, VA mails notice to the debtor(s). For over two years that notice has been sent by certified mail. Set forth in the notice are the debtor's procedural rights (if the debtor is a veteran or the spouse of a veteran). These include the right to dispute the existence or amount of the debt, the right to request waiver of collection and the right to an oral hearing in connection with the waiver request. Disputes and waiver requests that are denied may be appealed to the Board of Veterans Appeals and from there to the United States Court of Veterans Appeals. Decisions of latter may be appealed to the United States Courts of Appeals for the Federal Circuit.

Should section 3726 be repealed, VA would have two efficient means of seeking involuntary payment - Federal salary offset and income tax refund offset. Both of these must be preceded by notice before offset is requested from an employing agency or the Internal Revenue Service. The notice preceding a request for offset of salary includes the right to a hearing. Litigation is another means of seeking involuntary payment replete with its own notice and process requirements. As a practical matter, however, it is the least efficient and most expensive method of involuntary collection.

Failing this third tier of opportunity, the debtor (regardless of veteran status) always has the right to make a compromise offer or enter into a repayment plan.

Question: 2b. The savings estimate also seems a little high. After all, when we established the Guaranty and Indemnity home loan program, in 1989, we held that veterans would be indemnified and not be liable in the event of any default, with certain exceptions.

Answer: Despite the introduction of the Guaranty and Indemnity Fund program in 1990 and liberalized waiver criteria, more than $1.6 billion in loan guaranty debt remains outstanding.

Federal employees or retirees owe $270.5 million. Our Debt Management Center staff believes that a significant portion of that amount would be collectible should the proposed legislation be enacted and no catastrophic reduction in the Federal work force occurs over the next five fiscal years. That amount, alone, would far exceed the conservatively estimated savings of $108.7 million (the amount estimated before reduction to present value). Approximately 80 percent of loan guaranty debt is the result of nonjudicial foreclosure. At the current rate of collection, VA expects to recover $9.7 million in home loan debt in FY 1996 through the Federal Salary Offset Program (either involuntary salary

offsets or voluntary payments made after notice of intention to seek offset). The rate of collection from employees who were subject to judicial foreclosure is 2.4 times greater than that from employees whose home loans were subject to nonjudicial foreclosure. Allowing for a 15 percent reduction in the Federal work force each year for five years, collections attributable to the Federal Salary Offset Program should increase $86.4 million (not reduced for present value) over the same five year period should the proposed legislation be enacted.

A similar updated estimate of savings for the Income Tax Refund Offset Program would require running a computer program that might not be completed within the time frame of this response. However, similar principles would apply. VA expects to collect roughly $1.3 million from judicially foreclosed home loan debts in 1995. Again, only 20 percent of the home loan debt portfolio is the result of judicial foreclosure; thus, enactment of this proposal would result in significantly increased collections through the refund offset program.

We should note that the amount collected from the tax refund offset program has steadily diminished over the last few years, in part, from the enactment of the GIF program and liberalized waiver criteria. However, tax withholding and revenue enhancement policies as well as many other economic factors (employment, wage levels, etc.) can play a significant role in the amounts available for offset. Should substantial changes in tax policy (including withholding rates) be enacted in the near term, the rate of collection from this program could be profoundly affected.

An important factor in the submission of this proposal now, is the age of the home loan debt portfolio. Over 30 percent of that portfolio is more than six years old. Another 10 percent will reach its sixth anniversary in the next fiscal year. These debts cannot be referred for salary or tax refund offset once they have reached 10 years old. Litigation on a mass scale is not available for the vast majority of claims, regardless of the age of the debt. No claims may be referred for litigation that are over six years old. In real terms, this may be the last chance the Government has to initiate involuntary collection on a substantial portion of VA's debt portfolio.

Cost of Living Allowances

Question: 3. Why is the Administration singling out veterans by proposing to limit future cost of living allowances?

Answer: The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) cancelled the FY 1994 Montgomery GI Bill COLA and reduced the FY 1995 COLA by one-half. OBRA 93 also limited the FY 1994 COLA under the old DIC program by providing the surviving spouses of those who were in pay grade E-7 and above with one-half of the COLA in the base rate provided to spouses under the reformed DIC program. It should also be noted that these same pay grades (i.e., E-7 and above) which received the "half COLA" are already receiving more than their counterparts are receiving under DIC reform, and in some cases, considerably more. Also, OBRA 93 provided for rounding down all rate increases in the FY 1994 compensation COLA; and Public Law 103-446 providing for rounding down the FY 1995 compensation COLA.

The Administration's proposal to continue the Montgomery GI Bill, compensation, and DIC COLA limits in FYs 1996-2000 does not single out veterans. Rather, it is part of an overall deficit reduction plan that involves extending through FY 2000 the cost-saving provisions enacted by the Congress in OBRA 93. Extension of the OBRA 93 education

provision will contribute an estimated $200 million in deficit reduction over a five-year period and extensions of the compensation and DIC provisions, an estimated $582 million.

CONGRESSMAN BILIRAKIS

Spinal Cord Injury Unit

Question: 1. What is the current status of the Spinal Cord Injury (SCI) unit project at the James Haley Medical Center in Tampa, Florida?

Question: 2. How long does a construction documents development award take?

Question: 3. When do you anticipate requesting construction money for the SCI Unit?

Question: 4. Once construction begins, how long will it take to complete the construction of the SCI Unit?

Question: 5. What VA projects are considered to be higher priority than the Tampa SCI unit project?

Question: 6. Were any projects with a lower priority than the SCI unit included in the Administration's FY 1996 budget request? If so, why were they included?

Answer: With the $4 million Congress appropriated in FY 1995 for design, a construction documents award is anticipated to be made in May 1995. It is scheduled to be completed in eight months. Future funding for construction will be requested based on the availability of construction resources and other project priorities. Once construction funds are made available, the SCI unit can be completed in 28 months.

The Tampa SCI project's priority score is 13.77 (scored as a patient environment project). Other than the Brevard Medical Center/NHC project, all other projects included in the FY 1996 budget request have higher priority scores. Although, the Brevard County New Medical Center project has a lower priority score, the Secretary is committed to providing equity of access to America's veterans irrespective of residence. The East Central Florida area has been identified for over ten years as a critically underserved area with a growing population of retired, limited income veterans. The Brevard project also provides nursing home care and long-term psychiatry beds that will address statewide deficiencies.

Medical Care

Question: 7. How many inpatient beds are currently deactivated in the state of Florida? Please provide a breakdown on where these beds are located.

Answer:

VAMC	Number of Beds Out-Of-Service
Bay Pines	0
Gainesville	70
Lake City	33
Miami	38
Tampa	66
Total	207

Question: 8. Why are these beds not being utilized?

Answer:	VAMC Construction	Beds Out of Service Due to: Resources	Workload
Bay Pines	0	0	0
Gainesville	30	40	0
Lake City	33	0	0
Miami	20	0	18
Tampa	66	0	0
Total	149	40	18

Question: 9. Does VA have plans to reactivate these beds? If so, when?

Answer: All beds out-of-service due to construction will be reactivated when the various major and minor construction projects involved are complete. The VAMCs Gainesville and Miami will continue to assess whether resources and workload adjustments have occurred that would enable them to reactivate these beds.

CONGRESSMAN EVERETT

Veterans' Benefits Administration Staffing

Question: 1. In responding to a pre-hearing question, VA indicated they were not able to provide VBA staffing levels for its adjudication division because of impending reorganization. What are the current staffing totals for management, adjudicators, rating specialists, claims development, and support staff?

Answer: As of December 31, 1994, 4,364 people were employed in our 57 Adjudication divisions. Of this number, 2,201 were classified as adjudicators and 928 were formally assigned to rating activities. Many of the remainder (1,235) were involved in preparing awards and/or ratings, but held positions that were reported in other categories. Three examples would be development and burial clerks (who do burial awards), the 267 employees in the four Regional Processing Centers (who handle the centralized education workload) and our 331 managers (this category includes, in addition to Adjudication Officers, lower supervisors who may be called upon to prepare special awards or ratings, or to work as an adjudicator or rating specialists during overtime periods).

Board of Veterans' Appeals

Question: 2. How will the budget request reduce the existing appeals backlog at the Board of Veterans' Appeals?

Answer: The FY 1996 budget request for the Board of Veterans' Appeals will support an FTE level that can produce 33,600 decisions. This a is 20 percent increase over the estimated BVA decision production for FY 1995 and a 50% improvement over BVA's FY 1994 output of 22,045 decisions. Despite this improvement, appeal backlog problems will persist until appellate decisions output is equal to or greater than appellate receipts. Appeal receiots for FY 1996 are projected to remain constant at around 38,000.

Question: 3. How many FTE are needed to reduce claims processing below 100 days?

Answer: Additional FTE will not immediately improve timeliness. If we hired new, unskilled employees in our adjudication divisions in 1996, it would require at least two years of training before these individuals could manage the range of duties expected of a fully-trained GS-9 adjudicator. Acquiring all the technical expertise we expect of our GS-12 rating specialists would require 3-4 years.

A sustained level of staffing and overtime, coupled with management and technological initiatives, is a more effective approach to improving timeliness. Over the last 6-8 months this combination has allowed us to reduce the backlog of pending C&P claims and to improve the timeliness for initial disability compensation and pension claims significantly. We believe that by the end of FY 1995, the processing time for initial pension claims will be very close to the 100-day mark. If Adjudication staffing for FY 1996 remains at the 1995 level (4,558 FTE), and if our planned management and technological initiatives (e.g., a higher proportion of the decision-makers-especially in the rating area, the implementation of the first phases of the Veterans Service Network and the Claims Processing system) are implemented on schedule, by the end of 1996 the processing time for initial disability compensation claims should be down to 140 days. This is a substantial improvement over the 215-day average that prevailed in mid-1994. We anticipate this improvement will continue, and that by the end of FY 1998 the average initial compensation claim will be completed in 106 days.

CONGRESSMAN BUYER

Construction Program

Question: 1. VFW points out several flaws in the management of VA's construction program such as improper organization, overly broad application of ADA construction standards, setting standards in excess of general purpose hospital requirements, questionable natural hazard mitigation construction practices that emphasize operational capability over preservation of life, and other criticism of the VA Hospital Building System. The IB also urges greatly expanded leasing in lieu of major construction. In light of these criticisms, do you feel it is time for a major rethinking of VA's construction program?

Answer: VA is continuously reassessing its construction program. Over the last two years, the Office of Construction Management (CM) has been engaged in a vigorous effort to reinvent itself and significantly improve service to its customers. In fiscal year (FY) 1994, CM effected a major realignment of the organization's structure and operating philosophy. These changes closely mirror initiatives contained in the Vice-President's National Performance Review. CM's customers, as well as outside organizations, have complemented these recent efforts.

VA is pursuing expanded leasing to acquire more primary care clinics to better serve the nation's veterans. However, VA has a vast infrastructure that also needs to be maintained. The last two budgets have emphasized patient environment, ambulatory care, and infrastructure projects. In order to become competitive in the health care environment, VA must upgrade its facilities. Particular emphasis has been placed on converting wards to no more than two beds per room and having private bathrooms for each room. This type of construction, as well as correcting infrastructure deficiencies, usually exceed the minor construction threshold. VA has a need to continue its construction programs for the foreseeable future.

CM will re-evaluate the construction practices noted in the VSO independent budget. CM has compared VA accessibility standards with ADAAG and UFAS. CM's Barrier Free Design Officer is actively working with the Architectural and Transportation Barriers Compliance Board as they merge the ADA accessibility guidelines with the current UFAS requirements. Revisions to the VA standards will be coordinated with ADAAG and made to serve our clients' needs in the most cost effective method possible. Hurricane Andrew and the recent earthquakes in California and Japan have created a need to re-evaluate national "private" as well as VA seismic and disaster standards. VA has a standing advisory committee of private sector seismic experts to advise VA on such matters. VA standards will be updated consistent with the national codes and standards. There is a Construction Policy Oversight Board Task Force to look at standards for administrative space.

Question: 2. VFW states that Central Office is having second thoughts about allowing medical facility directors authority to lease up to 10,000 square feet of space for outpatient needs. Has VACO changed its mind on this decentralization of leasing authority and if so, why?

Answer: No, there are no plans to centralize this authority. There is a Construction Policy Oversight Board Task Force to look at standards for administrative space.

CONGRESSMAN FLANAGAN

Medical Care

Question: 1. Secretary Brown: The "Medical Programs" section of the Administration's 1996 budget submission claims to "continue the shift from hospital inpatient care to more appropriate care settings, such as outpatient and other non-institutional services." In what ways does this $16.9 billion proposal set forth a long-term strategic vision for such continued shifts in eligibility reform?

Answer: This budget request supports a continued shift from inpatient care to outpatient. However, VA must reform its health care system to best manage services to veterans and to remove barriers to providing care on an ambulatory basis. This means being able to provide veterans with the most appropriate level of care and improved access to primary and preventative care. VA is making a transition from an institutional-based, inpatient hospital system to integrated community-based networks of care with hospitals as components providing appropriate, accessible, comprehensive services to veterans.

Question: 2. Under Secretary Kizer: In what ways does this budget proposal address the issue of management reform and consolidation in the Chicago-area Veterans' Affairs hospitals?

Answer: Through the pilot Network FDP process, the Chicago Network has identified projects at various facility locations which are intended to enable the Network to more effectively support its combined workload, particularly in ambulatory care. The Network is also continuing its transportation network between medical centers and clinics in an effort to facilitate the movement of patients, staff and records. The Veterans Health Administration, its facilities and networks will continue to support management improvement initiatives through streamlining and integration of services and, in certain circumstances, facilities.

National Cemetery System-Chicago

Question: 3. Director Bowen, could you give me an update regarding how far along the VA is in the establishment of a Chicago area national cemetery for veterans? How does this budget proposal address the issue?

Answer: The Department of Veterans Affairs submitted a report to Congress in 1987 that identified Chicago as the number one area of the ten indicated in the report most in need of a new national cemetery. FY 1988 funds were appropriated to prepare an Environmental Impact Statement (EIS), which identified the northern portion of Fort Sheridan as the most viable site for the cemetery. Secretary Edward Derwinski signed the Record of Decision in October 1991.

The acreage needed for the cemetery had been appraised by the United States Army for more than $35 million; and the Army sought either "fair market value" or a "value-for-value transfer" based on provisions under the Base Closures and Realignment Act. VA spent many months negotiating for 162 acres of Fort Sheridan's land with the Army. Secretary Brown's ultimate offer of $6.945 million was rejected by the Department of the Army in May 1993. This rejection meant that VA would have to start the process of finding a new location for the cemetery all over again.

VA immediately began trying to locate a new site in an effort to uphold its commitment to Chicago-area veterans. Early June 1993 NCS staff visited Cissna Park, Grant Park, and Joliet Army Ammunition Plant (Hoff Woods) in search of a replacement for Fort Sheridan. A supplemental EIS contract

was awarded late June 1993. Hoff Woods was chosen as the most viable new site. An analysis of this new location estimated the availability of burial space well beyond the year 2030--a considerable amount over the acreage sought at the Fort Sheridan site. The preliminary draft for the EIS was submitted to VA in August 1993. It was distributed to members of the Congress in September and filed with the Environmental Protection Agency in October of the same year.

In addition to the need to locate a new site, delays have resulted from EIS and land use issues, as well as from issues regarding land transfer arrangements. Comments on the draft EIS were received from the Environmental Protection Agency, United States Fish and Wildlife Service, and the Illinois Department of Conservation. VA representatives met with the above-named organizations in February 1994 to determine a use for the land that all parties could agree upon. Secretary Brown signed the Record of Decision selecting Joliet as the site for the new cemetery in July 1994.

A bill, H.R. 4946, transferring a 900-1,000 acre parcel from the Department of the Army to VA for the new cemetery was introduced and passed by the House of Representatives in the 103rd Congress. The bill also included language that would transfer the remaining areas of the Joliet Army Ammunition Plant to the United States Department of Agriculture and adjacent local governments. The House of Representatives passed the bill in October of 1994; however, the 103rd Congress adjourned before the Senate took any action on the bill. A disagreement with the Will County transfer portion of the bill blocked the measure from being considered in the Senate. Identical proposals, H.R. 714 and S.449, have been introduced in the 104th Congress.

With the legislative transfer of the land at Joliet in question, negotiations were initiated with the Department of the Army for transfer of land to VA under Public Law 100-180. This public law will permit transfer of not less than 200 acres of the Joliet Army Ammunition Plant to VA at no cost and is an alternative to other legislative authority currently being considered by Congress. VA's meetings with the Army have been very positive. Unlike H.R. 714, it does not involve transfers to any other agencies. The boundary survey contract has been completed. The master planning contract is expected to be awarded by mid March 1995. Upon completion of the master plan NCS will proceed with design and construction of the new cemetery.

CONGRESSMAN WELLER

Third Party Reimbursements

Question: 1. We have heard from numerous veterans service organizations, including those represented today, requesting that the VA be allowed to retain 3rd party insurer payments rather than continue to return the funds to the US Treasury.

1a. What is the Administration's position on this issue?

Answer: The Medical Care Cost Recovery (MCCR) revolving fund, established by P.L. 101-508, is required to return collections to the US. Treasury. This program has been very successful, returning more than $2.2 billion to the Treasury. Legislation would be required to allow VA to retain third party insurer payments. The FY 1996 President's Budget Request did not include a proposal allowing VA to retain 3rd party insurer payments. If VA did retain these collections, there would need to be a PAYGO offset.

1b. How are these funds currently applied once they are returned to the US Treasury? Are these funds spent or are they used to offset the deficit?

Answer: Collections from third party insurance and outpatient copayments have been deposited in the Treasury VA-MCCR Fund. With the exception of the resources deemed necessary by the Secretary to support activities during the coming year, receipts are transferred to the General Fund Receipt Account by January 1 of each year. Treasury has no authority to spend these funds, so the funds collected are a reduction to the deficit.

1c. What is the impact of this request, if any, on the federal deficit?

Answer: If VA were to retain these funds without any offset, the federal deficit would be increased. Under PAYGO rules, an offset is required for a legislative change to a mandatory receipt account.

d. If such a change was made, what are the estimated funds from 3rd party private insurers vs. funds from the Medicare system for FY 1996?

Answer: If VA were allowed to retain collections recovered from third party insurers, it is estimated that VA would keep an additional $433 million in FY 1996. We do not have estimates on recoveries from Medicare.

Veterans' Compensation

The Administration has requested $694.1 million for the 1996 budget for the Veterans Benefit Administration, with average employment decreasing by 188 FTE positions. In addition, the average length of time required to complete an original compensation case is around 168 days as of January, 1995, an improvement over the average 212 days as of May, 1994.

Question: 2. If you are cutting 188 staff positions in VBA, how will you improve the currently atrocious backlog in veterans claims?

What measures are you currently undertaking to streamline the claims processing system?

Answer: The staffing in Adjudication, the division that processes veterans' compensation and pension claims, will not be reduced. The 188 positions will come from other programs in the regional offices and from Central Office staffing.

We have several initiatives underway that will enhance the claims processing system during 1995 and 1996.

Service Medical Record Center. VA has implemented an agreement with the military departments whereby the medical records for all active duty discharges are sent directly to VA's Service Medical Record Center (SMRC). The Center, in turn, forwards the records to the appropriate regional office if the veteran had filed a claim or stores them until such time as a claim is received. The new procedures for service records is contributing significantly to the improved timeliness in the processing of initial disability claims.

VA Physical Examination Requests. A new Memorandum of Understanding between VBA and the Veterans Health Administration (VHA) on processing physical examination requests reinforces VHA's commitment to provide VBA with timely, high quality examination reports. It also includes a provision for an Examination coordinator at each VBA regional office and each VHA medical center. These individuals will be the focal points for ensuring that, together, VHA and VBA work to provide the best possible service to veterans.

Consolidation of Education Claims. Consolidation of the adjudication of the Montgomery G.I. Bill claims at four sites confirmed that improved quality and efficiencies can be realized by concentrating education claims with an experienced cadre of adjudicators. Between 1994 and 1996 regional offices will transfer their education cases to one of the four centralized sites. This will not only improve customer satisfaction through more timely benefits delivery, but the operational efficiencies gained will allow adjudication personnel who would otherwise have worked education claims to concentrate on compensation and pension claims.

C&P Training Operations. Since its inception in February, 1990, through 1995, over 2,000 adjudication personnel will have received training conducted by the Compensation and Pension Training Staff at the VBA Training Academy in Baltimore. During 1996, over 700 individuals will attend one or more of the C&P courses. In light of the many organizational and procedural changes occurring in the area of claims processing, the standardized interpretations fostered by centralized training will be an important factor in maintaining timely, high quality service. Centralized training and centrally-produced training units transmitted to the regional offices will also reduce the amount of time experienced adjudicators devote to training duties, allowing them to concentrate on claims processing.

Use of New Computer Software. One of the goals of the VA's modernization program was realized in 1993 and 1994 with the installation of stage I computer hardware at all regional offices. This equipment not only provides the foundation for future modernization efforts (discussed in subsequent paragraphs), but is already supporting several new software packages. These include the Personal Computer Generated Letters application, the Automated reference Materials System, the revised Physician's Guide, and the Word Assisted Rating System.

Rating Board Automation. Under development is a computer application called Rating Board Automation (RBA). RBA's sophisticated programming and large database of standardized phrases, sentences and paragraphs will allow rating specialists to complete rating decisions and Statements of the Case with only minimal use of a keyboard. New regulations, policies and procedures can be quickly

programmed into RBA. This will make ratings more consistent, which, in turn, will improve quality and productivity. The new system is scheduled for deployment in the Spring of 1995.

Veterans Service Network (VETSNET). VBA is engaged in an effort to reengineer all claims processing by looking at the fundamental way we do business and then applying technology in the most effective manner to support redefined business structures. This long-term system redesign effort, titled Veterans Service Network (VETSNET), is focusing first on the processing of compensation and pension claims. This portion of VETSNET should begin to be implemented during 1996 and will be capable of handling many tasks that the current system cannot.

Claims Processing System (CPS). Based on the successful testing of a prototype system, the Compensation and Pension Service is developing a computer program to assist with the development of claims. This program, using information entered by adjudication personnel and data supplied through linkage with other systems, helps determine what additional evidence is needed to perfect claims and then automatically generates development letters and other documents to request the necessary evidence. We expect to complete initial testing and evaluation of the first phase of CPS during the third and fourth quarters of 1995.

Reorganization and Reengineering. For the past two years, VBA has been reviewing a wide range of ideas for functional and organizational realignment, including initiatives already underway in the regional offices in Jackson, Muskogee, New York, Oakland and Portland. In November, 1994, VBA issued a letter to the regional offices outlining four organizational models for the offices to choose among in realigning their Adjudication and Veterans Services Divisions. The offices will, over the next three to five years, change their current configurations to conform to one of the four models. The intent of this effort is deliver full service to veterans and their families while also improving the efficiency and flexibility of our operations.

CONGRESSMAN EDWARDS

Major Construction Program

Question: 1. The FY 1996 major construction budget has been criticized as continuing "the VA's bias" toward hospital-based care. How would you respond?

Answer: The FY 1996 request includes six projects that emphasize patient environment. These patient environment projects not only improve the conditions in which patients reside, but usually result in the reduction in the number of beds.

Although only 6 percent ($28 million) of the major construction budget is allotted to strictly ambulatory care projects, VA continues to emphasize outpatient care. The minor construction program includes $42.57 million (20 percent) in the outpatient improvements category. In addition the projects for the new VAMCs at Travis (85,000 visits) and Brevard County (126,000 visits) include ambulatory care and enhance veterans access to health care. Between FY 1980 and FY 1995 the VA has opened 149 outpatient clinics and is encouraging VAMCs to fully implement primary care and to establish new access points to better serve their patients.

The Travis project replaces a facility (Martinez) that was closed due to seismic deficiencies and the Brevard project is needed to address the needs of a rapidly growing veteran population and to provide much needed nursing home care and long-term psychiatry beds for the state of Florida.

State Health Care Reform

Question: 2. Do you continue to see a need for legislation to provide VA a role in States embarking on access-expanding health care reform?

Answer: The need for such legislation to ensure VA a role in State reform continues to exist. Particularly in States which are able to achieve universal coverage, veterans should be able to choose the VA health care system as an enrollment option. However, regardless of the extent to which States enact individual reforms, VA needs legislation which would allow it to operate an effective and rational integrated delivery system. Examples of the type of legislation needed include eligibility reform, additional personnel management flexibility, contracting and purchasing flexibility, and banking and financial system changes, all of which were addressed to some extent in the state pilot bills introduced in the 103rd Congress. Yes, VA continues to see a need for this type of legislation.

Third Party Reimbursements

Question: 3. PVA maintains that "with more efficient collections practices" VA could collect far more in third party reimbursements. Would you comment on that critical assessment? Do you see opportunities for improvements through contract or other mechanisms?

Answer: MCCR's recoveries have grown each year, especially since FY 1991 when VA's Medical Care Cost Recovery (MCCR) effort became a separate Program Office.

FY 1991	$266.9 million
FY 1992	$448.4 million
FY 1993	$506.4 million
FY 1994	$547.3 million*

* In FY 94, medication copayments decreased $26 million from their FY 1993 level because of the legislation providing exemptions to low income veterans and because of the decision to allow medication copayment debt to be

waived. Had these changes not occurred, FY 1994 total recoveries would have approximated at least $573 million.

Recoveries over the last eight years total over $2.2 billion dollars. In FY 1995 MCCR continues to expand its recovery horizons. Recoveries for the first quarter totaled $130.75 million. This is $10 million ahead of last fiscal year's recoveries for the same time period. January's recoveries of $43 million also exceeded last year's figure. MCCR is committed to exceeding prior years' recoveries through refining the established process, developing supporting technologies and identifying areas that need improvement.

The MCCR program recognizes multiple opportunities to improve efficiency. The program has implemented initiatives to maximize recoveries, streamline the process and minimize cost. These initiatives include:

Software development for accounts receivable, billing, and a national data base.

- Training for all software applications and process redesign.
- Electronic Data Interchange and the introduction of Electronic Fund Transfers.
- Facility specific performance measurement reports.
- Process Reengineering.
- Data Capture technology and software for ambulatory care clinics, including optical scanning of encounter forms, generic workstations and mobile pen-based workstations.
- Staffing redistribution model.

MCCR is in the process of determining whether opportunities exist at certain medical centers for contractual services that would provide a more cost efficient recovery operation. These contractual services, however, do not include every phase of the insurance identification, billing, and collecting process. Evaluators of contractual service efficiency must account for this fact when assessing total cost of operation. MCCR currently is examining the use of turnkey services in less efficient medical centers, measuring the expense to VA of a hybrid insurance identification, billing, and collecting operation (the turnkey contractors combined with VA employees who perform the function not covered in the contract) against the costs of MCCR alone.

Care of Mentally Ill

Question: 4. Last session this Committee criticized the Department's record of fiscal commitment to care of the mentally ill. Do the proposed medical care, construction, and research budgets for FY 96 offer any prospect for change as it relates to care of the mentally ill?

Answer: An important component of VA's plan for veterans with serious mental illness involves national dissemination of assertive case management teams, known within VA as Intensive Psychiatric Community Care (IPCC) Programs. IPCC teams deliver comprehensive, individualized mental health services in community settings, helping veterans who are among the highest users of VA psychiatric inpatient services to reduce their reliance on hospital care. In FY 1994, six new IPCC teams were implemented with intensive support from existing IPCC teams, coordinated by the Northeast Programs Evaluation Center. Twenty-three more teams are currently in development and should be well underway by the end of FY 1995. The FY 1994 and FY 1995 medical care appropriations also allowed VA to implement three (3) Unified Psychogeriatric Biopsychosocial Evaluation and Treatment (UPBEAT) programs at 9 VA medical centers. Within a cluster of three medical centers, one facility is the Hub UPBEAT program and two other facilities host

peripheral UPBEAT programs. UPBEAT programs are designed to improve clinical services to elderly veterans suffering from psychiatric disorders. Also in FY 1994 and FY 1995 funding was made available to expand services for homeless veterans suffering from mental illness. The FY 1995 appropriations also allowed for increases in PTSD programming. The FY 1996 budget will allow VA to maintain current services in these program areas and VA will continue to monitor the effectiveness of these initiatives.

Thirteen new research proposals were approved by the Mental Health and Behavioral Science Review Committee in the VA's fall 1994 Research Merit review cycle. In addition, a solicitation for Schizophrenia Research Centers was issued; following review three were approved and funded. In FY 1996, Research will continue its commitment to mental health programs and the funded centers.

The 1996 Budget request includes the following psychiatric projects in the Major Construction program:

Perry Point, MD	Renovate Psychiatric Wards	$15.1 million
Marion, IN.	Replace Psychiatric (100) Beds	$17.3 million

Other Major Construction projects include psychiatric care as part of the scope of construction. These include:

Brevard County, FL New Medical Center and Nursing Home, including 230 psychiatric beds $154.7 mil.
Reno, NV. Replacement Bed Bldg. and Ambulatory Care $20.1 mil.
Travis, CA. VA/Air Force Joint Venture $188.5 mil.

Brevard County, Florida	New Medical Center and New Nursing Home inlcuding 230 psychiatric beds	$154.7 million
Reno, NV.	Replacement Bed Bldg. and Ambulatory Care	$20.1 million
Travis, CA.	VA/Air Force Joint Venture	$188.5 million

In addition, the following Major projects which were funded for construction in previous budgets are included in the 1996 Medical Care Activation budget request:

Lyons, NJ 180 Bed Psychiatric Building
Marion, IN 240 Bed Geropsychiatric Facility
Tuscaloosa, AL 270 Bed Psychiatric Building

Customer Service

Question: 5. The authors of the Independent Budget identify steps taken at certain VA facilities without the benefit of added funding to reduce patient waiting times and improve service accessibility. Is better customer service a budget issue or only a management issue? What plans do you have to address this issue?

Answer: Customer service is both a management and a budget issue.

VA conducted an assessment in order to more clearly pinpoint areas that required improvement. Self-reported information was received from 86 medical facilities who identified 188 changes in several clinics. These facilities were able to decrease, on average, the time patients had to wait for their next appointment by 81 days. The amount of time that patients had to wait in clinics to be seen was decreased an average of 55 minutes. The request for information, from which this information was derived, was purposefully not specific. Therefore the resulting information received from medical facilities did not have a uniform construct nor similar content. To bring information into a single direction, assumptions were made and a format was developed that identified: WHO made the changes, WHAT clinics were addressed, WHAT kind of problem was found and addressed, WHAT changes were made, and WHAT cost was reported associated with those changes.

The majority of the changes made to improve timeliness would fit into the "management" category and required little or no "budgetary" action. However, about 20 percent of actions had budgetary impact. This assessment did not address accessibility (how long and/or how far a veteran must travel to receive services). Undoubtedly, improving access to services (not the timeliness of services) has a greater budgetary impact. Addressing the issue of access will require more 1) clinics, 2) mobile vans, 3) contracting of services, etc., and therefore, have more budget implications, though again some can be handled by management decisions. Beginning in May of 1995, VHA will be formally collecting information from all medical facilities on those waiting times that are related to our customer service timeliness goals, through the Quality Indicator Checklist Program. (QUIC). At this time there are no plans to collect information about the budgetary costs associated with improving timeliness.

Medical Care

Question: 6. You indicated that savings generated by the consolidation and integration of services at individual VA medical centers will be applied to direct patient care at those facilities, or in cases where costs may differ, move the savings to other areas. What methodology will be used for determining this and when?

Answer: Savings generated through the consolidation and integration of services will remain at the individual medical centers. Redirection and distribution of funds will be at the discretion of local management based local priorities and assessments of greatest need. It is anticipated that the majority of savings will be generated from administrative functions and that savings will be applied to areas providing direct patient care. There are no plans to provide central direction to the reallocation of funds within local service areas at this time.

Question: 7. VA's Decentralized Hospital Computer Program (DHCP) has had a major impact on VA care. Dr. Kizer, I think you'd agree that this is a dynamic area which requires a major investment in software maintenance and

enhancement. How many FTE will be devoted to those efforts in FY 1996 versus FY 1995 staffing?

Answer: I agree that DHCP has had a major positive impact on patient care in VA. Consequently, we will maintain 435 Medical Care FTE in the Information Systems Centers (ISCs)in FY 1996--the same number as in FY 1995. These FTE are responsible for the development, enhancement, technical and application support, customer support and security for over 60 DHCP applications and the two hardware platforms on which they run. Additionally, some of the staff provide advice and assistance on telecommunications issues. We are taking two major steps to enhance the software available to support patient care. First, through the Hybrid Open Systems Technology (HOST) initiative, we are "opening up" DHCP so that it can more easily be supplemented and enhanced by commercial off-the-shelf products. Secondly, we have a major re-engineering effort underway in the ISCs to help us to obtain even greater productivity from our existing resources.

CONGRESSWOMAN WATERS

Vocational Rehabilitation

Question: 1. Mr. Secretary, in the Administration budget you recommend that the Vocational Rehabilitation and Counseling Service be cut by one FTE. At the same time, you predict an improvement in the abysmal level of service now being provided to our nation's disabled veterans by VR&C.

Inadequate staffing has been the primary cause of the embarrassing low level of good and timely service in VR&C. Why do you expect any improvement in service?

Even your optimistic prediction for FY 1996 indicates it will still take 70 days for a veteran to get his or her first appointment in vocational rehabilitation and 6 1/2 months to get placed in a job following the program.

It seems to me, and I think most in Congress would agree, that vocational rehabilitation for service-connected disabled veterans should be the highest priority in the VA. What FTE level would you require in order to meet the quality and timeliness goals established by VA for this program? I expect you should be considering the Independent Budget recommendation that 600 FTE be added to VR&C--not recommending even a small additional reduction.

Answer: Vocational rehabilitation for service disabled veterans remains one of the highest priorities in VA. However, we do not agree that more FTE is the answer. A new VR&C Director has initiated a streamlining and reengineering approach to business processes nationwide. With this reengineering, we believe we will do much better than the 70 days a veteran currently waits for an initial appointment and the 6 1/2 months currently needed for placement in a job following training.

Until we have identified the best way to structure our service delivery for this program, we do not feel we are in a position to determine optimal FTE levels for the vocational rehabilitation program.

Question: 2. The vocational rehabilitation revolving fund ran out of money last year. Consequently, some disabled veterans who were in rather desperate need of assistance could not be provided a loan from this fund.

These loans are always repaid because deductions are made from the veteran's compensation or retired pay. What can you do to ensure, that, in the future, adequate funds are available in this fund? Would a legislative change be required?

Answer: Under Credit Reform, discretionary loan programs have enacted in their appropriation bills language limiting the amount of loans that can be made. During 1993, the rates of usage by veterans needing advances gave us serious concern that some would not be able to secure an advance because the revolving fund would not be able to secure an advance because the revolving fund limitation of $1,760,000 already would have been met. As it turned out, $1,730,000 was disbursed that year. No similar concern was presented in 1994, during which $2,201,000 was disbursed. We have insufficient information to predict a trend bearing on the future adequacy of the funding level for the revolving fund.

Legislation changing the program from a discretionary to a mandatory program would be required to ensure that no veteran in a chapter 31 rehabilitation program who is found in need be denied that advance solely because of the

unavailability of sufficient funds in the chapter 31 revolving fund.

Loan Guaranty

Question: 3. The Independent Budget recommends that Loan Guaranty staff be retained in the Loan Guaranty Service and not reassigned to claims processing. I am not insensitive to the need to reduce the level of pending claims. I agree, however, that this problem should not be solved by reducing the quality of service to veterans in other areas.

Is it your intention to shift Loan Guaranty field staff? If so, to what degree will this negatively affect the quality of services provided to veterans seeking to buy a home?

Answer: Final decisions on distribution of FTE resources rest with field station directors. Local management is in the best position to determine the most effective use of available resources. Claims processing has been given a high priority but this does not mean that benefits delivery in Loan Guaranty or any other program should be impacted negatively. FY 1994 was one of the biggest years in the history of the Loan Guaranty program with over 600,000 loans guaranteed. VA was able to provide these home loan benefits in a timely manner. We are confident that with the lesser loan volume projected for FY 1996 that veterans will continue to receive timely service in obtaining guaranteed home loans.

Veterans Services Program

Question: 4. Mr. Secretary, as stated in the VA's budget documents, the primary function of the Veterans Services program is to provide information, advice, and assistance regarding benefits available to our nation's veterans and their families. The importance of this program is obvious. Nonetheless, you predict that the quality of service provided by Veterans Service staff will decline in fiscal year 1996.

What are your long-term plans and expectations? Do you assume a continuing downward spiral with fewer and fewer veterans able to obtain needed information regarding their benefits?

What FTE level would be needed to meet the quality goals related to this program established by the VA?

Answer: Our ability to provide an acceptable level of service is a function of several variables to include the blocked call rate, available FTE, modern equipment, the introduction of telecommunications technology, and the initiatives to reengineer our business process. Several initiatives are expected to have a direct impact. The Administration is currently reengineering to provide a case management approach to our clientele. We are also reworking our pattern and computer generated letters to be more understandable, and are providing more information on status of claims processing on a recurring basis. Each of these initiatives, and others, will work to reduce the number of contacts veterans and their families will have to make to VA, freeing up FTE to respond to a greater number of those persons who are currently unable to reach us because of the high blocked call rates.

Workload accomplishments and other indicators do not suggest a significant downward spiral. However, significant improvements in service levels have not been achieved. It is anticipated that the service levels will remain constant unless the organization is able to impact on the capability to provide service to a greater number of veterans with our assigned resources. The minor decline in service levels

predicted in 1996 are related to the training efforts that will be required to implement the case management initiative mentioned above. Trainees normally take longer to do the job, and make more errors than fully trained staff.

The current situation with a high blocked call rate makes it difficult, if not impractical, to attempt to reach the desired quality goals through FTE increases alone. The introduction of technology provides several options to improving service and enables VBA to manage its telephone traffic in the same fashion as the business community. Current efforts to study the traffic patterns and make adjustments where possible will provide some relief. Other improvements will occur as new equipment is acquired and modern telephone features are introduced.

Montgomery GI Bill

Question: 5. If the benefits paid under the Montgomery GI Bill had kept up with the increases in education costs which have occurred since establishment of the program in 1985, what benefit would now be paid to an individual studying full-time under the GI Bill-Active Duty? Under the GI Bill-Selected Reserve?

Has the VA ever included an increase in the GI Bill basic benefit in its budget request to OMB? If not, why not?

In your personal view, is the current basic benefit level adequate? In other words, is the Montgomery GI Bill still a meaningful readjustment benefit?

Answer: The benefits paid under the Montgomery GI Bill have not kept pace with the increases in the annual cost of education since 1985. Since the inception of the Montgomery GI Bill, the Department of Education has reported that inflationary increases in the cost of education has varied between 6 and 8 percent annually. During the life of the program, we have not found the need to include in a request to OMB an increase in the basic benefit rate since the program has been effectively accomplishing its recruitment/retention and readjustment assistance purposes. The Montgomery GI Bill continues to be a valuable readjustment benefit (and recruitment tool) even though it has not kept pace with the rate of inflation.

Occupational Conversion and Training Act

Question: 6. Mr. Secretary, your budget does not include a request for additional funds for the Service-members' Occupational Conversion and Training Act - generally referred to as SMOCTA. This very successful program has enabled several thousand veterans to obtain training and employment.

I know you were very supportive of this program and at one time indicated that you would seek additional funding for it. Why is that request not included in this budget?

Answer: Funds for the Servicemembers Occupational Conversion and Training Act (SMOCTA) are not included in the 1996 Budget request. P.L. 103-335 only extended the availability of funds appropriated for SMOCTA through September 30, 1995. Consequently, the only funds paid for wage subsidies in 1996 will be those which have been obligated for training programs that commence before October 1, 1995. In addition, the authorization does not permit the expenditure of funds from the original appropriation for the administration of SMOCTA for the eighteen month period during which payments can be made after September 30, 1995. VBA will require $165,000 in 1996, and may require funds in 1997, to administer the phase-down and closing of SMOCTA.

The decision not to request FY 1996 appropriations for SMOCTA reflects the tight fiscal restraints under which the budget was formulated.

CONGRESSWOMAN BROWN

Assistance to Homeless Veterans

Question: 1. Assistance for Homeless Veterans: How can we best serve our veterans who have no home, no address, and no way to be contacted by family or by potential employers? I would like to work with you and with the Committee to develop a successful, cost-effective program.

Answer: VA has already developed a wide array of services and programs to address the clinical needs of homeless veterans, many of whom suffer from mental illnesses, including substance abuse disorders. The range of services provided to homeless veterans within these specially funded programs include outreach, case management, residential care in either community-based facilities through VA contracts or in VA's domiciliary care programs, therapeutic work opportunities to help homeless veterans regain work skills and work habits, assistance in improving access to Social Security benefits for homeless veterans who are determined eligible for those benefits and permanent housing coupled with ongoing case management. At the present time, the VA Medical Centers in Bay Pines, Tampa, and Miami have received special funding to implement programs for homeless veterans.

I would welcome your suggestions for improvements in VA's efforts to assist homeless veterans.

Florida's Fair Share

Question: 2. What are we doing to assist veterans who come to Florida, especially in the winter months, and require services? How can we alleviate the bottleneck at the St. Petersburg office where these veterans are processed? Are there any plans to expand this Center?

Answer: The St. Petersburg Regional Office is among the most efficient of regional offices, consistently providing timely, accurate, and compassionate service to veterans and their families residing in Florida. Productivity levels are higher than the national averages, resulting in quicker processing times and smaller pending balances. Although there are no plans to build an additional office in Florida, the pending relocation of the current office to the grounds of the Bay Pines VA Medical Center will enhance overall service levels by providing "one-stop service" to Florida's veterans.

Question: 3. I would like to work with you regarding the Special Separation Benefits program as it related to disability compensation.

Answer: We would be willing to discuss this subject with you or your staff at any time. Our position, however, has not changed since we commented on HR 3731 last year. The long-standing offset requirements of 10 U.S.C. 1174 apply not just to the Special Separation Bonus, program, but to several forms of separation and severance payments made by the Department of Defense. We do not believe that VA should support legislation which inequitably singles out one class of veterans for favorable treatment over other, similarly situated veterans.



PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

PARALYZED VETERANS OF AMERICA
RESPONSES TO QUESTIONS
SUBMITTED BY
HONORABLE CHET EDWARDS
REGARDING THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
HEARING ON FEBRUARY 24, 1995

1. Do you have any concerns that the FY 96 Medical Care budget will result in a cutback of services currently available to veterans?

The President's budget proposes a $17 billion budget in contrast to the FY 1996 *Independent Budget's* recommendation of $17.6 billion to maintain the FY 1995 current services level. The chief differences between the two figures are the Administration's estimation of the impact of management improvements (savings of $335 million) and the calculation of the *per diem* allowance to the state homes (the *Independent Budget* adds about $84 million to allow VA to meet its 1986 agreement to pay state home programs at 1/3 of costs VA incurred for the same type of care). Other differences in this estimation are a by-product of the methodologies VA and the IBVSOs used to determine costs.

The *Independent Budget* recommends a current services funding level of $17.6 billion and the Administration's budget is $600 million short of this funding level. Funding the system at this level also prohibits any strategic growth or personnel re-training in areas such as primary and long-term care that are critical to meeting veterans' needs, and thus, the survival of the system. It also fails to ameliorate the backlogs VA is experiencing in purchasing equipment, performing maintenance and repair, and building the appropriate information infrastructure to a state of the art a care provider now needs.

We feel that the "management improvements" VA estimates are premature. VA is in the midst of the *approval* process of a comprehensive overhaul of its management system. VA has no experience on which to base its estimation of the impacts of its management initiatives. Furthermore, the IBVSOs feel that implementation and recognition of any cost savings that the system could accrue will not be achieved until some time in the outyears. This is particularly true in the absence of any new legislation that would release VA managers from some of the bureaucratic restraints—particularly, eligibility criteria, personnel floors and ceilings and other imposed management criteria—under which the system now operates. If VA managers had the authority to treat their patients in appropriate care venues and expand and contract areas of care to meet veterans' need, the IBVSOs believe that savings could accrue to the system as the *Independent Budget* proposal demonstrates.

2. Would you explain why the VSO *Independent Budget* recommended VA invest $100 million annually for the VA medical system's information infrastructure during the next four years?

VA must have an information infrastructure that will support clinical decision-making, quality assurance, resource distribution, and strategic planning in the rapidly evolving health care environment. This is particularly essential as VA restructures its management and redirects its focus to more patient-centered information systems.

Several projects are essential to VA's decentralization effort. VHA's national databases must be integrated and updated to

minimize information overhead and to provide consistent systemwide information. VA must develop more effective cost accounting and billing systems in order to maximize medical care cost recovery from third-party payers and to allow VHA to negotiate contracts with private-sector payers and providers. VA facilities must be able to maintain real-time communications with all facilities involved in VA patient treatment to facilitate the shift toward managed care and primary care that may often be delivered "off-site". VA will also become increasingly involved with other payers and providers. To communicate effectively with these parties, VA must be able to interface with their decision support systems. These emerging trends in VA health care delivery require huge investments in software and hardware. At least $500 million will be required over the next five years. The *Independent Budget* recommendation is based on the VSO's support for VHA's long range information resource management strategy. This year's recommendation of $100 million is seen as the first installment on the five year plan.

3. Would you expand on your finding that VA spends only 2% of its budget on information resources management while the private sector typically spends 4%? What are the implications of that disparity?

VA has successfully implemented a state-of-the-art clinical information system which require ongoing maintenance. As the DHCP has grown, the portion of the Medical Information Resources Management (MIRMO) budget for maintenance and support has grown to match. At 2%, the funds left over after maintenance and support are insufficient to continue the development of new systems so critical to VHA restructuring and to allow VHA clinicians to keep pace with rapidly evolving information technology, i.e. telemedicine, video-imaging, managed care, outcomes measurements, cost containment, and quality evaluation. New program development that the VA medical system will require in creating a master veterans record, an automated patient record, creating networks to support the Vertically Integrated Services Networks (VISNs), and other top priority projects necessary to support medical decision-making in the emerging VA environment have been postponed as MIRMO has been compelled to become more involved in maintenance, staff training, and installation activities.

VHA has developed clinical systems for the delivery of health care that are as good as, or better than comparable systems in non-federal facilities. Now VHA must improve its systems for the business of health care which lag behind the profit-driven private sector. To do this, VHA must invest more of its budget in information systems. Ultimately, the veteran will benefit through the improved responsiveness of his or her medical care system. The alternative, inadequate investment in IRM, will compromise the viability of the system as a whole.

4. The VSO *Independent Budget* recommended that Congress authorize the establishment of a nonprofit VA information services foundation (modeled on the nonprofit VA research foundations) as a source of support for information resources development. Would you expand on this concept and offer any views on anticipated sources of funding support?

A non-profit Information Services Foundation would benefit the American taxpayer, veterans, and VHA by addressing three problems. First, a foundation would provide a mechanism by which support for VHA developed software could be made available to other U.S. government agencies, rural hospitals, and other potential users. Second, a foundation would allow non-VA entities in the public and private sector to fund the development of new software applications to extend the functionality of existing DHCP programs. Third, the foundation would create capital and human resources that could be supplement VHA resources for information systems development.

There is a "market" for VHA software. DHCP applications are robust, well tested, and easy to use. VHA has developed a set of clinical applications that, in combination, have a wider range of functionality than anything available in the private-sector. DHCP applications are currently in use by the Indian Health Service, the U.S. Department of Public Health, March Air Force Base, the University of Tennessee, Multiple sites in Finland and Nigeria, the German Heart Institute, and The National Cancer Institute in Cairo Egypt.

There is market demand for these programs that cannot be met. For example, Interest Quality of Care, a non-profit rural health provider recently expressed an interest in purchasing support for DHCP software but although they were willing to pay for support services, there was no mechanism by which VHA could convert their dollars to FTEE.

The DHCP software, all developed by VHA with taxpayers' dollars, is in the public domain. Anyone who wants the software can use it. But systems of this complexity require support in the form of documentation, help desks, maintenance, and the distribution of new versions. Currently, any support that VHA provides must come out of its budget. While there are many customers for VHA programs, this software is not really available because VHA cannot afford to provide free support. The taxpayer is the loser in this situation. DoD, the Public Health Service, and the Indian Health Service should be able to make use of public domain software developed at public expense without incurring unachievable new demands for support on VHA. Many poor rural hospitals need the clinical information services available through the DHCP but cannot afford the price tags on less functional off-the-shelf programs. A non-profit information services foundation could make these products available for broad use, multiplying the payoff on money that has already been spent.

Another function of the foundation would be to allow non-appropriated funds to be spent on software development in VHA environments. For example, PVA would like to contribute to the development of DHCP software that would improve the quality and responsiveness of services for veterans with spinal cord dysfunction. For-profit software developers might want to invest in DHCP compatible products or take advantage of VHA's capacity for large-scale beta-testing to prepare new products for the market. Both the public and the private sector could benefit by this sort of cooperation.

Both these activities, selling support services for public domain software, and outside funding for software development and testing in the VHA environment would generate capital that could be used to supplement appropriations for VHA investment in its information systems. Also, expanding the user-base of the DHCP software would create human resources, in the form of software engineering and programming skills. The foundation could become a pool of funding and talent that would give VHA an element of flexibility needed to meet new challenges and adapt to workload cycles.

A non-profit information services foundation offers many advantages to veterans, VHA, the U.S government, and other public and private entities and has no off-setting drawbacks. It is based on the precedent set by the non-profit research and education foundations which have pioneered the concept and worked out the details and the oversight mechanisms necessary to ensure that funds are spent wisely for the public good. PVA recommends that Congress act immediately to authorize the creation of a foundation so that the benefits of the excellent systems that VHA has developed can be realized by others.

Answers to Follow-Up Questions
Submitted by the Honorable Chet Edwards
to Veterans of Foreign Wars of the United States

1. As I understand it, the Independent Budget recommends that $257,406,000 of a $490 million major construction appropriation be targeted to "replacement and modernization" projects. Given the specificity of your figure, would you please identify the projects which you propose be funded.

The *Independent Budget* projects Replacement and Modernization costs based on one-half of the future needs the Department of Veterans Affairs designated for initiated projects in their FY 1995 Congressional budget request. The IBVSOs place priorities for any new projects on development of the primary and preventive care capacities and long-term care. However, the *Independent Budget* co-authors believe that all Major Construction projects should be fully funded upon their initiation so that construction activities do not have to stop and start according to funding availability. Funding construction projects in such a manner adds tremendous costs and time to construction activities. Funding Construction activities, as well as activations for these projects, in such a manner also allows appropriators to be fully cognizant of the funding implications of all "bricks and mortar" projects. While we take no particular position on the projects VA designated, we feel strongly about making funding for any projects initiated available from the project's initiation to its completion.

2. Do you support and believe the funding for a new VA facility in Brevard and a replacement facility at Travis are justified at a time when the VA has indicated it is evolving to providing more outpatient versus inpatient care?

The IBVSOs place priorities for any new construction projects on development of primary and preventive care capacities and long-term care. However, the IBVSOs are not prepared to concede the Brevard and Travis projects which are based on VA projections of veterans' need and which VA has already initiated.

Answers to Follow-Up Questions

Submitted by the Honorable Michael P. Flanagan to all *Independent Budget* Panelists

1. In your opinion, how adequate is the vision the Administration's budget proposal sets forth in addressing the issue of eligibility reform? How would you propose that the VA approach this issue, which is critical to providing more cost effective and modernized service to veterans?

While the FY 1996 VA budget refers to some of the problems inherent in eligibility categories guiding access to VA medical care, it does not directly address any specific course of action. We understand that VA is in the process of developing another proposal, but we are not aware of its details.

The *Independent Budget* co-authors agree with your assertion that correcting eligibility is a necessary precursor to improving cost-effectiveness and "modernizing" the care system. VA can achieve these goals by first creating an infrastructure that responds to the type of care that veterans need rather than perpetuates the type health care delivery that exists in the system today which is overly reliant on high-cost specialized care delivered in an inpatient setting. VA medical centers must create local, community access to primary care centers that have interactive links to regional tertiary care centers; they must diversify and enhance the types of long-term care they provide to both elderly and chronically ill populations; and they must share expensive overhead and equipment costs with other federal and community providers to get the maximum benefit from the federal government's investments. These factors must be in place before VA clinicians are able to provide care in the most appropriate venues.

The *Independent Budget* suggests that once you have both the infrastructure and new funding streams (third party payments and Medicare reimbursement for higher income veterans) in place, eligibility reform will result in significant savings to the system. Savings can accrue because VA providers will be able to take patients out of expensive hospital beds and put them into outpatient clinics, nursing homes, and other appropriate long-term settings. VA can shift many of its existing resources to accommodate needed changes.

2. What are your priorities for management reform in Veterans' Affairs hospitals?

The *Independent Budget* co-authors agree that a top priority for any reform of VA management is establishing adequate accountability to ensure the integrity of the specialized care programs, including spinal cord injury medicine, blind rehabilitation, treatment for prosthetics users, treatment for Post-Traumatic Stress Disorder, and treatment for exposure to various agents during war-time. Successful performance for VA system managers should include indicators of successful operation of the specialized care services that fall within their medical centers' missions.

The IBVSOs are supportive of the Under Secretary's Vertically Integrated Service Networks (VISN) plan. We believe that VA managers should have the responsibility, the authority, and the accountability for meeting established criteria developed to define "success". Bringing decision-making closer to the patient should be the goal of every level of management. VA managers should also have more authority for using their resources appropriately as long as they successfully execute their primary missions. Hospital directors should be able to enter into appropriate partnerships with other care providers, shift the allocation of their resources to different venues of care,

contract for care and lease facilities and expand their workloads to dependents and higher income veterans where their resources allow.

Implementing managed care should be a high priority systemwide. All managers should have the expertise to implement systems for their patient population. Patients, particularly those at highest risk for disease, should be assigned to one provider or team and their health status should be carefully monitored. When patients require unique or specialized services, such as SCI care, they should be assigned to a team with the expertise to deal with their conditions. Primary and preventive care must be accessible to patients either through VA clinics or through community providers. They must have adequate skills and tools, including accurate data sources, to make appropriate financial decisions for their medical center. They must be change agents. Directors must also lead their employees-care providers and others-through extensive reform of care delivery within the medical centers. Academic medicine will have to meet new goals which the medical centers and medical schools define collaboratively to meet patients' needs. Above all, they must also understand the unique characteristics of the patients they serve and meet their needs.

3. Does the Administration's budget proposal adequately address your priorities concerning management reform of VA hospitals?

The Administration's budget proposal recommends several management improvements it purports will result in savings of $335 million. While the IBVSOs have no specific concerns with the general direction these management initiatives or the VISN restructuring plan takes (other than the concern for ensuring the integrity of the specialized care programs addressed above), we disagree that they can so quickly result in savings for the system.

NOTE: Although the PVA provided the written answers to Congressmen Edwards' and Flanagan's questions, as a member of the Independent Budget, AMVETS concurs with the above responses.

RESPONSE OF
RICHARD F. SCHULTZ
NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
TO QUESTIONS OF
THE HONORABLE MICHAEL P. FLANAGAN
BEFORE THE
HOUSE VETERANS AFFAIRS COMMITTEE
FEBRUARY 24, 1995

QUESTION 1:

In your opinion, how adequate is the vision the Administration's budget proposal sets forth in addressing the issue of eligibility reform? How would you propose that the VA approach this issue, which is critical to providing more cost effective and modernized service to veterans?

ANSWER:

For many years the question of eligibility reform has been agreed upon by the House and Senate Veterans Affairs Committees, the VA and major Veterans' Service Organizations (VSOs) as the single most crucial issue needing to be addressed if the VA's health care system is to be structured in a way that will permit it to serve veterans in a meaningful fashion now and into the next century. Unfortunately, the Administration's FY 1996 budget request, while acknowledging the system's inadequacies and need to change, offers little of substance to actually effectuate change. Collectively and singularly, the VSOs have set forth strategies and developed a plan that, if followed, would provide the impetus needed to move VA into the era of contemporary health care delivery. By doing so, VA can maintain itself as a meaningful and viable national resource. From DAV's perspective, meaningful reform must include, as its cornerstone, the following:

Eligibility - Define a "core-group" of veterans (the current category A, and catastrophically disabled) providing them a full continuum of care; and a "non-core" group, encompassing virtually all other veterans.

Access - Create points of entry into the system by establishing a system permitting ready access to VA services via community-based clinics, some providing basic services while others having the capacity of providing a broad range of services and, while maintaining adequate inpatient capacity, move toward an ambulatory care model. By doing so quality of care will be enhanced and cost effectiveness will ensue.

Funding - Maintain an adequate level of appropriated funds for the care of the core-group while permitting VA to retain third party, including Medicare reimbursements; "non-core" group veterans and other new patients would be required to cover the cost of their care from third party payers or other funding streams.

The *Independent Budget* sets forth a plan and strategy in considerable detail that will enable meaningful reform to occur.

QUESTION 2:

What are your priorities for management reform in Veterans' Affairs hospitals?

ANSWER:

Critical to VA's success is a reorganization and restructuring of the Veterans' Health Administration both in the field and its Headquarters. More compelling is the field. DAV supports fully the concept embodied in the Under Secretary for Health's proposal to create Veterans' Integrated Service Networks (VISNs). As we understand it, the plan has as it's foundation the vision of putting "patients first." To do so, decentralization of decision making and day-to-day operations must occur. Local managers must be given the authority and incentives to provide needed health care services to veterans they are there to serve. Once this occurs, additional enhancements should logically follow: easier patient access, quality of care improvements, strategic alliances among VA medical facilities, purchasing agreements, sharing agreements, collaborative relationships with the private sector and improved labor relations. All these, and, of course, many other aspects of health care will be created and improved creating the end result of accomplishing an improved system for veterans.

QUESTION 3:

Does the Administration's budget proposal adequately address your priorities concerning management reform of VA hospitals?

ANSWER:

The Administration's budget request contains savings of $335 million and 3,429 FTE predicated upon a number of diverse management improvements, inclusive of decentralization and the above referenced field and headquarters reorganization. We would caution, however, that simply based on these worthwhile initiatives alone, immediate savings or efficiencies may not immediately occur. Adequate transition time is required. We do not, however, necessarily quarrel with the path VA wishes to follow.

Chairman Stump to Non Commissioned Officers Association

Question: In your opinion, how adequate is the vision the Administration's budget proposal sets forth in addressing the issue of eligibility reform? How would you propose that the VA approach this issue, which is critical to providing more cost effective and modernized service to veterans?

NCOA response: NCOA was hopeful that the experience of the last two years on the national health care reform debate would have led the Administration to include eligibility reform in the budget for veterans for 1996. While national health care reform didn't happen, a great deal of momentum was generated by the Administration, and supported by veterans organizations, that eligibility reform was absolutely crucial to the future viability of the VA health care system. NCOA considers it unfortunate and somewhat short-sighted that the Administration did not continue its emphasis for veteran eligibility reform by including specific legislative proposals in its budget submission. In this regard, it is NCOA's opinion that a long-term vision is absent in the budget even though the VA has indicated they plan to address the subject in the near future. It just seems to NCOA that the logical time and place to do so would have been in the budget because of the budgetary implications surrounding eligibility reform.

NCOA's recommended approach for the VA, as well as the Full Committee, would simply be to follow the outline of the specific proposals articulated by the ten veteran organizations comprising the Partnership for Veterans Health Care Reform. NCOA also believes that the eligibility reform bill introduced by Mr. Stump during the last session of Congress could serve as a starting point to address the subject. But clearly, and it needs to happen sooner than later, the handcuffs on VA have to be removed so the Department can provide health care in the most appropriate setting and to all eligible veterans. Medical care cost recovery efforts must be enhanced and VA must be allowed to retain such recoveries.

Question: What are your priorities for management reform in Veterans' Affairs hospitals?

NCOA response: The VA health care system is burdened by an inflexible, highly regulated, centrally-controlled management system. By statute and regulation, individual VA medical centers cannot easily respond to local factors in hiring, contracting, marketing and procurement. VA medical centers directors lack authority to streamline and improve services by adapting to these local conditions. The result is higher than necessary cost, unnecessary delay, and diminished service to veterans.

Veteran health care is a national issue and obligation; however, the delivery of that care to a veteran is a local issue. VA medical center directors must be given the responsibility and commensurate authority to tailor their programs to the dictates of local and area factors. Decentralizing veteran health administration operations will improve efficiency, reduce cost and increase responsiveness to veterans' health needs.

Question: Does the Administration's budget proposal adequately address your priorities concerning management reform of VA hospitals?

NCOA response: The short answer is no. But in fairness to the VA, NCOA must acknowledge the effort that Secretary Brown, assisted by Doctor Kizer, is devoting to management reform. A draft plan has been formulated and is being reviewed with input from veteran organizations. It is NCOA's impression that the VA is committed to management reform. The Association would urge the Veterans Affairs Committee to immediately consider the required legislation just as soon as the plan is finalized and submitted by the VA.

The American Legion

For God and Country

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March 17, 1995

Honorable Bob Stump, Chairman
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Stump:

The American Legion is pleased to respond to the Committee's request for additional comments on issues related to Fiscal Year 1996 Department of Veterans Affairs budget testimony presented to the Committee on February 24, 1995.

Follow-up question from Honorable Chet Edwards

1. You express skepticism that VA will be able to achieve the management efficiencies targeted in the FY-96 medical care budget. Would you expand on that concern and share with us any analysis The American Legion may have regarding the magnitude of management savings which <u>are</u> achievable?

<u>Answer:</u> The American Legion perceives the $335 million savings for management initiatives in FY 1996 as a budgetary goal rather than a reality. The Legion is not aware of any scientific analysis conducted by VA to validate this proposal. VA operations staff are currently working to determine how to achieve the proposed reduction.

The American Legion believes that substantial savings could be realized through outpatient eligibility reform. Current VA regulations prohibit the treatment of certain eligible veterans on an ambulatory basis, necessitating more costly inpatient care. A recent VA study suggested that up to forty percent of VA inpatient admissions could be shifted to an ambulatory care setting or other settings. GAO has held that VA medical centers ration outpatient care inconsistently to both high income and lower income veterans (GAO-HRD-93-106). Currently, VA does not operate a cost-efficient preventive or primary care program, nor does it apply patient eligibility guidelines in a consistent manner throughout the system.

The American Legion is very optimistic that internal efforts recommended by the Under Secretary for Health may generate greater savings and better utilization of resources. VA has estimated the planned facility

consolidations and integration of services will take as long as 1-2 years for full implementation. Some immediate savings will be realized. However, resources will have to be diverted from medical care funds to compensate for any miscalculation in the projected management initiative savings.

Follow-up questions from Honorable Michael P. Flanagan

1. In your opinion, how adequate is the vision the Administration's budget proposal sets forth in addressing the issue of eligibility reform? How would you propose that the VA approach this issue, which is critical to providing more cost effective and modernized service to veterans?

Answer: The American Legion views the Administration's FY 1996 budget proposal as unsatisfactory on the issue of eligibility reform. The FY 1996 VA budget proposal is based on current law. The American Legion believes that VA must present a comprehensive, incrementally attainable proposal to correct the disparity of equity of access to care for veterans, and to promote a more holistic, cost-efficient approach in the provision of medical care services.

Although Phase I of the Reinventing Government Initiative has created momentum toward more streamlined operations, and this restructuring may provide more efficient services, it alone is not a panacea for necessary eligibility reform.

2. What are your priorities for management reform in Veterans' Affairs hospitals?

Answer: The American Legion enthusiastically supports the proposal of the Under Secretary for Health to eliminate the current four medical region concept and initiate the Veterans Integrated Service Network (VISN) concept. This network will help streamline administrative layering and promote a more efficient utilization of resources.

In addition, streamlining VA bureaucracy will decentralize VA management operations to improve program efficiency, empower local managers and increase responsiveness to veterans' health needs. Also, this action will deregulate contracting, resource sharing and personnel management functions.

3. Does the Administration's budget proposal adequately address your priorities concerning management reform of VA hospitals?

Answer: The FY 1996 VA budget proposal does not directly mention the Under Secretary's VISN proposal. However, the proposal does include certain management and program changes which are forecast to result in a FY 1996 savings of $335 million and 3,429 FTE.

As far as setting forth a comprehensive initiative to streamline management functions, the proposals contained in VA's FY 1996 budget proposal are somewhat vague and ill-defined. There is not a clear road map included to adequately describe how VA will successfully transit all of the proposed program changes.

If The American Legion can be of further assistance with regard to these matters, please let me know.

Sincerely yours,

Carroll Williams

Carroll Williams, Director
National Veterans Affairs and
Rehabilitation Commission

HOUSE VETERANS' AFFAIRS COMMITTEE
HEARING ON
U.S. COURT OF VETERANS APPEALS
FISCAL YEAR 1996 BUDGET
FEBRUARY 24, 1995

QUESTIONS FOR THE RECORD
CHAIRMAN BOB STUMP

Court of Veterans Appeals

1. QUESTION: What is the actual docket size?

ANSWER: At the end of February 1995, the Court had 1052 cases pending on its docket.

2. QUESTION: Since COVA's inception, how many cases have been decided on a monthly basis?

ANSWER: The Court has decided an average of 115 cases per month since it issued its first decision in January 1990.

3. QUESTION: What are the apparent docket trends?

ANSWER: The Court's new case filings have remained fairly steady over the last two fiscal years at about 1,200 per year. If the predictions of increased output by the Board of Veterans' Appeals come to pass, the Court expects a commensurate increase in appeals.

4. QUESTION: What is the average time for a case pending before COVA?

ANSWER: The Court's most recently decided cases took an average of 375 days from initial filing to decision.

5. QUESTION: What type of measurements were used to determine the efficiency and effectiveness of maintaining COVA's case load?

ANSWER: Like other courts, the Court uses internal peer review processes to monitor the timeliness and legal consistency of its judicial actions. Within the last year, it has increased the use of alternative dispute resolution (ADR) through Court-directed telephone and in-person conferences between the parties. Court efficiency has also been enhanced by the involvement of pro bono counsel, who bring helpful focus to the often-unstructured arguments of unrepresented appellants.

6. QUESTION: What has been the rate of pro se cases each year (after legal representation was offered)?

ANSWER: For cases decided in fiscal year (FY) 1994, the new-appeals pro se rate of 80% was reduced to 58% by the time of decision. The latter figure was not calculated before FY 1994.

7. QUESTION: What type of cases are offered free legal representation? Describe the case-screening process.

ANSWER: Each appellant who requests assistance through the Veterans Pro Bono Representation Program (Program) has his or her case screened initially for financial eligibility by staff of the Veterans Pro Bono Consortium (Consortium). If the appellant meets the financial eligibility criteria, then the case is evaluated for merit by the Consortium. The Court's case file, maintained by the Court, and the claims file, maintained by the Department of Veterans Affairs (VA), is then reviewed. This review is conducted to determine whether a case should be accepted or rejected based on the merit or lack of merit of the appeal. This legal review examines whether there are constitutional, statutory, or regulatory issues which should be considered. If the case is accepted into the Program and placed with a pro bono attorney, that attorney is furnished with a screening memorandum which details the salient

issues found during the screening review. If the case is rejected, the screening memorandum forms the basis for written advice to the appellant, explaining in detail why the case has not been accepted for placement with a Program attorney. This advice may include information regarding any evidentiary flaws in the case, and a recommended course of action to be pursued at the agency level. While most of the cases concern disability issues, the Consortium also receives cases related to VA home loan, insurance, education, pension, and death benefits, as well as other claims.

8. QUESTION: Define eligibility requirements for free legal representation and free legal advice? What are the different thresholds for each?

ANSWER: As noted above, each claimant who seeks assistance through the Pro Bono Program must pass an initial financial eligibility test. In order to qualify for representation under the Program, an appellant must: (1) have received a needs-based waiver of the $50 filing fee by the Court; (2) have income, not counting VA disability or pension income, less than twice the weighted average poverty threshold for non-farm families of a specified size; or (3) present a claim involving an amount in controversy of less than $2,000. If the appellant meets any one of these three financial criteria, the case is then evaluated for merit. There are no different eligibility requirements for legal representation versus legal advice. If the case is placed with an attorney assigned through the Program, the Consortium only monitors the progress of the case and does not otherwise intrude in the attorney-client relationship. The assigned attorney can seek advice or assistance from Program mentors, but that is at the option of the pro bono attorney. When a case is not accepted into the Program, the appellant is advised why his or her case was rejected. As stated earlier in the answer to question 7, the Program advises an appellant whose case has been rejected of substantive or procedural claims defects discovered during the evaluation process, and, where appropriate, the appellant is informed how such a problem can possibly be remedied. For example, if an appellant has been denied service connection for a disability because he or she lacks medical evidence supporting a claim that the disability was incurred in, or aggravated by, military service, Program staff may suggest that the appellant attempt to obtain a medical opinion supporting the claim and then seek to reopen the claim at the VA Regional Office based on "new and material" evidence.

9. QUESTION: Define the difference between legal advice and actual representation? What constitutes bare-bones legal advice?

ANSWER: See number 8, above. The Program does not officially use the term "bare-bones" legal advice, but an instance that might fit this description would be a situation where Program staff informs an appellant that his or her case fails to meet the Court's jurisdictional requirements. For example, the appellant's Notice of Disagreement (with the Regional Office decision) may have been filed at the VA before November 1988, or the appellant may have failed to file a Notice of Appeal with the Court within 120 days after notice of the BVA decision is mailed. Under the statutory grant of authority to the Court, both situations deprive it of jurisdiction, and there is nothing the Program can suggest to an appellant that would cure these "show stopping" defects. The appellants in such cases are normally advised to withdraw their appeals.

10 and 11. QUESTION 10: Since the inception of the Pro Bono Program, how much money has been allotted for training volunteer attorneys? QUESTION 11: What are total expenditures, to date, for the attorney training programs? What is the cost per attorney?

ANSWER: The FY 93 and FY 94 Annual Reports reflect the following amounts allotted and actually expended, respectively, for

the Education Component of the Consortium, which is responsible for the training of pro bono attorneys:

	ALLOTTED	EXPENDED
FY 93	$128,222	$177,959
FY 94	$122,316	$126,604
FY 95	$128,122	$ 23,963 (First Qtr.)

The training cost per attorney, as reported in the FY 94 Annual Report, was computed at $917. This was calculated by dividing the total cost of the Education Component ($126,604) by the number of attorneys (138) who accepted cases.[1] This represented a substantial reduction in training costs per attorney from the FY 93 figure of $1,235, as reported in the FY 93 Annual Report of the Pro Bono Program. The average cost for training an attorney is substantially less in FY 94 because there were no start-up costs in FY 94 and because many volunteers took more than one case. Mentoring costs are also included in the overall "training budget."

12. QUESTION: How many attorneys have participated from the Washington, D.C., metropolitan area? How many attorneys have participated and are located outside D.C.?

ANSWER: The majority of Program attorneys come from the greater Washington, D.C. metropolitan area (broadly defined to include both the Baltimore and Washington metropolitan areas, and adjacent Maryland and Virginia counties and cities), although the Program has been successful in attracting the participation of Program attorneys from a total of 25 other jurisdictions from the Program's inception. The term "participated" is susceptible of several definitions. For example, the Program has "recruited" attorneys who may or may not have required training, and those requiring training may or may not have attended some form of training in veterans law. In addition, some "trained" attorneys have not yet been assigned a case.

As reported in the FY 93 Annual Report, 185 attorneys were recruited into the Program. In FY 93, 140 attorneys attended one of three day-long training courses offered in conjunction with the D.C. Bar, and an additional 21 attorneys were provided with a training videotape. As reported in the FY 94 Annual Report, 123 attorneys were recruited into the Program in FY 94[2]; 99 attorneys attended one of three training courses; and 11 attorneys received the training videotape. In the Program's first year of operation, 148 or 80% of Program attorneys, representing 43 area law firms, came from the D.C. metropolitan area. In FY 94, the number and percentage of attorneys from the D.C. metropolitan area declined to 89 and 72%, respectively (from 50 area law firms), as the Program expanded its scope to include additional jurisdictions. Not only is the Program assisting claimants with their appeals, but it is assisting the Court in developing a nationwide bar of attorneys trained and qualified to represent claimants before the Court. At the present time, 35 attorneys are undergoing "at home" training by reviewing Consortium-produced videotapes.

Since the Program's inception, 264[3] attorneys (including "B" grant attorneys [please see the answer provided for question 14 for a definition of "B" grant attorneys]) have participated from the

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[1] *See* Annual Report 1994 at 7, n. 8.

[2] *Id.*

[3] This total of 264 is comprised of 140 D.C. area attorneys recruited in FY 93, 89 D.C. area attorneys recruited in FY 94, and 35 D.C. area attorneys recruited in the first quarter of FY 95.

D.C. metropolitan area, and 83[4] attorneys (including "B" grant attorneys) from outside the D.C. metropolitan area have participated in the Program.

The thrice-yearly training sessions are essential focal points for recruiting. The D.C. Bar provides free assistance (mailings, facilities, etc.) to the Program since these events complement the D.C. Bar's overall on-going continuing legal education program.

13. QUESTION: Is it true that only 159 attorneys have completed at least one case?

ANSWER: No. Two hundred fifty-one attorneys have completed at least one case ("completed" being defined as awaiting a decision of the Court after having filed an initial and, if appropriate, a reply brief (49) or having received a decision from the Court (202). One hundred and forty two attorneys have cases pending (not yet "completed").

14. QUESTION: Describe the difference between the Consortium-run training program and those attorneys who have participated in the pro bono program?

ANSWER: The Program has two different kinds of attorneys: (1) pro bono attorneys under the "A" grant; and (2) "B" grant attorneys. Pro bono attorneys are recruited from the private bar to participate in the Program under the "A" grant. If the attorney has prior knowledge and experience in veterans law (for example, he/she may already be admitted to the Court's bar, and may have previously represented one or more claimants at the Court or before the BVA), then the training requirement can be waived. If training is required, it is provided by the Consortium through either training classes, or by means of a training videotape. In addition, pro bono attorneys are furnished extensive resource materials (the two-volume Veterans Benefits Manual and latest Supplement), and can consult with the Program's case monitors and mentoring attorneys on the Court's Rules of Practice and Procedure and substantive legal issues; sample briefs and pleadings are also available. By definition, pro bono attorneys perform all services for the appellant without any charge to the individual claimant being represented.

About 16 percent of the grant funds are designated for the Pro Bono Program's "B" grant. This is an expansion grant with specific contractual provisions, and augments the representation provided by volunteer attorneys through the "A" grant. In FY 94 there were two joint "B" grantees - the National Veterans Legal Services Project (NVLSP) and the Paralyzed Veterans of America (PVA). They received a grant to represent appellants in a minimum of 46 cases. The "B" grantees actually accepted 49 cases which are assigned through the Consortium. The "B" grantees are required to provide matching funds in an amount equal to the amount of "B" grant funds actually expended during the year (please note that the total non-reimbursed contribution of the organizations supporting the "B" grant approximated $80,000 in FY 94). However, the total amount of matching funds provided by the four organizations participating in the Consortium and in the "B" grant approximated $300,000 in FY 1994.

The "B" grant in FY 95 requires a minimum of 30 case assignments; this expansion grant enables the Consortium to assign more complex or demanding cases, or those with some immediate problem, to attorneys with in-depth knowledge and training in veterans law. The "B" grant makes an invaluable contribution to the effectiveness of the overall Pro Bono Program.

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[4] This total of 83 attorneys from outside the D.C. area is comprised of 37 non-D.C. area attorneys recruited in FY 93, 34 non-D.C. area attorneys recruited in FY 94, and 12 non-D.C. area attorneys recruited in the first quarter of FY 95.

