FISCAL YEAR 1995 DEPARTMENT OF VETERANS AFFAIRS BUDGET

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

FEBRUARY 10, 1994

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CONTENTS

MATERIAL SUBMITTED FOR THE RECORD

FISCAL YEAR 1995 DEPARTMENT OF VETERANS AFFAIRS BUDGET

THURSDAY, FEBRUARY 10, 1994

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

The committee met, pursuant to call, at 9:30 a.m., in room 334, Cannon House Office Building, Hon. G.V. (Sonny) Montgomery, (chairman of the committee) presiding.

Present: Representative Montgomery, Evans, Penny, Rowland, Kennedy, Sangmeister, Long, Edwards of Texas, Tejeda, Gutierrez, Baesler, Kreidler, Brown, Stump, Smith, Hutchinson, Everett, Buyer, Quinn, Bachus, Linder, and Stearns.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

The CHAIRMAN. The committee will be in order.

Thank you, Mr. Secretary. I want to welcome you to the committee. This is the third time in 10 days that you have been before us. I want to thank you for giving us this opportunity.

The budget for veterans programs which you are presenting to us this year is a very tight one. We knew it would be. These are tough economic times, and everyone wants to get the country's financial house back in order. We are fully aware that the VA and all other government agencies must participate in deficit reduction. Veterans, Mr. Secretary, only ask that they be treated fairly in the process.

Based on a quick review of the budget for all departments, I question whether the veterans' programs are given the priority they deserve.

For the first time in many years, health care employment levels would be cut, which would do great harm to the VA's ability to delivery timely services to veterans. In response to this, I introduced legislation on Tuesday to exempt VA from across-the-board Federal workforce reductions. Now my purpose is not intended to freeze the staff, but it would buy time for the VA to gear up for its role in health care reform.

When we start reducing hospital staff personnel by five or six thousand people in the next 6 to 12 months, we've got a problem. This would buy VA time to gear up for its role in the health care reform. Why make such deep cuts before the VA can assess the demands on its health care system under health care reform?

Furthermore, the level of funding for the Veterans Benefits Administration and deep employee cuts there mean longer delays and less service, but perhaps the biggest disappointment in this budget

for veterans is the failure to provide support for the VA medical research program.

Mr. Secretary, I have been telling a lot of people what a great investment the VA research budget is. We do a lot for a lot of people. For each dollar we spend, we get back several dollars in better quality care for our veterans today and improved treatment for the veterans of tomorrow. In fact, everyone benefits from the VA medical research, but this OMB budget proposal ignores that message.

It invests funds in the NIH research budget, in the drug treatment budget, in claims processing for Social Security. The list goes on and on of those who got increases, but there isn't any investment in the programs for veterans. University based research will increase to roughly $12 billion, a 3-percent increase over 1994, but VA research takes a $41 million cut.

The President has expressed the opinion that the veterans health care system is a national resource, and he has proposed an investment fund to make the VA a competitive provider under health reform. We support him in his efforts, but this budget taps into that investment fund to fund current budget needs. It really robs Peter to pay Paul.

The National Performance Review made a big deal about making government customer oriented. This budget does not provide the means to meet veterans' need for basic services in a timely manner. In over—Listen to this. In over three out of five cases, a veteran calling the VA to ask a simple question gets a busy signal.

Waiting times in the VA outpatient clinics continue to be a problem. A veteran in Louisiana complained bitterly to the President about this during the President's recent visit to Louisiana.

Mr. Secretary, for VA to be a customer oriented agency, you need a customer oriented budget.

While there are significant increases in discretionary spending for the Departments of Labor, up $1.1 billion; Education, up $1.7 billion; HUD, up $1 billion; Health and Human Services, up $1.1 billion; and Justice, up almost $3 billion; the VA gets a $200 million increase.

In closing, Mr. Secretary, my remarks are not critical of your performance. I know that you worked for Mr. Panetta. You spoke very strongly there for veterans' programs, and the OMB just wouldn't let us have these funds. So we know where you're coming from.

I'd like at this time to yield to Mr. Stump for his opening remarks.

[The prepared statement of Chairman Montgomery appears on p. 55.]

OPENING STATEMENT OF HON. BOB STUMP

Mr. STUMP. Thank you, Mr. Chairman.

I'd like to join with you in welcoming our good friend, the Secretary, Jesse Brown, who over the years has done many great things for the veterans of this Nation.

Last year we couldn't say much about this budget, a new administration coming in, not wanting to be too critical, to give you a start. It closely resembled those of the Bush administration. De-

spite that, we wanted to see more resources provided the VA, but there are no two ways about this budget.

The first real Clinton budget is an outrage and a travesty for veterans and the VA. This budget claims a $500 million increase in health care funding. Yet VA's own conservative estimate is that what it needs to even provide a current level of services is $611 million.

This budget is severely lacking in resources necessary to make the VA health care system competitive with the private sector under the Clinton Health Security Act. It undermines all claims to maintaining a separate, independent system which could credibly be expected to compete for veteran patients.

The almost cavalier attitude toward making any significant progress in the claims processing backlog invites future litigation and denial of due process as delays get ridiculously long.

This budget claims that VA can compete and survive in national health reform. Yet the budget expects VA to treat 27,000 more veterans with less than current services and 3,680 fewer employees.

Last year we were told the fiscal year 1994 budget decrease of $26 million to VA's research account was a one-time thing, a short term measure, but the 1995 budget cuts VA's research program by $41 million.

This budget requests a Veterans Benefits Administration decrease of 622 employees. Yet timeliness on compensation and pension claims processing continues to slip.

The reduction of 29 employees for vocational rehabilitation and counseling is completely inconsistent with the stated goal of providing the highest quality counseling and rehabilitation services.

Mr. Secretary, this committee worked long and hard to turn the VA into a cabinet level department, but this budget surely does not justify that effort.

Thank you, Mr. Chairman.

[The prepared statement of Congressman Stump appears on p. 58.]

The CHAIRMAN. Thank you, Mr. Stump. Mr. Evans.

OPENNING STATEMENT OF HON. LANE EVANS

Mr. EVANS. Thank you, Mr. Chairman. Like you and Mr. Stump, I welcome Secretary Brown for being with us today. We know his job today is a difficult one, to explain and discuss the President's proposed budget for fiscal year 1995.

I am associating myself with both of your comments. Rather than providing the Veterans' Administration with the resources necessary to ensure that it can compete eventually under national health care, this budget reduces VA's staffing, support for VA research, and the Department's construction program.

It also delays VA's plans to develop new community primary care facilities needed to improve services to veterans by making VA health care more accessible and more user friendly, and they would give the VA health care system a better chance to succeed in a more competitive marketplace.

I just wanted to associate myself with both your remarks.

[The prepared statement of Congressman Evans appears on p. 61.]

The CHAIRMAN. Anybody else have any comments? Dr. Rowland, go ahead, sir.

OPENNING STATEMENT OF HON. ROY ROWLAND

Mr. ROWLAND. Thank you very much, Mr. Chairman. Mr. Secretary, thank you and all the folks that are here this morning for coming again to sit on the hot seat, I guess you might say.

Mr. Chairman, I'm really pleased that you are having this hearing this morning to give us an opportunity to look at the budget request put forward by the Department of Veterans Affairs. This hearing is an important part of the process in that it allows us to discuss and closely examine the funding for programs that benefit veterans and their families.

While I'm gratified that the President has demonstrated his support for our Nation's veterans by an increase in the VA budget, I do have concerns about specific proposals relating to employee reductions and funding for research and construction.

Like the chairman, I find it troubling that the Veterans Health Administration will be required to absorb an unprecedented reduction in total employment as a part of Government-wide FTEE reduction; but exclusive of FTEE for funding facility activations, the fiscal year 1995 budget proposes a reduction of some 5,800 positions. Of that number, funding for contracting will be available for some 4,900 positions, which may result in higher costs rather than savings. These employee reductions will inevitably result in cuts in programs and services.

It is particularly difficult to understand the reasoning behind the proposed $41 million cut in VA medical research. You are well aware, Congress rejected a similar proposal last year.

DVA research benefits not only veterans but the entire population, as demonstrated by a long list of remarkable accomplishments. Furthermore, this cut in research funding will have far reaching effects on the recruitment and retention of VA physicians and other health care providers. It appears to me that a cut in research is in direct conflict with our current need and reliance on research to address the health concerns of our Persian Gulf veterans.

Mr. Chairman, I have some additional remarks, but I would just ask unanimous consent that they be inserted in the record.

The CHAIRMAN. Without objection, so ordered.

Mr. Hutchinson of Arkansas.

OPENING STATEMENT OF HON. TIM HUTCHINSON

Mr. HUTCHINSON. Thank you, Mr. Chairman.

I appreciate, Mr. Secretary, your willingness to come and testify today, and appreciate the chairman organizing this hearing to give us some answers. I'll not be able to stay for it all, but I will, with anticipation, look to reading the answers to the questions, I know, will be posed today.

It seems to me, instead of making the VA competitive under the Clinton health care plan, the VA is being held hostage, that there will be no up front commitment to make the VA competitive or to value the sacrifices that the veterans have made in defending our country.

The $37.8 billion VA budget proposal calls for a net reduction of nearly 5,320 personnel. The budget slashes VA medical research by $41 million to $211 million and is expected to remain at that figure for the next 5 years.

In 1970 R&D was 3.5 percent of the medical care budget. In 1981 it was 2 percent, and this budget puts it at 1.5 percent. Research will virtually cease to exist with such a meager budget.

The budget reduces basic construction by $253 million to $115 million, and it's my understanding that nearly 80 percent of replacement construction is going to be spent on one project in one state. The plan calls for another 622 employees to be dropped from VA Benefits Division at a time when claims for veterans benefits are piling up.

I think we all can understand the need for a lean budget, and we all understand the need for personnel reductions, but it seems to me that the VA is bearing a very disproportionate part of that burden. In the Board of Veterans' Appeals, by the end of 1995, the processing time for an appeal could take as long as 2,500 days, almost 7 years.

Given the increased volume of new claims due to military downsizing, additional benefits authorized to veterans exposed to Agent Orange and mustard gas, and the already existent delays of months, oftentimes years, to receiving benefits, how do we handle the major administrative crisis that is sure to occur by cutting the DVA staff by 622?

So I look forward to hearing your testimony and your comments and your responses, and I thank you for your willingness to be here.

The CHAIRMAN. Thank you. Mr. Kennedy.

OPENING STATEMENT OF HON. JOSEPH P. KENNEDY II

Mr. KENNEDY. Thank you very much, Mr. Chairman. I want to associate myself with the remarks you've already made, Mr. Chairman, as well as Mr. Stump and other members of the committee.

The fact is that anyway you look at this budget, even with tight budgetary times, it's having terribly serious implications for the strapped VA program. I'd like to point out that the $37.8 billion budget represents a mere $225 million increase in real discretionary spending.

With the national health care reform debate now front and center, the VA's medical care budget receives only a $500 million increase above last year's level, and at this rate the VA cannot even meet the current health care needs, not to mention prepare to compete with national health reform.

The insufficient budget request is compounded by rigid cutbacks of 4,000 VA health employees, and will further imperil the VA's ability to care for veterans today and exist in the health care competitive world of tomorrow.

Many people have already mentioned the $211 million cutback in the research budget, but we've also got to point out that there are some 900,000 unprocessed claims, and we all have pressed the VA to move quicker than the average 235 days that it takes today. Without more money, I don't see how they're going to get the job done.

Mr. Chairman, I also want to point out to you that, while we've seen an increase in the homeless budget by the rest of the country—by the rest of the Government, we have not seen anything close to that with regard to the VA's priority. It just seems to me, with the tremendous number of homeless veterans that exist in our country today, the $8 million request was really always intended to just be a beginning.

I know that the Secretary has been an outspoken advocate of dealing with homeless veterans' needs, but the fundamental fact is that we're not getting anything close to the kind of funding levels that we need to be able to deal with the problem.

Even in Boston, Mr. Chairman, the issue that you dealt with just several weeks ago on $48 million when you attended the meeting with Chairman Moakley, now that $48 million has been cut, and they say that they're going to link it to national health reform; but that means that that whole outpatient clinic and all the rest of the issues that we talked about up in Chairman Moakley's office the other day are right out the window.

So there are some very serious implications with this budget. I look forward to working with you, Mr. Chairman, and other members of the committee and the Secretary to straighten out the lack of funding that the VA is currently receiving.

Thank you, Mr. Chairman.

[The prepared statement of Congressman Kennedy appears on p. 62.]

The CHAIRMAN. Thank you, Mr. Kennedy.

Mr. Stearns.

OPENING STATEMENT OF HON. CLIFF STEARNS

Mr. STEARNS. Thank you, Mr. Chairman. Mr. Secretary, I also want to welcome you. I'm from central Florida, and we have a mutual friend in Malcolm Randolph and that hospital. I no longer represent that veteran's hospital. Corrine Brown does and Representative Thurmond, but I also want to work with them.

I'm, obviously, concerned with the construction fund side of the budget. The VA has allotted $115 million for construction, and 80 percent of the replacement and modernization subtotal goes for seismic construction in Tennessee. The last known earthquake in Tennessee was in the 1800s. So I think—I hope the staff will look at that. We in Florida are getting more and more veterans. We need for your office to help us in construction of more and more facilities.

I know I share the views of other members here, that we would like to see more money provided for Desert Storm Syndrome. We have many people coming to these hospitals. They can't get taken care of. They're given maybe a half-hour of tests when it really should be at least a full day test. So I hope you will focus on that.

I look forward to your testimony. Also, Mr. Chairman, I'd like to make a part of the record questions from my colleague, Bill McCollum, from Orlando that he has in here, as well as my complete opening statement.

The CHAIRMAN. Without objection, those reports will be put in the record.

[The prepared statement of Congressman Stearns appears on p. 63.]

The CHAIRMAN. The gentleman from the State of Washington.

OPENING STATEMENT OF HON. MIKE KREIDLER

Mr. KREIDLER. Thank you, Mr. Chairman. I, too, thank you for holding this hearing, and thank the Secretary for appearing here before us.

I think, like everybody who has spoken before me, I share the concerns of many of us about the programmatic changes that are going to be made as a result of these budget reductions and look forward eagerly to the testimony from the Secretary and others as to its direct impact on the VA medical system and VA services in general.

All of us realize that we're going through a very tough time in government, and we're going to make some very hard decisions. None of them are going to be easy. We're going to have to look at the areas where government is spending more money and, when we do that, we're going to have to look at the areas that deal with health care and with Social Security as the two areas which are probably the most out of line with overall government increases in spending.

As we make those tough decisions, it, obviously, is going to fall to some degree to the VA medical systems. I am looking forward to the testimony that will speak specifically to issues that relate to the contracting out issue as it might impact the budget for the VA system and how that, in fact, may be something where some money might be saved without reducing services.

Mr. Chairman, I very much look forward to the Secretary's comments, and again appreciate the opportunity to be here and be part of this testimony.

The CHAIRMAN. Thank you.

The gentleman from Alabama, Mr. Everett.

OPENING STATEMENT OF HON. TERRY EVERETT

Mr. EVERETT. Thank you, Mr. Chairman. Like Mr. Kennedy, I too would like to associate myself with your remarks and the remarks of our ranking member, Mr. Stump.

Mr. Chairman, let's take a closer look at what this budget really says about this administration's commitment to our veterans. The administration, through Secretary Brown, has assured this committee and our veterans that research was a priority in the Clinton White House. However, there's a major disconnect in this budget calling for a reduction in the research workforce by 830 people.

I don't believe this recommendation would help us break the mystery of the Gulf War Syndrome.

Mr. Chairman, to cripple a department and its health programs in the name of making government more effective, when it actually makes government less effective, is irresponsible. This is evidently especially true since 90 percent of the VA workforce is involved in the delivery of vital health care services to our veterans.

The headline of the December 1993 issue of Veteran's Service publication simply asks, does the President's health care conform to classic care of the VA? This question has in some part, I think,

been answered with this budget proposal, especially if a Health Security Act is enacted.

I have additional remarks, Mr. Chairman, but I'd just like to submit them for the record.

The CHAIRMAN. Without objection, the additional remarks will be printed in the record.

Ms. Brown of Florida.

Ms. BROWN. Thank you, Mr. Chairman. I just would like to have my remarks put in the record, but I just wanted to add to the cry that the budget that's submitted—Now I understand this is the first step, but it is very depressing, and I'm hoping that we can change the direction.

The CHAIRMAN. Thank you very much.

The gentleman from New York.

OPENING STATEMENT OF HON. JACK QUINN

Mr. Quinn. Thank you, Mr. Chairman, and welcome, I think, to friendly confines Mr. Secretary.

We have some real challenges here, and I say we, because I think we're going to make some adjustments in this budget together, the Democrats and Republicans on this committee, with your help, Mr. Secretary, and your staff.

I have remarks that I'd like to submit, but I'm anxious to hear from the Secretary. I'll say just one final thing. We need to be careful that we are not making any assumptions on the President's overall health care reform scheme and plan for the rest of the year, because we don't know what that's going to be, and I don't want us to make assumptions with this veterans' budget, hoping something might happen later this year when we're not certain what will happen.

So I will join the others and urge all of us to work together to solve it, Mr. Secretary. Thank you.

The CHAIRMAN. The chair recognizes Mr. Edwards, then Mr. Penny.

OPENING STATEMENT OF HON. CHET EDWARDS

Mr. EDWARDS OF TEXAS. Thank you. I'll be brief. Mr. Secretary, welcome again. I associate my remarks with those of my colleagues that, along with you, probably feel that veterans haven't always gotten their fair share from the Federal Government.

I also think we need to be honest, though, with ourselves. Many of us on this committee voted against the tax bill. Almost all of us have supported the votes to reduce the number of Federal employees by 252,000. Most of us go home and talk about reducing spending, and most of us want to spend $5 billion here in new money to put 100,000 cops on the streets.

Now we're going to again have to pay the piper and make the tough choices, and I assume you will talk about those.

I guess the two points I would make, Mr. Secretary, would be, one, I think it's incumbent upon all of us that we attack this budget to figure out where we're going to get the money. Perhaps we can find it in other areas of the budget, but I don't think it's just good enough for us to say this is inadequate and vote against taxes

and vote for reduction in Federal employees with, here we go again, saying don't do it to us.

Having made those comments, I would be interested if you and your staff would help provide us with a comparison of how the cuts in the VA budget in medical research compare to cuts in other parts of the budget because I do not want to wait in line behind anybody in seeing that veterans get their fair share of what Federal revenues we do have to spend.

Thank you, Mr. Secretary. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Penny.

OPENING STATEMENT OF HON. TIMOTHY J. PENNY

Mr. PENNY. Thank you, Mr. Chairman. I don't want to hold up Secretary Brown's testimony for very long, but I did want to add some remarks at this point along the lines of the remarks just made by my colleague from Texas.

This is a tough budget year and we will see similar budget difficulties for the next several years. That is a fact of life. I know that today all throughout Capitol Hill every committee is looking at the budget allocation for the programs under their jurisdiction and wondering why there aren't enough resources to do all the things that we'd like to do.

In most cases, I would venture to say, the criticism is being expressed in a bipartisan fashion. I know in the Armed Services Committee Democrats and Republicans alike are bemoaning the deep cuts in the Pentagon. In the Public Works Committee they are criticizing the fact that they can't spend all of the trust fund monies that are available or should be available for those programs.

Every committee is going to be complaining that there just isn't enough money for the top priority programs that that committee has advanced over the years. The fact is we can't have everything we want. We cannot do it all.

Presently, the Federal Government is providing $230 billion worth of spending for programs that the American taxpayers are unwilling to pay for. We're already $230 billion over budget, even in this budget which all of us this morning have criticized as being too tight and too punitive to the veterans of America.

I think it's rather inconsistent for us to sit here looking at a $230 billion deficit, claiming that we need more money for vets' programs, and I'm sure all across Capitol Hill Democrats and Republicans are declaring this morning their desire to see more money for a vast array of other programs.

We're stuck with a tight budget. It will not go away. Difficult choices will continue to have to be made in order to stay within this budget. I think it's remarkable that we have in this Federal department one of the few success stories in the budget.

It's one of the few departments that's actually getting an increase this year. Not a big increase, 3½ percent is certainly not all that we would like, but it's all we're going to get. If anybody can manage a tight budget, watch those dollars closely, and deliver the best possible service to our veterans within a tight budget, I think it's Secretary Brown, and I think we ought to proceed with the understanding that this is the order of the day and that we need to

work with this Secretary to do the best job possible with a limited budget.

The CHAIRMAN. Well, thank you, Tim, and let the chair comment. You know, I've always said in government, if you treat all departments the same, which includes cost-of-living increases and the inflation factor, you get along better.

I think my problem is in research, every other department of government gets a lot more money than we do. Department of Labor gets an increase, Education, HUD, Justice. It's across the board. If it was a proposal to everybody, then I would be a little more satisfied, but I guess that you didn't holler loud enough, Mr. Secretary, and I didn't holler loud enough to get a budget that would be fair in comparison with other departments of government.

Anybody else have any comment now? Yes?

Mr. Bachus. Very brief, Mr. Chairman.

Mr. Secretary, we've got a $41 million cut in research, and at the same time what really sticks out is that we're building two research facilities costing $26 million. If we chose not to build those two facilities, one in West Virginia and one in Oregon, and added that money back into the research budget, instead of cutting research by, I think, 18 percent we would only cut it one-third of that, 6 percent.

Mr. PENNY. If the gentleman from Alabama would offer that amendment, I would happily support it.

Mr. Bachus. Thank you. I plan to. I would like to add one comment on why we would be cutting $41 million out of research and at the same time building, actually, $26 million worth of new research facilities. It's very incredible.

The CHAIRMAN. Thank you.

The gentleman from Indiana.

OPENING STATEMENT OF HON. STEVE BUYER

Mr. BUYER. Thank you, Mr. Chairman. I have enjoyed my service on this committee for the past year, because of the tremendous bipartisan support that this committee has, and of course its work for the veterans. I have tremendous regard for Mr. Penny and for Mr. Edwards and your leadership on fiscal responsibilities.

I understand your comments here this morning, but let me remind you also it was President Lincoln who said in his second inaugural address that "To care for him who shall have borne the battle and for his widow and for his orphan." That is all of our purposes. That's why we labor on this committee and do what we do.

I understand the cuts in the budgetary process that we all face, but I think the tone that's been set here by this budget, that many of us have some problems with, Mr. Secretary, is that when I look at the review in the first part of this budget, I really see the infiltration of the President's health care plan as if it's going to happen. Clearly, this plan holds the Department of Veterans Affairs kind of hostage, saying, you're welcome to go with the VA plan, then we're going to increase our budgets later on.

It's almost like saying to all those veterans' organizations that you had better come along with the President's plan. You expect to beef up the VA and make them comparable and competitive.

There are going to be some real spirited debates, Mr. Secretary, as we move into that and as I comprehend my personal relationships with members of the veterans' communities, because on the face of this, we know, just as GAO reported 2 years ago, if we nationalize health care in America, nearly 50 percent of the veterans are not going to choose the VA. They're going to go somewhere else.

That's why they've given you, Mr. Secretary, discretion to open up the VA to those who are not veterans, to other dependents. So it's going to be a lively, spirited debate.

I welcome you here today, and let's go have at it, Mr. Chairman.

The CHAIRMAN. Mr. Gutierrez.

OPENING STATEMENT OF HON. LUIS V. GUTIERREZ

Mr. GUTIERREZ. Thank you very much, Mr. Chairman, for calling this hearing, and I'd like to associate myself with many of the remarks made here by members of the committee.

I guess, Mr. Secretary, welcome. You know that one of the most spirited debates we had back in Chicago, and you were kind and generous enough to come and meet with the veterans' group. We talked about many issues, and I guess people are going to be concerned when last year there was a million dollars for a cemetery for northeastern Illinois, and in the current budget there's $149,000.

So I know you're going to come back to Chicago. It's kind of your home town. It's my home town. When we get back there, they're going to be asking us about that, and I know your commitment to making that a reality. So I welcome you here and, hopefully, since all politics is local, you and I can go back to Chicago and discuss with our veterans this cut and still achieve this much needed cemetery.

Thank you very much.

The CHAIRMAN. Thank you.

Mr. Secretary.

STATEMENT OF HON. JESSE BROWN, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY HON. HERSHEL GOBER, DEPUTY SECRETARY, DR. JOHN FARRAR, ACTING UNDER SECRETARY FOR HEALTH, MR. R.J. VOGEL, DEPUTY UNDER SECRETARY FOR BENEFITS, MR. JERRY BOWEN, DIRECTOR, NATIONAL CEMETERY SYSTEM, MS. MARY LOU KEENER, GENERAL COUNSEL, MR. MARK CATLETT, ASSISTANT SECRETARY FOR FINANCE AND INFORMATION RESOURCES MANAGEMENT, AND MS. SHIRLEY CAROZZA, DEPUTY ASSISTANT SECRETARY FOR BUDGET

Secretary BROWN. Thank you, Mr. Chairman, and members of the committee.

First of all, I would say to you that I've listened very carefully to your expressed concerns about this budget, and I do not, as a general rule, with a few exceptions, take issue with that expressed concern.

As a number of you have already observed, these are tough and difficult times and, as a result, we have to do the best we can with what we have. We have to maximize the resources available to us.

In that respect, VA's budget of $37.8 billion represents an increase of $1.3 billion over last year.

VA, as has been pointed out, is one of only seven cabinet departments requesting increases in both budget authority and outlays above the 1994 levels. While some may not view this budget as the best possible one, it is important to view it in its proper context, reflecting the mandated austerity in Federal spending.

As you know, the Omnibus Budget Reconciliation Act essentially froze Federal discretionary spending at the 1993 level, and the administration is committed to reducing the Federal debt and deficit, a commitment which includes reducing Federal employment by 252,000.

While recognizing the importance of these national priorities, we did not hesitate to fight for the resources needed to provide adequate services for VA. This effort extended to an appeal directly to the President, which resulted in a substantial increase.

The VA's budget contains $16.1 billion for medical care, which is $500 million over last year, and VA received special consideration with respect to employment levels. We will not be required to take the full reduction that has been targeted for 1995 as part of the administration's streamlining efforts. Without this exemption from employment reduction, we would have been down by nearly twice as much, 9,500 FTE instead of 5,000 FTE.

With careful management, our budget, especially when linked with the funds from the Health Security Act, will allow us to fulfill our commitment to excellence in providing benefits and services to America's veterans.

We have had to make tough decisions. These decisions were guided by one basic principle: Minimize any direct impact on veterans. As a result, major construction and research will absorb reductions.

As noted, medical care will increase by $500 million. With those funds, we will treat 27,000 more veterans in 1995 than we will this year. Access to VA medical care will be expanded in 1995. We will open a new hospital in Florida, five nursing homes and three clinics and, as we prepare for national health care reform, we are anticipating support from the investment fund, which will inject an additional $3.3 billion into the VA's health care delivery system over 3 years.

With passage of the Health Security Act, the first billion dollars will be made available to us in fiscal year 1995. Among the projects to be funded from the first installment are eight new ambulatory health care centers. The investment fund dollars demonstrate yet another commitment to VA by this administration, and will provide necessary funding to prepare VA for health care reform.

VA will not take cuts in its claims adjudication function. Modernization will move forward into its next phase so we can better address the trend toward increasing backlogs in claims processing.

We will also pursue a variety of recommendations of the recently concluded Blue Ribbon Commission on Improving Claims Processing in the coming years, and pending legislation will allow the Board of Veterans' Appeals to implement single-member decisions which will increase BVA's productivity by 27 percent.

This budget will permit an expansion in the National Cemetery Service. This will include a slight increase in employment and the

construction of a new cemetery in Seattle. We are also proceeding with land acquisition for three additional cemeteries.

Our main goal remains the same, the best service we can give to American veterans. You can be assured I will be doing everything in my power to honor that commitment in the coming months and years.

Mr. Chairman, this concludes my statement, and now I will be delighted to respond to your questions and those of this committee.

[The prepared statement of Secretary Brown appears on p. 64.]

The CHAIRMAN. The chair will implement the 5-minute rule. I think it's an excellent rule, and I think also for the chairman to keep within 5 minutes, which some of them don't do in some committees.

One question: The Service Members Occupation Conversion and Training Act of 1992, SMOCTA—The administration has requested $7.3 billion for other employment programs to find jobs for people. I notice we didn't get anything for veterans who are working in that area. Did you request any funds? Looks like we ought to get something. Mr. Vogel?

Mr. VOGEL. Mr. Chairman, we did not. We still have quite a bit available in that program. We have 1,700 employers approved for training. We have received a number of applications, with 1,000 veterans in training. At this point I think we're okay for the rest of this fiscal year and into 1995.

The CHAIRMAN. So you made no request of that whole $7 billion.

Mr. Secretary, why don't you introduce the other people at the desk before I recognize Mr. Stump.

Secretary BROWN. Mary Lou Keener, our General Counsel.

The CHAIRMAN. Hold up your hand, will you?

Secretary BROWN. Mark Catlett; John Vogel; Dr. Farrar; and Jerry Bowen.

The CHAIRMAN. You didn't tell me what they did, though.

Secretary BROWN. I'll tell you, let each one of them introduce themselves and give their title.

Ms. KEENER. Mary Lou Keener. I'm the General Counsel, Mr. Chairman.

Mr. CATLETT. Mark Catlett, Assistant Secretary for Finance and IRM.

Mr. VOGEL. John Vogel, the Deputy Under Secretary for Benefits.

Dr. FARRAR. John Farrar, the Acting Under Secretary for Health.

Mr. BOWEN. I'm Jerry W. Bowen, Director of the National Cemetery System.

The CHAIRMAN. Thank you. Mr. Stump.

Mr. STUMP. Thank you, Mr. Chairman. Mr. Secretary, I need to begin first by expressing my appreciation to you and other VA officials for the event we had in Phoenix last weekend, the groundbreaking for construction of a new nursing home, which is scheduled to be completed in 1995.

We also announced at that ceremony that the VA was probably going to be able to lease a facility on Williams Air Force Base in a step toward maintaining that hospital for those people and not having to travel fifty-some miles, which will help tremendously. However, as significant as these projects are, they are only nibbling at the edges of what we need in Phoenix.

As you know, Mr. Secretary, the Phoenix VA Medical Center's long range facility development plan showed that the clinical space at the Phoenix Center needs to be doubled in size. They are currently doing about 240,000 outpatients a year in a facility that was opened in 1975 to handle only 60,000, 270,000 last year.

Normally, I would not go into these details, but there is nothing in the VA's five year construction plan that even contemplates a clinical addition to Phoenix. I would like to ask you, how many VA medical centers have completed their FEBs, and how many of those centers have shown the need to double their capacity?

Dr. FARRAR. Well, I think first, Mr. Stump, I'll respond by saying that we are moving ahead on the Williams Air Force Base clinic as planned. We haven't yet gone to Secretary Brown for approval of this, but this is already approved by us, and we're moving ahead.

We are aware, Mr. Stump, of the crying need for more outpatient facilities in Phoenix. As to the other 5-year plans, the information will be submitted directly to your office.

Mr. STUMP. That will be fine. Let me ask you one question, though. How many other clinics in this country have shown the need to double their capacity? Do you know that offhand?

Dr. FARRAR. No, Mr. Stump, we don't know that right now. We're going through the records to find the answer to that question. Again, we'll provide that information to your office.

We do have a number of medical centers, though, that are deficient in ambulatory care space.

As I mentioned earlier, we are currently considering the proposal to shift 40,000 visits to be conducted at Williams Air Force Base with 57 FTE. We're prepared to begin this clinic this year.

Mr. STUMP. Mr. Chairman, let me say that looking at all the needs across this country, especially the needs of Arizonans, I must tell you that I've lost all confidence in the VA's ability to withstand political pressure and bring to Congress an objective list of national construction priorities for the VA system.

I believe this committee should seriously consider issuing subpoenas for the records pertaining to all their priority scorings and all locally justified major construction projects. Perhaps, additionally, this VA committee should consider putting some of these people under oath to testify before us, so that we can assure the entire membership that our actions are based on an absolutely objective analysis rather than political influence with the administration.

Thank you, Mr. Chairman. Thank you, Mr. Secretary.

The CHAIRMAN. Thank you, Mr. Stump.

Secretary BROWN. Mr. Chairman, I'd like to just respond to that. Mr. Stump, let me just say, that's fine, but it's not necessary to do that, sir. We're going to cooperate with you. Any information VA has is available to you. All you have to do is ask for it.

Mr. STUMP. Mr. Secretary, I'm going to ask for those records, not to be submitted for the record but for our construction hearing when we have it later on.

Secretary BROWN. We'll make them available to you. If you want to do it by subpoena, you can do that, but we can work in a spirit of cooperation. Anything you want, that we can legally give to you, we'll give it to you with no problem whatsoever.

We want to cooperate with you.

Mr. STUMP. Thank you, Mr. Chairman. I appreciate that. Let me tell you, I'm not speaking only of Phoenix. I mentioned Phoenix, because I'm familiar with it.

Secretary BROWN. I understand.

Mr. STUMP. On these construction projects——

Secretary BROWN. Yes, sir. We are looking into this whole process. We're looking at the process and at how we prioritize our projects and so forth. We'll give you everything you need.

Mr. STUMP. Thank you, Mr. Secretary.

The CHAIRMAN. Thank you. Before recognizing Dr. Rowland, Mr. Penny—Mr. Penny, I want you to listen to this. This is the savings that we could implement by having the Defense Department and the Veterans Department working more closely together.

We talked to Secretary Perry yesterday, Secretary of Defense, and he said he had talked to you. We're doing sharing agreements for our medical care, and it's working very well.

There are other ways that we could save millions of dollars, and we would like to do that and not to take anything away from the veterans; but, Mr. Secretary, I hope you will look into that. We are concerned about it.

Secretary BROWN. Absolutely. In fact, we had a meeting with Secretary Perry to make sure that we are included in his overall plan to bring some type of health care reform to the Department of Defense.

We want to make sure that we take advantage of every opportunity to enter into sharing arrangements. Williams Air Force Base, by the way—Dr. Farrar said it was not approved, but it is approved now, sir.

We want to take advantage of that window of opportunity whenever we can. It's all taxpayers' dollars, and we think it makes good sense to take advantage of any sharing arrangement that will allow us to take advantage of the economies of scale. That's one of the things that we are doing.

The CHAIRMAN. We are building hospitals together now, Tim. We're saving the taxpayers in New Mexico from $50 million to $75 million building that hospital.

Secretary BROWN. Down in Florida, we're working very hard. As a result of Travis and as a result of Ms. Brown's expressed interest in the Orlando base, we are working very hard to acquire that property for a VA nursing home and an ambulatory health care center.

We are trying to maximize resources available.

Mr. BUYER. Mr. Chairman, may I ask a question based on yours.

The CHAIRMAN. Is that all right, Dr. Rowland? Go ahead then.

Mr. BUYER. I was just curious. When you talked about the mutuality between the armed services and this committee, are you talking about also all these base closures and veterans who live outside the non-catchment areas but are closer to veterans hospitals?

I mean, Jill Long has a veterans hospital in Ft. Wayne that's outside the catchment area of Grissom Air Force Base. Is that what you're talking about?

The CHAIRMAN. That's a good question. Mr. Secretary, do you want to respond to that, that we're closing bases. They're more in-

terested in health care than they are other services they could benefit from.

Secretary BROWN. Well, obviously, my first concern is to take care of our veterans, and that's exactly what we are doing under national health care.

The CHAIRMAN. But military retirees are veterans.

Secretary BROWN. Yes, but when you're talking about opening it up strictly to military retirees, you are also talking about their families, because they are entitled by law. If I'm retired from the military, I'm entitled to medical care. My children are entitled to medical care. My wife is also entitled to medical care.

So it's a little bit different criteria there, but let me deal with your question a little later. The point I want to make is that my first concern is, number one, to make comprehensive health care available to all veterans.

Right now we are only treating about 2.7 million. We expect to treat about 2.8 in 1995. I want to open that system up to all veterans. At this point, as I have stated many times before this committee, we don't know exactly what impact that is going to have on some of our facilities.

Given that reality, I want to move forward with all deliberate speed, but also to have the necessary flexibility to make changes. We know there are some facilities where we still are going to have excessive vacancy rates. There will be excess capacity.

In those facilities, we are going to talk about maybe treating dependents. We are already experimenting in North Carolina or South Carolina with opening the system up, here again, to give us some idea of the impact on the system. But the bottom line remains the same; we want to take care of our veterans first.

Once that has taken place, if there is any excess capacity, we will expand the system, but keep it within the veterans' family. At no time will I agree that we are going to open the system up to just regular nonveterans.

The CHAIRMAN. That really wasn't the question. A military retiree is a veteran, and then you have to consider bringing in dependents at a later date.

Secretary BROWN. Will we treat a military retiree? Absolutely. If he enrolls in our system, yes. But the military retiree eligibility definition is different from a veteran definition. By that I mean a veteran is entitled to care from VA, but his wife and his children are not.

If a person is retired from the military, that person is eligible, and so is his family, which is a little bit different mix.

The CHAIRMAN. Dr. Rowland.

Mr. ROWLAND. Mr. Chairman, I assume I'll have an additional 5 minutes. I want to tell you that I am really pleased with the course that this discussion has taken this morning, because the Subcommittee on Hospitals and Health Care next Friday morning, Friday morning of next week, will be having a hearing on this question in Augusta, Georgia, talking about the sharing that takes place between the Eisenhower Medical Center at Ft. Gordon and the VA hospitals in Augusta and the Medical College of Georgia.

So I want to invite every member of this committee who does not have a previous commitment to come to Augusta, Georgia, Friday morning of next week, and we will talk about this.

Mr. STUMP. Can you play golf?

Mr. ROWLAND. If they do, I'd like for them to take me with them.

Mr. Secretary, in responding to a prehearing question regarding reduction of the research budget and, as you know, that's something I'm very interested in from our conversation before, you acknowledged that there would be a negative impact on recruitment and retention, an issue which I contend, if that happens, then it's going to really place our hospitals in an inferior position insofar as being able to continue to provide the kind of care, the top quality care, that we think that veterans ought to get.

Would you just elaborate a little bit on what you think the extent of that impact might be?

Secretary BROWN. I would agree with you with respect to the important role that research plays in VA. As you so rightly pointed out, it allows us to attract some of the best and brightest into the system, primarily because of our research program.

Once there, we are able to keep them and, in a lot of instances, we're able to convert them. Not only are they involved in research, but they are also involved in direct, hands-on patient care. So in that respect, there is no question about the contribution it makes.

In addition to that, the research program plays a significant role in improving the quality of life, not only for our veterans but also for the entire country and indeed the entire world.

I don't think there has ever been a question about whether research is important. Mr. Rowland—Dr. Rowland, the reason that took place—and I'll say this up front—is that I have requested $275 million for this program.

We had to make choices. There is only a certain amount of money there. Once we decided exactly how much money it's going to require to maintain current services in health care, that was $611 million, then we backed out all the additional things, and got it down to $500 million. That's exactly where we are.

There is no fat there, none whatsoever. It will, as we pointed out, allow us to treat 27,000 more veterans, but it doesn't do some of the things that were also mentioned here. It doesn't give us the resources necessary to reduce waiting lines for our specialty clinics. It's too long, and we need to be doing something.

It allows us, basically, to function in 1995 as we will in 1994. So there is absolutely no fat at all in that $500 million.

If we move from there, sir, to VBA's budget, there we are going to absorb about 622 FTE. Here again, I think that we will try to stabilize the situation, but I probably would suggest to you that the backlog and the timeliness standards will continue to deteriorate.

Here again, there is no money there, none whatsoever. In Cemetery Service we have a slight increase of about $2.2 million. We had to increase our equipment backlog to pay for an additional twenty-five FTE. So there is no money there.

Once we went through the process, there just wasn't any additional money to increase the research account. It had nothing whatsoever to do with what was less valuable than anything else. We just had to make some tough choices. We had to prioritize our

needs and, once that happened, research ended up being reduced by approximately $40 million.

Mr. ROWLAND. I understand the very difficult position that you find yourself in, in trying to deal with that. Really, the comments of the gentleman from Alabama, I believe, that about additional construction research and reduction in possible personnel are an issue in research.

Anyway, I'll look forward to working with you to see what we can do to find some way to be sure that that research budget is fine. Thank you very much.

The CHAIRMAN. Thank you, Dr. Rowland. Mr. Quinn of New York left. Mr. Edwards of Texas.

Mr. EDWARDS OF TEXAS. Mr. Chairman, I don't have any additional comments or questions other than to underscore what I said before. I think you've taken a tough budget situation. I share with you and members of this committee concerns about the tight budgets. I hope we can find ways to bring more money into this VA budget.

I hope members of both sides of the aisle on this committee will not just talk today but will go, as the chairman has done repeatedly, to the Budget Committee. That's when a real difference is going to be made.

I will still not back down from my position that we can't have it both ways. We've got to recognize there are tough budget decisions, and to criticize the Clinton administration for being insensitive to the needs of veterans, I think, borders on hypocrisy.

To express a genuine concern about cuts, I think, is certainly fair play, and I respect that in all our colleagues. So I look forward to rolling up our sleeves, Mr. Secretary, working together, and seeing that veterans get their fair share, recognizing that we in this committee have been part of the process to reduce the number of Federal employees by 252,000 and reduce the Federal budget to the extent that we have said that.

Thank you, Mr. Secretary, for being here.

The CHAIRMAN. Thank you, Mr. Edwards. Mr. Linder of Georgia was here. He's gone. Scotty Baesler of Kentucky?

Mr. BAESLER. I have no questions.

The CHAIRMAN. Mr. Baesler has no questions. The gentleman from Washington, Mr. Kreidler.

Mr. KREIDLER. Mr. Secretary, let me take a question that relates to potential budget savings, and that is contracting out in some areas. I assume that you are also contemplating some changes in just how you use health care personnel, perhaps using nonphysicians or physician extenders in situations where using a physician isn't critical, and where other people could provide a comparable level of services.

Could you elaborate at all on whether that's a direction that you're contemplating?

Secretary BROWN. Yes, sir. One of the things that I tried to do with this very lean budget was to minimize the direct impact on veterans. We had to make cuts. You can see these cuts in the dollar amount, from a billion to $500 million in health care.

So exactly how do you go about doing that? There are some accounting adjustments we made because we have less expense

where we change the way we do business. An example would be—let's just take the Chicago area.

In the Chicago area we have three facilities that are probably within a radius of 3 miles of each other. We have the Lakeside Hospital, the West Side Hospital, and our regional office. In those facilities we have three separate personnel divisions. I don't think we need three.

I think we could get by with just one to serve all three of them. That will generate savings, and at the same time result in increased efficiency.

Using the same example, let's take the two hospitals there and add another one about 6 miles west—Hines, IL. So you have three hospitals within, let's say, a 6 to 10 mile radius of each other.

Why do we need three laboratories in those hospitals? Maybe we can pick one of the them to provide the lab service to all. Not only that, maybe we could provide lab services to private sector hospitals in the area.

Those are some examples of how we hope to take advantage of economies of scale and redirect our resources in a way that minimizes the direct impact on care to our veterans.

Mr. KREIDLER. Along that same vein, one area that I've had some people make comment to me would be in just exactly the role for the VA in long term care and whether there is some potential, in order to maximize the resources that we have, to look at some form of contracting out in that area as opposed to building and operating our own facilities. Could you comment at all on that?

Secretary BROWN. We do quite a bit today in terms of contracting out long-term care. We have an excellent program with the States. We have sufficient money in a grant program whereby the States put up about thirty-five cents out of a dollar, and we put up 65 cents to build a veterans' nursing home or domiciliary facility.

Then we turn it over to them, and we pay about $35 a day to maintain each veteran. They are very cost effective. So that's one way we are expanding, taking advantage of other people's resources. The State maintains the facility, and they also have the responsibility of paying the daily cost minus, of course, the per diem that we pay.

In addition to that, we contract out to the private sector for nursing home care. Certainly, we will look at that in terms of fulfilling our needs, and at the same time I think that's one of the things that we do very, very, very well.

I would hate to see VA get into a situation where we cannot continue to expand our nursing home facilities. I think we have made a moral commitment or at least the country has, in my judgment, a moral commitment to our World War II veterans, and right behind them are our Korean veterans. Right behind our Korean veterans are people like myself.

So I think we should continue in that effort, and I think the country will be well served. We will at the same time be fulfilling our obligation to look out for our veterans at a time when they are in need.

Mr. KREIDLER. Thank you very much, Mr. Secretary. I'm very pleased that we have somebody as capable and as thoughtful and caring in this very tough position right now, with the kind of

changes in government's role in general, as Mr. Edwards has pointed out. As we go through those changes we need somebody with your talent and skill to make sure it happens in the most thoughtful fashion that it possibly can. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Lane Evans of Illinois.

Mr. EVANS. Thank you, Mr. Chairman. Mr. Secretary, as I understand it, the $41 million in research cuts would mean not only that no new projects would be funded but that 500 might be halted in fiscal year 1995, even though some of those are expected to be completed during that same fiscal year.

Do you know which projects will be terminated and, if so, could you supply the committee with a list of those projects, the principal investigators on the research side?

Secretary BROWN. No, sir, not at this point. They will have to be prioritized, and I really like that flexibility. Someone on this side of the aisle raised a question about how we are going to move forward in trying to identify the etiology or the origin of the problems that have been plaguing our Persian Gulf veterans, so we want to be able to prioritize based on our needs.

If we need to fund a research project that may shed some light on multiple chemical sensitivity syndrome, or on depleted uranium, or on biological or chemical agents, then we want to be able to do that. Under the plan we have in force, our scoring process, we will be able to accomplish those goals while minimizing the direct impact on the people we serve.

Mr. EVANS. You anticipated my next question, because I was going to ask about the research initiatives. Do you know when this process would be evolving in terms of prioritizing?

Secretary BROWN. We intend to—and then I'll let Dr. Farrar expound. This project is going to cost us. We can go up to three research facilities. Each one is going to cost us about $500,000 a piece or $1.5 million, if we do all three of them, and we probably will do all three.

I don't know how that will play out, and Dr. Farrar can speak to that, because I'm insisting that the researchers and the scientists that we have involved in this research project come from inside and outside government. I want all government scientists. I want to be able to look from all—look out all across America and identify the best minds that we have to help us find a solution to this problem.

I'm going to ask Dr. Farrar to clarify anything that I've said.

Dr. FARRAR. I was assured yesterday, Mr. Evans, that we will not have to go back on commitments that we have made for this research. However, in 1995 there can be no new starts or no competitive renewals.

Now if we take into account the Persian Gulf research, we may have to tax some of the program a little bit, but we do plan on using some of the DOD money that the chairman has helped us get. This funding has been of enormous importance to the VA Research Program, and will be of particular importance in funding the Persian Gulf research initiatives.

Mr. EVANS. While I also appreciate that the funding and staffing of VA's homeless programs will not decrease in fiscal year 1995, I

would like to know why an increase was not proposed, given the President's commitment to increase the overall federal commitment for homeless programs.

Secretary BROWN. I think—I think we have enough at this point, because we have a lot of unresolved issues that we need to move forward. Between 1993 and 1994, we increased our homeless initiative by 40 percent. We went from $50 million to $70 million.

Within that, we now have authority to make direct grants. We have $5 million set aside that we can make direct grants to 501–C3, nonprofit organizations and also public organizations that are doing a good job, to help them not only expand their infrastructure but at the same time to defray the daily costs of looking out for and helping homeless veterans.

We do not have that up and running. In addition to that, there is an additional amount of money that we can make grants up to $4,500 that I just found out about, and we haven't been doing anything. So we're trying to pull all of this together, and on February 24th and 25th, I've invited all homeless advocates from all over the country to come to Washington and sit down with us to share information, and at the same time we can talk about sharing resources.

I believe that once we are able to get that information that we have a better vision of the direction that we can take, so that we can really make a difference.

Ever since I've been involved in this business now, I've been hearing that we have 250,000 veterans on the streets of America every night without a place to call home. I want to see that number go down. I want a program in effect not just where we are spending $70 million or $100 million or $200–$300 million on homeless veterans and still see the number increasing.

We need to identify a program or programs that work so that we can help veterans to move from the streets and to begin to live productive lives for themselves and for the country.

Mr. EVANS. I was on the Speaker's task force. We recently released a report, and we did, before we released our report, come up with one of our key objectives, and that is naming a homeless czar within the VA, Mr. Reno. I look forward to participating in the summit and working these issues through with you.

Secretary BROWN. Yes, sir.

Mr. EVANS. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Mr. Everett.

Mr. EVERETT. Thank you, Mr. Chairman. I have questions which I will submit for the record, but I would like to make a general comment about the administration's budget cut and the impact it has on research.

As you said yourself, Mr. Chairman, this budget provides additional money for research in many other areas but cuts veterans, and I'm simply stating in my remarks that I feel like those who have put their lives on the line for this country deserve as much consideration.

As I said, Mr. Chairman, I want to submit other questions. Thank you.

The CHAIRMAN. Thank you. I certainly agree with the gentleman's statement. Mr. Tejeda of Texas.

Mr. TEJEDA. Thank you, Mr. Chairman. It's been mentioned before on the cut of $41 million in the research. Knowing of that strong correlation between research and quality care, Mr. Secretary, do you feel that the proposed reduction in the VA research funding will have an impact on quality care at the VA hospitals?

Secretary BROWN. I see a relationship, sir. The only way I can respond in a way that makes sense, is to say we just had to make tough choices. None of those choices had anything to do with the merits of research.

I think the research program is a wonderful program. As I've mentioned to you, that's one of the reasons I went in from the start asking $275 million for that program. But the bottom line is that, when we looked at all the realities influencing the budgetary process, we had to prioritize.

When I looked at what was needed in order to just keep our heads above water, current services in health care, I saw no extra dollars there. None whatsoever in health care. There are none in VBA, and there are none in the Cemetery Service.

We simply did not have additional funds to move forward.

Mr. TEJEDA. Let me just follow up on that. It was mentioned, I believe, earlier that the budget proposed some $26 million in major construction funding for two research facilities, I believe one in Huntington, West Virginia, and one in Portland, Oregon, which had not been identified in the past as VA priorities.

Would you support a shift of these dollars to medical research?

Secretary BROWN. Let me respond, sir, this way. That's in the request of the administration. You mentioned the word priority. I can tell you that the Portland project was not scored on our priority list, and that the West Virginia project ranked 298 out of 380.

Mr. TEJEDA. So you had nothing to do with, yourself, putting these on this particular budget?

Secretary BROWN. I think I've tried to respond to that, sir.

Mr. TEJEDA. Let me—and I think it was pretty clear. In the testimony of the Disabled American Veterans, they say that the $500 million increase for medical care will not even pay for rising payroll costs and inflationary factors. How does the VA intend to expand its care to accommodate an aging veterans population requiring more care?

Secretary BROWN. Our numbers were based on an old formula reflecting a different reality. They will show a decrease in overall inflation. For instance, I'm going to ask Mark Catlett to explain to you how we ended up at $500 million, which in essence we are presenting to you, saying that it is equivalent to the billion dollars we received in 1994 and 1993.

I'm going to ask Mark to explain exactly how we arrived at that, which, in our judgment, makes sense.

Mr. CATLETT. In terms of the adjustment for payroll and inflation, we've treated those in the same way we've had in the past. We take the economic assumptions that we have and apply them as those formulas.

In fact, the $289 million we are requesting for inflation is $30 million higher than what we proposed last year; the same for payroll. The 1995 payroll increases of $265 million is down by $162 million from the requested increase that we had last year, and

that's based on the formulas, lower retirement costs, one less payday, and lower health care costs that everyone is benefitting by now with the low inflation rates in health care.

So we've tracked it in the same way we've done in the past and, as was mentioned, our current service requirements are $611 million. The reduction of $111 million to get to the $500 million are the result of some management improvements and efficiencies that have been identified in the past that will have to be implemented in 1995 in order to live within the $500 million.

Mr. TEJEDA. Mr. Secretary, let me also follow up with this question, that the budget proposed a reduction in full-time employees in the Veterans Benefits Administration. How does the VA intend to reduce the backlog of more than 500,000 while reducing employment by 622?

The backlog is expected to grow to more than 700,000 claims in fiscal year 1994 and 900,000 claims in fiscal year 1995.

Secretary BROWN. You put your finger, sir, on one of the weaknesses. We are going to have to do business much smarter, and I don't mean just verbiage, just rhetoric, that we have heard for many, many years.

First of all, I think it is important to state that, number one, we are not going to take any employees from our C&P account, none whatsoever. Most of these employees are going to come from our over-account. These are people that are theoretical people that are out there that have been collecting money by matching Social Security and different types of—with VA files to end up generating additional funds to them, based upon an assumption that that has just about—since we ran that a number of times and based on the assumption that that workload is going to be reduced, it will require about 400-some-odd less people.

So that's not going—So the direct impact there is not going to affect the people that are actually making the decision. I'm talking about now rating boards and also that are adjudicators.

Now at the same time, we are moving forward on our modernization program. Modernization is really something that, I think, for the first time that's going to help us really, really, increase our efficiency.

Just a good example: I visited our office in Baltimore. There the way we used to do it when I was in the regional office, a rating specialist would dictate the decision. It will go to the transcriptionist pool. They would transcribe it, and it would come back to the rating specialist. They make all of the changes, and it goes back, and then they correct those changes and it comes back, and then maybe after a while it is signed.

Now what happens, a format of a rating decision comes up on a screen, and the rating specialist actually types the decision in there. So it is ready on the first shot, and we are able to get rid of all of the people in the transcribing pool, and we are able to turn those, theoretically, into decision makers to increase our productivity.

Then the way we transfer that information to the authorizers to be able to go ahead and pay the veteran is much, much cleaner. So those are some of the kinds of things that we are doing to be able to manage the problem.

Now I'm not going to sit here and tell you, because I'm not sure exactly how this is going to play out—One of the problems that I have with—that we have here, I am trying to keep this thing under control right now. We are comfortable—and you correct me, John, if I'm wrong. We are comfortable with about 350,000 cases per year. I'm talking about system-wide.

We are now at around 570,000 to 600,000, and we expect that to increase. So my whole effort, because of the budget, is to try to keep things under control until we get all of these various things that we've been working on in force.

In addition to that, we have—We recognized last year that we were in trouble. So we asked a representative from the various service organizations who work in the regional office on a day to day basis with our rating specialists, our adjudicators, and all the support people, to come together, sit down with us at a table, to figure out how best to do this.

They came up with, in my judgment, an outstanding report. We are in the process now of implementing all or most of those recommendations. I think that is going to help.

Have I missed anything, John?

The CHAIRMAN. I'd like to ask Mr. Sangmeister to take the chair temporarily. While he's coming up, Mr. Secretary, why don't you go to the NIH. They make a lot of grants over there. They've got more money than anybody else for research.

You've got patients that you work on. They bring people in and pay them money to come up for research. Why don't you ask them for some of this grant money?

Secretary BROWN. I'll ask Dr. Farrar to respond to that, sir.

Dr. FARRAR. We already receive substantial funding from NIH grants—about $150 million in 1993.

The CHAIRMAN. They get over $7 billion. Correct?

Dr. FARRAR. Yes.

The CHAIRMAN. For research. Looks like another pinch wouldn't hurt.

Mr. SANGMEISTER [presiding]. The chair recognizes the gentleman from Illinois, Mr. Sangmeister.

A couple of questions deal with the subcommittee that I have, which oversees housing and cemeteries. As I think you're well aware, the Fort Sheridan cemetery site has fallen through, and we need to speed the process as much as we can to get a cemetery in Illinois.

I might say, and I'm not saying it because he's sitting here, but you've got a very competent man right on top of that, Mr. Jerry Bowen, who has been doing yeoman's work. I want you to know that. He's very good, but you have to make the final decision.

In working with him, you're going to get a proposal very shortly of three sites from which to pick. All I would say to you is that please don't let that lay on your desk. Make that decision, because we need to be moving forward.

The other question is, not dealing directly with my committee, but I've been working since I've been sitting on this committee for an outpatient clinic near Joliet, Illinois, and that has now been funded. I had a letter from you stating that, if we could get it funded, it was going to go forward.

I did meet with Dr. Cummings at Hines Hospital just last week, and apparently the Department is now in the process of getting that done. I just want to again say to you that I hope everything goes well from your perspective. It's beginning to look well at the Hines Hospital.

The veterans are really clamoring for this. It's a real necessity, and I guess outpatient clinics are still the wave of the future for our veterans. Do you have any thoughts on that?

Secretary BROWN. First of all, let me make an observation on your question regarding a cemetery. We have an awkward situation here because of the limited resources made available to us. We are moving forward with only one cemetery, and that's the one in Seattle.

The original information was that we would not move forward on any other cemetery at all, but as a direct result of my appeal to the President, we were successful in getting their permission to purchase the land, and Joliet is one of those.

So we will end up buying the land at today's prices, even though we're going to have to worry about getting funding to move forward on construction later. But I'm excited about that. I would have, of course, preferred going forward with three projects.

We identified them as top priorities, but at the same time I think this is a good compromise. It was an unusual agreement that they allowed us to enter into, and for that I am appreciative.

Mr. SANGMEISTER. So am I. On the outpatient clinic?

Secretary BROWN. On the outpatient clinic, sir, we are in the process of evaluating all that under national health care reform. One of the things we are doing is operating a clearinghouse.

We've had just about 200–400 people come into Washington, DC, experts from all across the country, to help us make some sense of exactly what resources we have and how we want to make those resources available to provide care. That's one of the things we are going to do.

With respect to the Joliet outpatient clinic, here again you are 100 percent. So on that, we are moving forward.

Mr. SANGMEISTER. Thank you.

Secretary BROWN. I'm glad you're Chairing.

Mr. SANGMEISTER. On loan guaranties, your budget indicates that in 1994 there were six regional offices scheduled to consolidate their loan guaranty finance functions to three other offices. Can you elaborate as to what your specific plans are on that consolidation?

Secretary BROWN. Yes. I'm going to ask Mr. Vogel to do that, but I want to say here, that we have done something that has never been done in the history of the VA, that I'm aware of.

When the interest rates went down to an all time low, we took the initiative of writing to every veteran who had an interest rate between 8 and 17 percent, encouraging him or her to apply for refinancing. We sent out about 1.2 million letters, half of which have already been mailed. I'm very proud of that accomplishment.

With respect to the other part of your question, I'm going to ask Mr. Vogel to respond.

Mr. VOGEL. Thank you, Mr. Secretary. Mr. Chairman, this year we will consolidate loan guaranty accounting functions at some

western stations. Honolulu, Anchorage and Ft. Harrison will be done out of Denver. We will do Wichita work out of Milwaukee.

With our electronic transmission of data, we don't have to have the work done at every one of our offices that have loan guaranty operations.

This is one of the many things that you're going to see more of as we try to get better economies of scale by having work done in other sites. There is no reason, with electronic media, to duplicate every function at every one of our offices, especially in the loan guaranty activities.

Mr. SANGMEISTER. So you're saying that consolidation should not be a problem then.

Mr. VOGEL. No, sir.

Mr. SANGMEISTER. I see my time is up, too. The gentlelady from Indiana, Ms. Long.

Ms. LONG. Thank you, Mr. Chairman. I don't know that I have a question so much as a statement that I would like to make, following up on something that Mr. Quinn—a point that Mr. Quinn made.

I know that the funding for construction projects is considerably reduced, and I understand that eight ambulatory projects are included in the President's Health Security Act. I think that is a very good approach, in the sense that it allows us to stretch the veteran dollar farther than to use other funds for veterans projects that wouldn't otherwise be used.

My concern is that, should we not pass a health care reform bill this year or should we pass a reform bill that doesn't include the funding for those projects, then that means that we have lost ground substantially in terms of construction projects.

I guess I'd like you to respond to—It's not really a question, but I'd like your response. But also to make the point that those of us on the committee need to be very conscientious in watching what happens in health care reform; because we will, more than likely, pass a budget, a veterans budget, long before we get a health care reform bill passed, and we're going to be doing so possibly based on the assumption that this funding will be from somewhere else in the budget.

I do have concerns about that, because we don't know what the final package of health care reform will look like. So I guess I would just like your response.

Secretary BROWN. Ms. Long, your observations are some of the same that we have had to deal with. I can only respond by simply saying to you, ma'am, that we wanted to make sure that this budget had the least impact on providing direct access and quality service.

We had these eight projects on our priority list for quite some time, and they were based on need. We needed to make those facilities available to veterans who did not have access to the system or we needed to expand current facilities, because the ones there, the existing facilities, were simply no longer able to handle the load.

Now given that, and in the presence of the limited resources that were made available to us, we had to make, again, some creative decisions. One of those creative decisions—and again with, of

course, the concurrence of the President, that was our only alternative.

The other alternative, of course, would have been to leave them out. I believe they are needed. I think our veterans need those facilities, and that's the reason we ended up with the request that is now before you, ma'am.

Ms. LONG. Thank you.

Mr. SANGMEISTER. The gentleman from Alabama, Mr. Bachus.

Mr. BACHUS. Thank you. Would you give me, Secretary Brown, again those figures on the Portland facility and the Huntington facility on where they rated in priority?

Secretary BROWN. Portland was not rated, and——

Mr. BACHUS. Out of how many projects? How many were rated?

Secretary BROWN. Well, at least 380.

Mr. BACHUS. How many?

Secretary BROWN. At least 380.

Mr. BACHUS. So it didn't make the top 380?

Secretary BROWN. Right. Wasn't even considered. West Virginia, 298 out of 380.

Mr. BACHUS. 298 out of 380? So it didn't quite make the top ten then. How does a project which isn't even considered, and one that's 298, suddenly leap into the budget as one of the five or six major projects on priority? Was that something to do with the California earthquake? Was it something bigger with it more force than that?

Secretary BROWN. Well, we're in Washington, DC, and that's possible. It was a request of the administration.

Mr. BACHUS. Is that right? So the administration suddenly said, Secretary Brown, we've got to have a research facility in Huntington, West Virginia?

Secretary BROWN. It was at the request of the administration.

Mr. BACHUS. Did the administration know when they asked for this $26 million that it would mean reducing—or did they realize that, while they were asking for $26 million for these research facilities, that at the very same time they were cutting almost one out of $5 out of the research for prostheses and for blindness projects, for Gulf War health problems, for post-traumatic stress syndrome? In other words, they were cutting 18 percent out of the research budget and eliminating what you described, I think, correctly as 830 full time positions in research?

Secretary BROWN. Your characterization is not completely correct. First of all, that money was in our capital reserve fund, and we did not have the authority to move it from there into research, even if we wanted to. So that was not a viable option for us.

There was no way we could have said, look, this is some extra money down here, and we're going to reduce research by $41 million. So let us take this $26 million and put it up there. We couldn't do that.

Mr. BACHUS. I'm looking at all these charts. Do you mean we are reducing housing and program guaranties, where we're reducing construction of state extended care facilities. Could we have put it in there?

Secretary BROWN. We're fully funding that.

Mr. BACHUS. Well, the chart shows it's going down.

Secretary BROWN. Yes, sir. That's based on our request. So it is not as if we were cut there. We are getting what we needed in those areas.

Mr. BACHUS. That medical care is going down $310 million. Is that correct?

Secretary BROWN. Medical care is going down a billion dollars, if you compare that to 1994. For current services per se, there is a difference between about $500 million and $611 million. But we think that with the necessary adjustments that Mark Catlett explained, we will be able to make up the difference between the $611 and the $500 million. But I understand the point you are trying to make, but the money in that account wasn't flexible enough.

It's not money I can take and move to here or move to there. There are very limited places we could use that working reserve.

Mr. BACHUS. But we could certainly—When we are reducing medical care, as you say, almost a billion dollars, we're cutting research by $41 million, and yet we're building two new research facilities at a cost of $26 million. Isn't this a little inconsistent? Isn't this inconsistent?

Secretary BROWN. Medical care going down by a billion? No, no, no. What I've said is that in 1994 we got a billion-dollar increase. In 1995 we have $500 million. So it's an increase. So the difference is $500 million. That was my only point.

Mr. BACHUS. Isn't it inconsistent to cut the research budget by $41 million, and yet decide we need two new research facilities?

Secretary BROWN. Well, sir, I can't debate that with you. I'm simply saying that even if I wanted to take that $26 million and add it to the $211 million in our request, I could not do that.

Now you, of course——

Mr. BACHUS. We could do that.

Secretary BROWN. You can do anything you want to.

Mr. BACHUS. I think, you know, we talk about a lean budget. Well, I'll tell you this. I can look at that budget, and I know there's a strip of fat, and it's $26 million, and it runs right through the middle of it. It's just like a weight plan with these two $26 million new projects that just came out of nowhere.

This is my last question. You say the administration made the decision to build these two facilities. Do you have any idea how they came to make that hard choice?

Secretary BROWN. I can tell you, sir, that it was at the request of the administration.

Mr. SANGMEISTER. The gentleman's time has expired. The gentleman from New Jersey, Mr. Smith.

OPENING STATEMENT OF HON. CHRISTOPHER H. SMITH

Mr. SMITH. Thank you very much, Mr. Chairman. I will associate my remarks with the previous gentleman. I, too, am concerned about a possible politicization of very scarce veterans dollars by the administration.

I know, Mr. Secretary, that it has not been your choice. You said you were requested to do it. I read in what you said that you were ordered to do it. I remember when Mr. Derwinski and others used to come up here and would present budgets that we were not happy with, while we very often found out that it was OMB who

was calling the shots and not the people that were within the VA building.

So I'm certainly in empathy for the water that you have to carry on behalf of the administration, and I'm very concerned about it.

As you know, Mr. Secretary, the DAV will testify very shortly that the President's fiscal year 1995 budget is "below current services budget . . ." and they go on to say, "that the realities of this budget provided for a very bleak picture of the VA's future."

Mr. Mank of the Paralyzed Veterans of America, will testify that "The administration fiscal year 1995 budget request is a blueprint for disaster." Now my question is, especially looking at this graph or this data that's provided, when Mr. Derwinski used to come up every year and suggest a billion dollar increase, to a large extent his statements did not pass the straight face test.

We've kept hearing on this committee, particularly on our Subcommittee on Hospitals and Health Care that administrators, especially as September rolled around, were short. They could not continue to provide adequate services to veterans and were forced to close down a ward. They would not hire nurses that were required, just to continue current services, and that would save close to a billion dollars more in terms of the previous year.

In fiscal year 1994 there was a $921 million increase. The President's budget, now is down to a $500 million increase.

My question is: Is it your testimony—I mean this very sincerely. Is it your testimony that this budget, despite what VSOs will testify to, despite our most recent experience with more money not providing current services, that this will truly be a current services budget?

Secretary BROWN. I think, as I mentioned not in this committee, but as I've said before, we do not view current services in the traditional context that we have before. We have different realities working here.

What I am saying to you is this, that based upon the numbers, and they are honest numbers, they are straight numbers—based upon the numbers, that we will be able to do in 1994 plus 27—in terms of providing services, plus providing 27,000 more veterans with service in 1995 with this budget. That's what I'm saying to you.

At the same time, as I've said before this committee today, that does not necessarily give us the resources that we need in order to address some of the concerns that we need to be addressing, such as the access time to some of our specialty clinics.

It does not give us the necessary resources that we need in order to be able to actually bring down rather than trying to stabilize. What I'm talking about, bring down our escalating backlog or our deteriorating timely standards.

It doesn't give us the kind of resources that we need, but we have things in place that we, hopefully, will be able to stabilize it, and then, by stabilizing that, hopefully, we'll be able to make some adjustments so that we can begin to reduce those things. That's what I'm telling you.

Mr. SMITH. I hope, and we'll look at this very carefully, trying to correct independently and in consultation with you as well to figure out again whether or not the veterans who need these services

will not be woefully underfunded in terms of—as has been suggested by some of the VSOs.

Assuming the President's health care reform legislation does not pass, what plans does the VA have to implement needed reform such as eligibility reform, recent changes in realignments, and the infrastructure improvements identified in the Health and Security Act investment fund, in order to meet the future needs of the veterans?

Secretary BROWN. Would you restate that, sir?

Mr. SMITH. If the President's plan does not pass, and I think, you know, now that it's a coin flip perhaps. I think a lot of people are beginning to take a second look, and you spoke about the eight projects that were included in that plan, which are a coin flip or perhaps even less than a fifty/fifty chance.

What plan does the VA have to implement eligibility reforms and any mission changes? If we wait until health care reform passes, we can wait until the end of this decade, because I don't think that it is on the fast track that it was just a couple of months ago. There are more skeptics now than ever, particularly in my own Congressional district.

I've been holding meetings and finding people who were originally for it are now saying, wait a minute, I didn't realize that this is what it meant. So my hope is that the VA does not go on a holding pattern with regard to these other issues while the expectation of passage seems to diminish.

Secretary BROWN. I believe, sir, that we are going to have health care reform in some shape or fashion. As a result, I think we need to proceed as if it is going to become reality. But at the same time, if it does not, we have been working on eligibility reform for years now.

We have all the information we need to take a look in another direction. We know that our patient population is not going to go anywhere, hopefully, it will continue to expand.

We have been shrinking the system not because there is a lack of demand, but because there has been historically a lack of resources. This is nothing new. Everybody talks about what great things that billion dollars bought for the last 5 or 6 years—and I, too, was very, very appreciative, but at the same time, when we put it into context, it shows that VA has never, ever received the kind of resources it needs to be able to continue to expand services to our veterans.

Mr. SMITH. Just to ask some questions for the record, that in a sense is my point with regard to this fiscal year 1995 budget, that it comes even shorter. I thank you.

Mr. PENNY [presiding]. Mr. Stump.

Mr. STUMP. Thank you, Mr. Chairman. Mr. Secretary, I want you to know that my questions to you regarding the FEP were not meant as a personal affront to you. This discussion has somewhat gotten carried away, I think, and I want you to know that I don't think anybody intended to question your motive or your integrity.

I've been in this business for 36 years. I know how the system works, and I just want to assure you that I think what we are talking about as we work through that objective list, it would save a lot of this and in a sense be a protection for you.

Secretary BROWN. Mr. Stump, I want you to know I have the greatest respect for you. I've worked with you for many, many years now, and I have never, ever taken anything you said personally. I know that you want the same thing we want. You want the very, very best that's available for our veterans.

Quite frankly, I think this process really works in our veterans' behalf, and that's one of the reasons why I was suggesting to you that anything that we have, all you have to do, sir, is—and you're going to have to do it, just have any of your aides or secretaries get on the phone and call, and we'll get it to you.

Mr. STUMP. Thank you, sir.

Mr. PENNY. We're hoping one of our colleagues will return from the vote in order to keep the committee meeting moving but, if not, at the end of my two or three questions we will take a brief recess to allow some members to return from the House floor.

Secretary Brown, are there any Presidential appointees that you are still waiting to have confirmed within your Department? Are there any instances where the appointments haven't even been made yet?

Secretary BROWN. Yes, sir. We have three. Mr. Vogel has already had his confirmation hearing, and we are waiting for it to be considered by the full Senate.

We also have not yet identified our Under Secretary for Health. We are in the process. Hopefully, no later than the first week of March, they will present to me a list of about thirteen candidates out of a field of about sixty who have already been interviewed. I will then make my recommendations in priority order to the President.

We also have not yet filled our position for acquisition, which is an Assistant Secretary position. So we are still looking for that individual. Those are the three remaining outstanding positions that we have to fill, sir.

Mr. PENNY. I think all of us share some level of frustration that it's taking so long, because I know it's difficult for all of you who have these departments and agencies to move forward at full speed when you haven't received a sign-off at the White House level for vacancies in these various slots.

I've worked over the last few years to streamline and improve the transition assistance program. Are you satisfied that, together with Department of Labor and Department of Defense, we're doing the best we can with the transition assistance program at this point?

Secretary BROWN. Yes, sir. There was one statement made that I disagreed with. Someone here said that we have an increasing number of claims, because of the downsizing. The fact of the matter is, we are not seeing an increase in the number of claims.

The number of claims has remained fairly stable. But there is a problem associated with the downsizing. When I got out of the military, I only filed for two disabilities. Now the average is six or seven, which also has to be reflected in processing time.

In addition, the court, which has proven tremendously advantageous to our veterans, has at the same time caused us to experience a tremendous backlog.

That's what we are seeing not only at the Board of Veterans' Appeals but also at our regional offices, because they're becoming much more sophisticated about due process requirements, and every decision the court makes is a precedent decision.

Mr. PENNY. You have to apply it in other cases.

Secretary BROWN. Yes, sir. Now on your question regarding whether or not I'm satisfied with our TAP and DTAP program, yes, sir, I am. I think we are doing a good job. I think we need to continue to expand it wherever possible. We can get more sophisticated.

For the first time, I think, it is not just organizations like the DAV and some of the other organizations who are advising veterans about disability claims. We in VA are actually looking at the service records and filing the form, and helping them write their resumes. We are helping them identify ways to tap into the job market.

So it's a much more comprehensive program, and I'm pleased with the direction it is moving in.

Mr. PENNY. Well, I'm pleased to receive that report on the status of that program.

I'm going to have to call a temporary recess. I trust that other members will return shortly, we can wrap up the questioning, and for my part, I want to thank you for your testimony this morning and for your outstanding leadership in the Department of Veterans Affairs.

Secretary BROWN. Thank you, Mr. Penny.

(Recess.)

Mr. EVANS [presiding]. We would like to resume and, Mr. Secretary, we would like to call you back for a few final questions here. First, I would like to enter into the record a question to be submitted to you, Mr. Secretary, by Congressman Slattery who could not be here with us, and we would like you to respond to it. You have an opportunity to do so, and the question and your response will be made part of the record.

We would also like to do that for Congresswoman Brown who has a series of questions here and, of course, your responses would also be made part of the record.

I've been asked to ask one question or a series of questions concerning California by Congressman Edwards who couldn't join us today.

As you know, Mr. Secretary, you testified last time about this issue before you, about the situation dealing with the destruction of Martinez Hospital. We are all, of course, aware of the destruction caused by the most recent earthquake, but many veterans in northern California are still waiting replacement of facilities affected by the 1989 Loma Prieta earthquake 5 years ago.

I wanted to underscore for you the deep commitment that members of this committee have for full funding of the Martinez replacement hospital slated for construction at Travis Air Force Base at Clarefield, California.

As it now stands, the new hospital will not be open until as late as mid-1999. That is almost 8 years after the closing of the Martinez facility. I, along with a number of other members of the Cali-

fornia delegation, would like to see us appropriate additional funds and accelerate the timetable for construction of this project.

This has one of the largest catchment areas, in fact, larger than twenty- nine states, I understand, in terms of the overall veterans population that they serve. In fiscal year 1995 budget, $7.3 million has been set aside for this replacement hospital, and some previously appropriated money will be reprogrammed for use in this fiscal year.

If further funds were available, would you be able to shorten this timetable by hiring additional people to do the design and construction work? Could additional funds be used to simultaneously work on separate aspects of the construction? What can I and other members of the committee do to help you shorten this timetable?

For the record, identify yourself.

Mr. NEARY. Mr. Chairman, my name is Bob Neary, and I'm with the Office of Construction Management.

We've been working diligently over the last several months to attempt to accelerate the schedule, and we have accelerated it into 1998. We've recently entered into an agreement with out architectural and engineering firm to look at ways to try to accelerate it.

At this point, it appears to us, however, that the monies that have been requested in 1995 joined with the previously appropriated funds would be adequate to carry us through the beginning of the year 1995. We've phased the project so we can begin construction in 1994 and an additional phase of construction in 1995. We believe the funds we've asked for are adequate.

Mr. EVANS. There's nothing that we can ask for, for additional funding or simultaneous work going on, on some of the aspects of this construction? You say 1998, but that's December 1998. Isn't that correct?

Mr. NEARY. Yes, it is, and we're looking at trying to move that further ahead.

With respect to your question about having the AE firm add more personnel, we're talking with the firm about that, although it's difficult to have too many people working on the same set of drawings, and we don't have an answer to that, but that's not typically easy to do.

We've asked them to do as much as they can to speed up the design process, and that's one of the reasons we have phased the job in the way that we have, so we can begin the early parts of construction sooner than we would if we waited until the design was completed.

Mr. EVANS. Well, as we gear up for national health care with the VA people, it's going to be very important to have this facility on line as that transition period unfolds, if we're going to be competitive in an area that has got as big a veterans population as twenty-nine states do.

So we would like to have you take a quick look at this, a close look at this, and see if there's anything else that you can do. Of course, this committee will be very interested in following through on this.

I would like to recognize the gentleman from Arizona. He has another question.

Mr. STUMP. Mr. Chairman, I don't have any question, but I would like to ask unanimous consent that all members be allowed to submit questions for the record.

Mr. EVANS. Without objection, so ordered, and the written responses will be made part of the record.

At this time, Mr. Secretary, we are done with your presentation. We appreciate your time.

The committee will recess now for 15 minutes.

(Recess.)

Mr. EVANS. The chair now recognizes Preston Taylor. Mr. Taylor, we appreciate your coming before the committee. He has just been named Assistant Secretary for Veterans Employment and Training, and he's a former Adjutant General in New Jersey.

Mr. Secretary, we appreciate your coming in. Now you may proceed.

STATEMENT OF HON. PRESTON M. TAYLOR, JR., ASSISTANT SECRETARY FOR VETERANS EMPLOYMENT AND TRAINING, DEPARTMENT OF LABOR

Mr. TAYLOR. Thank you. Mr. Chairman, members of the committee, it is with great pleasure and honor and appreciation that I appear before you as Assistant Secretary for Veterans' Employment and Training to present the fiscal year 1995 Department of Labor budget as it pertains to veterans' employment and training programs.

On this first opportunity for me to testify before you regarding VETS' budget, I would like to preface my remarks by providing a brief statement of my vision for this agency, followed by a sampling of the agency's recent accomplishments that I have learned about during the 2 months that I've been on the job.

It has become clear to me that VETS' has not done enough in the past to make those interested in veterans aware of the outstanding work that this agency does on behalf of our veterans. I believe a brief listing of some of VETS' recent successes will provide compelling support for the presentation of VETS' fiscal year 1995 budget request which I will provide today.

First, please allow me to explain my vision for VETS'. I want VETS' to be recognized as a world class organization ensuring employment and training services to our veterans. The agency must keep pace with the demands and rewards of putting the customer, our veterans and prospective employers, also our customers, 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 its employees. The emphasis now within the agency is on total quality management, TQM, and the teamwork principles underlying this philosophy.

During fiscal year 1993, VETS achieved many significant accomplishments that will have a continuing impact on the agency's operations and on the veterans being served:

1.8 million veterans registered with State disabled veterans outreach program specialists, DVOPs, and local veterans' employment representatives, LVERs, and 561,587 veterans were helped into jobs through VETS funded staff and State Employment Security Agencies or SESAs.

145,092 military men and women and their spouses were trained at 3,424 Transition Assistance Program, TAP, workshops on how to find employment in the civilian labor force.

8,415 homeless veterans are being assisted by the VETS Homeless Veterans Reintegration Project, HVRP, and its 32 grants, with over 3,800 expected to find jobs.

Over 5,800 service-connected, Vietnam-era or recently separated veterans will have received training under Job Training Partnership Act Title IV–C, JTPA IV–C, grants, with over 3,900 of these veterans expected to be placed in jobs upon completion of their training.

Over 3,500 State employment service agency staff, Department of Labor staff, and Department of Veterans Affairs staff were trained in the implementation procedures for the new Service Members Occupational Conversion and Training Act, SMOCTA, program, through "train the trainer" instruction developed by VETS through the National Veterans' Training Institute, NVTI, over a period of less than 90 days.

Enacted in fiscal year 1992, with implementation in the fourth quarter of fiscal year 1993 and ending in fiscal year 1996, the SMOCTA program develops on-the-job training agreements between unemployed veterans and employers, focusing on job development in stable and/or growth industries.

2,206 veterans' service providers were trained at NVTI. A new initiative was the NVTI training of 110 Native American veterans' service providers, representing seventy different tribes and twenty-three states, to provide training and employment services to Native American veterans.

1,560 Veterans' Reemployment Rights, VRR, cases were closed, with $332,700 having been recovered for claimants through litigation and $810,000 having been recovered through VETS' compliance activity.

Long range planning was accomplished during fiscal year 1993 by VETS' Automation Steering Committee to improve VETS' automation systems capacity over the next 5 years. Plans developed should increase both staff productivity and the efficiency of intra-agency communications and data transmission.

During fiscal year 1993 VETS also completed acquisition of new equipment and software for every State and Regional Office, as well as for the National Office, positioning VETS to participate fully in the new Information Resource Management environment in development by the Department.

The agency also entered into an agreement with the Employment and Training Administration, ETA, to participate in their development and testing of a wide area network.

Fiscal year 1994 has also produced numerous highlights in VETS' operations:

During fiscal year 1994, VETS is streamlining its Job Training Partnership Act Title IV, Part C grants process through recommendations developed by an internal ad hoc committee, including elimination of the existing regulations and the phasing in over the next several years of a revamped process to administer fewer, larger valued grants over multi-year grant periods, subject to satisfactory annual performance by the grantees.

The improved operational efficiency of these plans is one example of how VETS plans to cope effectively with the impact of staffing level reductions while also maintaining and improving direct client services.

Also in progress during fiscal year 1994 are three other VETS projects designed to reach specific agency goals. Three separate ad hoc committees within VETS are involved in planning fundamental changes in the DVOP/LVER programs; conducting customer satisfaction surveys and increasing employer participation in VETS programs; and reviewing and changing, as appropriate, VETS' internal operations and organizational structures.

These far reaching projects are designed to change and improve significantly both VETS' delivery of services through its delivery systems and the operations of the agency itself.

The potential impact of the agency's ad hoc committees' work is illustrated by the Loaned Executive Program, LEP, currently under development by the committee responsible for increasing employer participation in VETS' programs. This initiative will provide for a loaned executive from the business community to work with VETS as an advocate and spokesperson for job ready veterans.

With public relations and marketing efforts, as well as the executive's established business network, the loaned executive will enhance VETS' efforts to enlist the support of employers and employer groups nationwide to promote the hiring and training of veterans, marketing the advantages of employing veterans to improve and increase veteran employment opportunities.

The individual will represent VETS in advancing and advocating the employment of veterans to the business community, identifying ways to raise employer awareness of the skills and attributes of veterans, and helping to dispel any negative misconceptions about veterans.

In addition to marketing veterans, the loaned executive will enhance VETS' understanding of employers' needs, wants, and concerns. The LEP initiative will enhance VETS' ability to develop a national policy to meet employer needs while promoting the labor market competitiveness of veterans.

25,500 veterans have applied for SMOCTA services since the August 1, 1993, implementation date. Through January 28, 1994, 1,352 veterans have been matched with employers to pursue SMOCTA on-the-job training programs. VETS and its State DVOP and LVER staff have continued to assist the Department of Veterans Affairs in the implementation of the SMOCTA program.

VETS is in the process of developing training through NVTI for SESA and VETS' staff in case management, and in the successful management and oversight of the case management process. Case management enables the DVOPs and LVERs providing veterans with direct employment and training services to facilitate effectively the development and achievement of the veterans' employment goals.

The two case management training courses being developed will improve skills in this function, which is so critical to effective client service in SMOCTA and other VETS programs. NVTI will begin delivery of the case management training curricula in April 1994.

VETS' total quality management or TQM program will begin in fiscal year 1994 with the identification of the initial functional components to be targeted; that is, those processes that we think need to be improved immediately. TQM will then be implemented in a vertical manner; that is, throughout the agency's entire hierarchy for the identified components.

Appropriate training will be a prerequisite for those involved in this initial phase and all later phases of VETS' TQM program.

Improvements in VRR case processing procedures have been developed by another VETS ad hoc committee in fiscal year 1994. These procedures include provisions to increase the quality of investigation in VRR cases, while continuing to emphasize timely case resolution.

A second generation of VETS' Automated Reporting System, VARS, is being implemented in fiscal year 1994. This will include elimination of duplicate reporting by manual, hard copy methods for all essential information required by VARS.

VETS has also established the Computer Support Team, CST, consisting of front line VETS employees in each VETS region who receive hands-on "train the trainer" training before implementation of each new VARS module. In this training, each CST member will receive copies of the training materials that the member will need to be able to pass on this VARS training to computer users within their own regions.

The CST will also become a training resource for each region to provide all its VETS staff computer/automation training in off-the-shelf software applications, with additional extensive training to be made available to VETS staff from NVTI and other qualified training vendors to meet their individual needs.

A comprehensive assessment of the types of training needed by VETS and SESA staff will be completed also during fiscal year 1994 under the direction of VETS' Training Needs Assessment Committee. This needs assessment will focus on the training needs of specific audiences within NVTI's training universe by defining the knowledge, skills, and abilities, KSAs, for each training group, followed by the delineation of specific training needs for each group relevant to one or more of the group's KSAs.

The results of this needs assessment, the first undertaken since 1988, will be used both to facilitate decision making regarding new NVTI courses to be developed, and to provide guidance in the development of VETS' Annual Training Plan for NVTI courses to be developed in fiscal year 1994.

The agency has signed a Memorandum of Agreement with the Department of Defense to help identify and assist military personnel separating to pursue a teaching career, targeted to low income schools. A grant will fund a pilot program to connect military personnel with teacher certification training options and assist with placement in low income schools. The agreement is in support of the "Troops to Teachers Program."

VETS is in the process of implementing the requirement which establishes the Advisory Committee on Veterans' Employment and Training, as required by 38 U.S.C. Section 4110. The agency's current plans call for the Advisory Committee to meet before the end of fiscal year 1994.

For fiscal year 1995 VETS is requesting a total of $190.276 million to fund 272 Federal positions and 3,167 State positions by the end of that fiscal year. This amount is comprised of $167.795 million for grants to states, $21.495 million for administration, and $2.986 million for the National Veterans' Training Institute.

Mr. EVANS. I'm sorry. I'm going to have to interrupt. We all have the statement before us. If you could summarize a little bit and try to finish up, we would appreciate it.

Mr. TAYLOR. Okay. It is tentatively planned that VETS' reduced staffing level for fiscal year 1995, which is 272 FTE positions or four fewer than in fiscal year 1994 and thirteen fewer than in fiscal year 1993, will be accommodated through elimination of all ten of VETS' assistant regional administrator positions, along with reductions from other field staff and from among National Office staff over the fiscal year 1994–95 period.

The nature and scope of all FTE reductions in the field offices and the National Office will be specifically determined through the deliberations of VETS' fiscal year 1994 ad hoc committees, currently engaged in planning VETS' organizational restructuring as part of their work on the agency's fiscal year 1994 goals.

fiscal year 1995 will be the third year of implementation of the Service Members' Occupational Conversion and Training Act, SMOCTA, program. The LVERs and DVOPs will provide participating veterans with case management services and will be helping to develop on-the-job training agreements between eligible veterans and prospective employers.

VETS' current efforts to reinvent the JTPA IV–C grants process include plans to eliminate the present IV–C regulations.

The Homeless Veterans Reintegration Project will serve approximately 8,500 homeless veterans in fiscal year 1995.

Mr. Chairman, I appreciate the opportunity to begin discussion of change within the Veterans' Employment and Training Service. I look forward to working closely with the committee, as has already been occurring at the staff levels on several recent occasions with respect to our reinvention efforts and the NPR recommendations.

Thank you.

[The prepared statement of Mr. Taylor appears on p. 75.]

Mr. EVANS. Thank you, General. We appreciate your testimony.

The President in his budget request for disabled veterans' outreach programs specialists and local veterans' employment representatives does not comply with the statutory staffing level formulas contained in Chapter 41 of Title 38. In fact, the President's budget would result in at least 400 fewer DVOP and LVER positions that then would be provided under the Congressionally mandated staffing level.

Additionally, the administration's budget would reduce these personnel by 240 positions from the fiscal year 1994 level. In recent years the duties of DVOPs and LVERs has increased significantly, due to the downsizing of the military. Yet the number of these veterans' employment specialists is decreasing.

Under the reduced staffing levels, what responsibility will DVOPs and LVERs be unable to fulfill? How many veterans will not receive the assistance they need? Which veterans will not be

served, and what will be the reduced staffing levels' effect on the ability of DVOPs and LVERs to participate in the Transitional Assistance Program?

I give you a multi-part question there, I realize.

Mr. TAYLOR. Well, the fiscal year 1995 request is adequate to fund the activities and initiatives which are described in the budget request. We feel we can meet all of our obligations. Can we meet the needs of all veterans? I think it is always possible to do more and to do better.

To that end, we are mid-way through a comprehensive look at VETS, the agency, and its programs, as I mentioned. When we did the math in accordance with the formula that determines the number of DVOPs and LVERs within each state for fiscal year 1995, the number was somewhat more than the fiscal year 1994 number. So that the difference that you see between fiscal year 1994 and fiscal year 1995 is partly due to the fact that the formula allocates many more positions than were authorized in fiscal year 1994. We are going to have to ask SESAs, the State Employment Security Agencies, to help us with our workload, especially now that our DVOPs and LVERs are asked to conduct TAP classes.

We feel that the SESAs can help us, especially with job ready veterans. The DVOPs and LVERs are there primarily to help the disabled veteran and those who are in special need. Those veterans who are job ready may not be able to be served by DVOPs or LVERs. We probably will have to ask the SESAs to give us a hand with that workload.

Mr. EVANS. You have not asked any of the States at this point to do that, though, have you?

Mr. TAYLOR. We are starting to ask them to do it now, yes.

Mr. EVANS. What has been the response?

Mr. TAYLOR. I think they are beginning to understand the situation that we are in, especially when we ask them to provide DVOPs and LVERs to conduct the TAP workshops, which is an additional workload. DVOPs and LVERs conducted about 1,600 workshops in fiscal year 1994.

Mr. EVANS. You're saying, though, that the TAP workshops——

Mr. TAYLOR. In 1993, I'm sorry.

Mr. EVANS. TAP workshops will, in fact, be reduced by 350, according to the budget documents provided to the committee. Why is the number of classes being reduced at the time that downsizing is increasing? We would have many more people, it seems to me, leaving the armed forces, many people who had thought of making it a career and probably need more help making that transition than perhaps we've been able to give in the past.

Mr. TAYLOR. Of the number of individuals leaving the service, and TAP is not just there for the military man or woman leaving the service but also for his or her spouse, we conducted about 3,400 TAP workshops in fiscal year 1993. We expect to conduct approximately that same number in fiscal year 1994. However, in fiscal year 1995, we expect to conduct only about 3,000 or so workshops, because of the budget constraint.

In fiscal year 1993 and fiscal year 1994, we have trained and will train approximately 40 percent of the military people and their spouses that are leaving the service. We project that that number

will drop down to about 43 percent in fiscal year 1995 because of budgetary constraints.

Mr. EVANS. Thank you. Let me recognize the gentleman from Arizona.

Mr. STUMP. Thank you, Mr. Chairman. Mr. Secretary, let me welcome you to your first appearance, I believe, before this committee.

Mr. TAYLOR. Yes, sir. Thank you.

Mr. STUMP. Mr. Secretary, your budget submission for 1995 shows a reduction of four FTEs for Employment and Training Service and a drop in the TAP program from 1,696 to 1,561. In your opinion, will this provide adequate services to veterans, particularly those who are under the transition services for all those that are eligible?

Mr. TAYLOR. We are mandated across the board in the Department of Labor, as in other departments, to reduce the FTE. Our FTE has been reduced by four from fiscal year 1994 to fiscal year 1995, but I don't believe that will adversely impact the way that we provide services to our veterans; because we are in the process now of reinventing ourselves, as I mentioned earlier on in my testimony.

We believe that we can more efficiently and more effectively provide services to our customers, once we complete certain reinvention efforts. We're looking at the way that we provide grants to the DVOPs and LVERs. We're looking at the SMOCTA program. We're looking at the TAP program.

We're about to establish another ad hoc committee to look a TAP. We need to look at DTAP, the disabled program in TAP. We need to look at the size of the classes. There are about forty-six participants in each class. That may be too large.

We have contractor support. We don't have enough DVOPs and LVERs to provide all of the classes. So we had to have supplemental help by letting a contract. So we have a contractor that's actually teaching some of the classes.

We need to look at the demographics. Where are the people getting out? California has a heavy workload of people being discharged from their bases. The same thing exists on the east coast; but many of those who are being discharged from the east coast and west coast and the TAP training at those sites are going back home, which is probably in another State.

So the DVOPs and the LVERs and the contractors who are providing TAP training in California or in South Carolina may actually be training people who are going back to Wyoming or South Dakota. So we can do this. It's going to be difficult, because our funds are constrained, but I think once we complete the reinvention process, we're going to be able to provide a better quality service to our customers, our veterans.

Mr. STUMP. Mr. Secretary, I think you made the statement that you may not be able to service about 3,000 service members. Is that correct?

Mr. TAYLOR. I think it's really closer to 15,000, sir.

Mr. STUMP. Then how much more funding would you need to be able to service those?

Mr. TAYLOR. Well, I think if the funding level were closer to where it was in fiscal year 1994, we could probably service all of those. Of course, the number of people getting out as a result of downsizing in fiscal year 1995 is not much different than it was in fiscal year 1994.

Mr. STUMP. Thank you. Thank you, Mr. Chairman.

Mr. EVANS. The gentleman from Texas, Mr. Edwards.

Mr. EDWARDS OF TEXAS. I have no questions.

Mr. EVANS. All right. Mr. Secretary, you did very well on your first appearance before our committee. We appreciate your answers and your testimony, and look forward to working with you.

Mr. TAYLOR. Thank you.

Mr. EVANS. Our first panel is comprised of representatives of the Independent Budget: Joseph Violante, Legislative Counsel, Disabled American Veterans; Russell Mank, National Legislative Director, Paralyzed Veterans of America; Jim Magill, Director, National Legislative Service, Veterans of Foreign Wars; and Mr. Mike Brinck, National Legislative Director, AMVETS.

Mr. Brinck, we will start with you, as soon as you are situated.

STATEMENT OF JOSEPH A. VIOLANTE, LEGISLATIVE COUNSEL, DISABLED AMERICAN VETERANS; RUSSELL W. MANK, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; JAMES N. MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS, AND MIKE BRINCK, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

STATEMENT OF MIKE BRINCK

Mr. BRINCK. Good morning, Mr. Chairman. For the eighth year, we are pleased to co-sponsor the independent budget, along with our friends from the DAV, PVA and VFW.

The independent budget is our assessment of what the VA needs to accomplish its mission. Unfortunately, the short time between the President's submission of his budget and the hearing today will allow for only very general comment on his budget.

In that vein, the President has requested $37.1 billion, excluding medical care cost recovery money, to run the VA this year, while we will recommend $41.9 billion. To help put that in perspective, a million dollars buys about 5,000 outpatient visits.

Today the DAV will present GOE and Benefits section, followed by PVA's assessment of VA medical program requirements, including the VA medical care system, research, and other medical accounts.

VFW will address the construction programs, and finally, I will present the National Cemetery System recommendations.

The Independent Budget will be available to the committee on February 21, and we look forward to any comments you or the staff may have.

Because of the importance of this year's budget in terms of how we view the VA's transition under health care reform, we request that the Independent Budget be made a part of the record.

With your permission, I'd like to start off with Mr. Magill from the VFW so he can make a subsequent commitment.

[The prepared statement of Mr. Brinck appears on p. 85.]

Mr. EVANS. Without objection, Mr. Magill.

STATEMENT OF JAMES N. MAGILL

Mr. MAGILL. Thank you, sir. The VFW is again proud to be a co-author of the Independent Budget, 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 and the likelihood that some form of national health care will be implemented, we are particularly concerned that VA have the physical capability of providing care to an expanded veteran population and be competitive with respect to national health care program.

Perhaps the most difficult problem facing the construction manager is the coordination of mission and program planning for facilities and the facility development program. The Independent Budget continues to believe that the FDP program should be discontinued until the VA national health care plan is adopted and specific missions and types of facilities within the VA system's health plans are determined.

VA and Congress are likely to commit to an inappropriate structure from plans based on the present delivery system and mission if the current FDP remains in place.

For example, a hospital authorized in fiscal year 1995 may not be activated until the year 2001 or 2002. This is likely to result in a hospital with too many beds and support services. The U.S. already has too many hospitals and too many beds, and VA should not compound the problem.

If VHA is to be competitive in health care reform, it must practice acute and some extended care medicine, as the private sector does, substituting more appropriate care in community and ambulatory care settings for inpatient care. The IB co-authors believe VHA needs to begin extensive primary care outreach through more remote and satellite clinics in this fiscal year and in fiscal year 1995.

In the short run, clinic activities must move closer to patients and potential patients. In keeping with the Government's one-stop service concept, the IB believes some primary care clinics should be sited contiguous to or within veterans' outreach centers or via vet centers.

Expanding leasing authority is an essential, immediate need to allow VHA to reconfigure its delivery system expeditiously. In certain situations, with smaller user veteran user populations far from VA facilities, VA hospital directors should be granted authority to contract with private sector providers.

The present outreach and community clinic criteria for VA's facility sizing model needs to be reviewed and determined if distance and travel time from home to care site are too great. The VA's two hour driving time criterion is not competitive with the 30 minute criterion based in other proposals.

Ultimately, enactment of legislation for both national health care reform and VA eligibility expansions will facilitate a more realistic

approach to setting priorities for future construction projects for the system.

VA should also revise its planning models and guidelines to account for veteran demographics. Current and future population needs should determine system priorities and the allocation of construction resources. Added emphasis should be given for 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 population is declining, the strategic and facility development plans must include alternatives to provide needed care in different settings or organizations.

With respect to major construction, the Independent Budget recommends a $294 million major construction appropriation. The majority of the Independent Budget recommended appropriation is for leases, for outpatient clinics and nursing homes.

In these uncertain times, the IB co-authors believe leasing is preferable to new construction. Leasing offers an affordable, expedient and nonpermanent solution to the immediate need for VA capacity in the outpatient and nursing home venues.

With respect to minor construction, the Independent Budget recommends a $412 million appropriation. The requested increment reflects the IB's growing concern about VA facilities' urgent updating and repair needs.

This concludes my portion of the budget. Thank you very much.

[The prepared statement of Mr. Magill appears on p. 91.]

Mr. EVANS. I don't have any questions, and it appears that others don't either.

STATEMENT OF JOSEPH A. VIOLANTE

Mr. VIOLANTE. Mr. Chairman, members of the committee, on behalf of Disabled American Veterans and its Women's Auxiliary, I wish to thank you for the opportunity to present DAV's views on the Independent Budget and President Clinton's budget.

DAV has drafted the Benefits Program and General Operating Expense portion of the IB, and I'll discuss highlights of those toward the end of my statement.

As you are aware, the President's budget shows funding levels for VA will reach $37.8 billion in fiscal year 1995. Outlays, however, will increase by only 0.52 percent above the fiscal year 1994 budget.

When we examine what this increase really means, we see that it means a below current service budget. VA cannot provide timely benefits or services today. How can we expect VA to do so in the future with inadequate funding and severe employee cuts?

We've heard this morning that these are fiscally tough times. However, while total spending on all social welfare programs is projected to increase by nearly $145 billion between 1994 and 1998, VA appropriations will decline by $2.5 billion. During a time when expenditures for other Federal programs are increasing at an extraordinary pace, the cost of veterans' benefits is held to a virtual straight line.

With increased demand and runaway backlogs and delays at VBA and BVA, something must be done to adequately fund VA. As

pointed out in the IB, without a significant increase in the number of employees available to adjudicate veterans' benefits claims, claims backlogs will continue to increase beyond the already unacceptable levels, rendering Congressional authorized benefits meaningless and causing even more hardships for those who depend on VA compensation payments to provide for their basic daily necessities.

Mr. Chairman, last year the VA estimated that it would take approximately 1,050 additional employees to reduce the claims backlog to 200,000 claims. Yet the President's budget calls for a reduction of 622 employees from VBA.

In addition, should Congress reject the administration's proposal to provide GOE with some of the administrative cost of VA's insurance program, VBA will be faced with an additional loss of 546 employees, for a total of 1,168 employees less for fiscal year 1995 than are currently available to provide services to veterans and their families.

Worst case scenario then: There's a total of 2,200 employees below what the VA needs to reduce its backlog to 200,000 claims. We believe that a crisis situation currently exists in VA Comp and Pen, and drastic measures are necessary to correct the erosion of services.

The military Reduction in Force has been noted as a major source of increased compensation claims workload, and it is contributing to the ever increasing backlog of compensation claims. It would only seem fair that VA also receive funds from DOD to assist in handling the increasing compensation workload created by the military Reduction in Force.

The President has requested a budget of $16.122 billion to fund the Veterans' Health Administration provision of direct health care for services to our Nation's veterans. What is immediately apparent is the immense inadequacy of funding to permit VA to provide quality and timely health care to veterans.

This represents an inadequate budget in the face of VA preparing to embark down the road towards reforming their health care delivery system in context with the President's overall health care reform proposals for the Nation.

Mr. Chairman, although DAV has not and will not take a position on nor endorse the President's overall health care proposal, we are generally in agreement with and supportive of the role identified for the VA in the context of the national health care reform. However, we are not confident that VA will be able to proceed down the path of meaningful and sustainable reform unless and until an adequate budget is enacted that will permit them to do so.

The cornerstone of the independent Budget funding recommendations is an entitlement's inseparability from its timely delivery. This principle should also be the basis for VA's management budgetary planning. Now is the time to link veterans' entitlements and their timely and accurate delivery. With proper equipment and sufficient numbers of trained employees, VA management has the talent and dedication to meet the reasonable timeliness and accuracy standards cost effectively.

Congress should authorize funding for VBA's personnel costs through transfers from mandatory spending entitlement accounts.

VBA's budget should also include a line item for training, which we believe should be $8 million.

For Veterans' Services, the IB VSOs recommend 2,440 employees, almost 320 more employees than provided for in the administration's budget. We request that there be 600 additional employees for vocational rehabilitation and counseling.

While this is a significant increase above the current employee level, from a purely economic standpoint it is sound public policy and cost effective to return disabled veterans to meaningful employment as soon as practical following an injury or onset of disease.

For compensation and pension services, without the necessary equipment, training and employees to adjudicate veterans' claims, little progress can be made to reduce the overwhelming backlog of claims. Therefore, we recommend an increase in employment level to 4,700. This is 540 more than the current budget proposal.

Rarely do goals of deficit reduction, program integrity and efficiency, and good service to veterans coincide so exactly as they do in improving loan servicing. Accordingly, an additional fifty employees for loan guaranty, specifically for loan servicing activities, make financial sense.

Mr. Chairman, I see that my time is up, and I'll conclude my statement at this point. I'd be pleased to answer any questions.

[The prepared statement of Mr. Violante appears on p. 99.]

STATEMENT OF RUSSELL W. MANK

Mr. MANK. Mr. Chairman, on behalf of the Paralyzed Veterans of America, I appreciate the opportunity to testify before this committee and to address the fiscal needs of the Department of Veterans Affairs' Medical Programs for fiscal year 1995.

Before I continue, I would like to mention that our National President, Mr. Richard F. Johnson, flew in yesterday afternoon from California to be here for this hearing. I would appreciate if you would recognize him.

Mr. EVANS. Perhaps you would like to recognize him for applause.

Mr. MANK. Sir, before I continue I'd like to highlight five points from my written testimony: (1) appropriations for medical care; (2) for medical research; (3) staffing; (4) competition that VA is facing with state health care reform; and (5) the President's national health care reform.

PVA believes that we have the makings for a crisis with the administration's fiscal year 1995 budget request for VA medical programs. Without your intervention, veterans are fearful they may lose their health care system.

VA staffing levels are proposed to be cut drastically. However, H.R. 3808 may prevent that from happening. VA is now being forced to compete with its hands tied behind its back in many states which are implementing major health care reform initiatives.

Many of these states offer eligible VA beneficiaries a richer benefits package than VA is able to make available to them under current eligibility rules, but the action in the States is still not the end of it; because if the combined impact of all these factors doesn't kill

the VA system, comprehensive national health care reform under these conditions will.

Mr. Chairman, the administration has asked for $16.1 billion. We believe that it's short by $2.3 billion, just for current services based upon the fiscal year 1988 standard, and $3.6 billion less than the independent budget's full recommendation.

Even more critical is the research budget. The Administration's request for $211 million is $41 million less than last year's budget. In times of fiscal austerity, research is always the first item on the chopping block. The immediate need for dollars perpetuates a cycle of forfeiting research opportunities and advancements in medical technology which could serve the system well in the future. Investment in research and science in VA and elsewhere is no less important than the investment in other domestic concerns.

Reduction in staffing and funding will prohibit VA from developing services it needs to be competitive under a comprehensive health care reform plan. Reform is not remote. It is occurring at the State level today. VA must be liberated from the restrictive legislation, so it can compete as necessary.

Of greatest concern to the Independent Budget co-authors is VA's restrictive eligibility criteria. VA's eligibility criteria are its greatest obstacle to delivering cost effective and appropriate care. The administration claims this problem will be settled once VA is able to deliver a standard benefits package to its enrollees like other providers, but in states where reform is emerging, enactment of comprehensive national reform may come too late.

Mr. Chairman, we realize things are tough all over, and we've heard from people that the VSOs always have their hands out; but PVA believes the VA's management could redirect its resources or better manage its services.

VA's future depends on being able to deliver medically necessary services to veterans in convenient settings. We end where we have so often begun. We urge Congress to amend eligibility criteria which are trapping VA in an anachronistic practice style which is over-reliant on inpatient care. VA's eligibility criteria must be changed.

VA needs to be enhancing ambulatory care clinics to prevent veterans from leaving the system in droves, should other cost competitive options become available.

Finally, Mr. Chairman, the Veterans Service Organizations have been asked to support, in concept, the President's health care reform proposal. We have done so with the promise that the VA health care system would remain a viable, quality, independent health resource.

If the conditions are right, the President's proposal could offer VA a chance to come out ahead in health care reform, but this can only happen if the system is given the tools, the staff, the funding and the motivation to accomplish that goal.

Mr. Chairman, we believe the administration's fiscal year 1995 budget request is a blueprint for disaster. If approved intact, it will send a VA, already bankrupt by a decade of underfunding, out to compete in a reformed national health care environment with both hands tied behind its back.

The President's health care reform bill promises $3.3 billion for VA at some point down the road, but that is a promise of future support which does not provide much comfort right now as we face a fiscal crisis. Mr. Chairman, I am afraid that the veterans may vote with their feet in the near future if our VA system is not funded adequately.

Thank you for your time, and that concludes my statement.

[The prepared statement of Mr. Mank appears on p. 109.]

Mr. EVANS. Thank you, Russell. We appreciate all of your testimony. Of course, we see the drafted Independent Budget. That's going to be very helpful in the next few weeks, because the Budget Committee has asked for our views to be submitted by February 25. So we will use your advice in the next few weeks, and we appreciate your testimony here today.

The gentleman from Arizona.

Mr. STUMP. Thank you, Mr. Chairman. Let me take this opportunity to thank each one of you and your respective organizations for work you do on this Independent Budget. I know all the members of this committee really appreciate that service, because it does give us something to compare to the administration and the rest of the budgets we have to face.

I would like to ask each of you a question, and I think, Mike, you just answered it, and I believe Jim made his position clear a while ago; but do you believe that the Clinton budget request will adequately provide the VA with the necessary funds to be able to compete under the national health care program?

Mr. VIOLANTE. No.

Mr. BRINCK. No.

Mr. STUMP. I take it, your answer will be no, and I believe Jim said the same thing.

Mr. MANK. It will not.

Mr. STUMP. Thank you. Let me ask you another question. Do you believe that the VA should come forward with their eligibility reform now or wait until after action on the national health care program?

Mr. VIOLANTE. I think the time for them to come forward is now.

Mr. MANK. We're ready to step forward right now.

Mr. BRINCK. There should be—You know, we've been preaching for 2 years I've been doing this that eligibility, for certain, does not need to wait on national health care.

Mr. STUMP. I just wanted to clarify that. I thank each one of you. Thank you very much, Mr. Chairman.

Mr. EVANS. Thank you. Does the gentleman from Texas have any questions?

Mr. EDWARDS OF TEXAS. Thank you, Mr. Chairman. I want to thank you all for coming. Clearly, your organizations, along with other VSOs here today, have done more for veterans than anybody in this country.

The question I have of you is whether each of your organizations has any plan in place to lobby through grassroots effort the Budget Committee? Having you here today is very important, and Mr. Stump's record in fighting for veterans and Mr. Evans' record in fighting for veterans is unquestioned by anybody that knows their records, and I think that's true with other members of this commit-

tee, generally; but where we've got to win this fight is in the Budget Committee.

I'm not aware—I know you've made efforts, but I'm not aware, for example, of what you did last year. Maybe you did. Maybe you had a letter writing campaign from the grassroots level focused on Budget Committee members, but could you inform me of maybe what you did last year before the Budget Committee and whether you have any plans this year to put together not just testimony, which is helpful, but a real grassroots political effort to help this committee get some more funds out of the Budget Committee.

Mr. BRINCK. We, in our policy session, decided that we were going to expend a good deal of effort briefing the Budget Committee staffers and any of the members we can, obviously, which to my knowledge was not done in the past. So that's, obviously, something we're working on setting up right now.

I'm confident that each of the organizations will do its usual fine job of alerting its members to put some pressure on the Budget Committee, because, obviously, we're preaching to the choir here. So your point is exactly right.

Mr. MANK. Mr. Chairman and Mr. Edwards, our chapter members have called both—the Budget Committee and the Appropriations Committee. As we speak today, your colleagues are receiving letters to support a long term care bill. So that also is coming forth.

Mr. EDWARDS OF TEXAS. When you say the chapters contacted the Budget Committee members, could I ask you specifically, do you put out in your newsletter a specific request asking every member of your organizations to contact Budget Committee members, and then do you give them the name and address of those members? How do you initiate that effort?

Mr. MANK. We do it over our National President or our Executive Directors' signature in a memo or a letter. We are very selective about what particular issues we focus on.

Mr. BRINCK. We will end up—We have 1,500 posts throughout the country, and we will send out a mailing to each one of those posts identifying members of the Budget Committee that they need to contact. So that's exactly how we do it.

Mr. EDWARDS OF TEXAS. Great.

Mr. VIOLANTE. With regards to DAV, we rely heavily on our members' grassroots efforts, and we provide them, our local chapters, our State departments and our legislative committees in each of our States, with bulletins that are sent out by our national Director.

Mr. EDWARDS OF TEXAS. I know I'm preaching to the choir, just as you are today, but I urge you to start now, if you haven't already, you know. I hope that the people who express genuine concerns about the budget today in this committee—I think we will work together on a bipartisan basis. Maybe we can make some progress with the Budget Committee, but we're going to need your help.

Thank you.

Mr. BRINCK. In yesterday's hearing over on the—at the Senate Veterans' Affairs Committee, one of the witnesses who is a Chief of Staff at one of the VA hospitals testified. I'm saying this, be-

cause all the attention has been focused on R&D today. He testified that his research budget was $4 million for his facility.

His estimate on direct health care provided to veteran patients as a result of that $4 million was $8 million, a lot of leverage there.

Mr. EVANS. All right. Thank you all very much for testifying. We appreciate the budget coalition that's been built by veterans' organizations and look forward to working with you.

Mr. EVANS. Our final panel consists of Larry Rhea, the deputy Director of Legislative Affairs, Non Commissioned Officers Association, and Mr. John Hanson, Director, National Veterans Affairs and Rehabilitation Commission for The American Legion.

STATEMENT OF LARRY D. RHEA, DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS, NON COMMISSIONED OFFICERS ASSOCIATION; JOHN HANSON, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

STATEMENT OF LARRY D. RHEA

Mr. RHEA. Thank you, Mr. Chairman. My notes say good morning, but I guess it's good afternoon now.

Once again, it's a pleasure for the Non Commissioned Officers Association to be invited to testify regarding the budget. As a rookie in this business I would be less than candid if I gave the pretense of not being a little bit overwhelmed at the moment, principally for two reasons.

Now having had 48 hours to ingest five volumes of VA budget, I have the task of somehow representing NCOA's views, and for an old Midwestern farm boy who gave up that life about 30 years ago for an enlisted career in the Navy, that's not an easy task. More daunting, in my view at least, is the requirement to fill a chair that has largely been occupied by Mr. Dick Johnson for the past 17 years for the Association.

For me, Mr. Chairman, that is a personal task of sizeable proportion in many ways. But on a completely sincere note, Mr. Johnson sends his warm personal regards, and the entire Association, as always, is grateful to the committee.

In my prepared statement that I submitted to the committee, I didn't focus on any of the specifics in the 1995 budget, but what I did, reflected in my prepared remarks that I submitted to you, was the trends of the last several years and also the feelings and beliefs that are held by many veterans.

Now having had the opportunity to ponder what is in the 1995 budget, I will comment upon what NCOA believes to be some positive things and some areas that are also of major concern, and they won't depart too much from what we've already heard here.

Certainly, there was a substantial effort undertaken by the Secretary, in view of some very difficult realities that confronted him. We appreciate that effort on his part and the sincerity of Secretary Brown is never in question, as far as NCOA is concerned.

We certainly appreciate that his budget included a 3-percent cost of living allowance for compensation beneficiaries, based on the anticipated change in the CPI. We appreciate the increase that he provided for readjustment benefits authority and the start-up costs

for the new cemetery in Seattle and land acquisitions for three others.

We were hopeful that Seattle would represent a very positive trend in cemetery construction in the future, but somehow now that doesn't seem to be the case. Much of what I believe we saw in the VA budget was shaped upon what, I think and Secretary Brown also acknowledges as his biggest challenge—that is improving VA's health care delivery system to compete in some sort of anticipated new environment on health care.

We appreciate the emphasis that the Secretary put on ambulatory care in the budget, and we hope that that emphasis continues in the future; but NCOA does suggest to the committee that you examine the eligibility rules, as has been stated here, and encourage change to allow the VA to provide ambulatory care to those who can now only be treated on an inpatient basis. We, too, believe the time to do that is now.

We also would encourage the committee to examine the rationale and the criteria used by the VA for selecting sites for ambulatory care improvement and all other construction projects and their method of prioritizing those projects.

Let me state frankly that there are some things regarding medical care in there that concern us very, very greatly, not the least of which is the decrease in medical care personnel, as has been cited here, and the trend that continues. Even though the intended cut was over 9,000, of which 4,500 apparently has been waived. Somehow trying to convince veterans that dodging one bullet is a good thing belies the fact that the continuing reduction trend continues.

We are also concerned about the inattention that the budget gives to the equipment upgrades. Combine that with the decline in research that has been cited here today and the Association believes that these reductions will reduce talent and clinical service capability that the VA simply cannot afford to lose.

It was also noted that budget authority for the construction programs has dropped by more than half. That concerns us deeply. But while the budget cites a $500 million increase in medical care for fiscal year 1995, it appears that more than 20 percent, some $111 million of that $500 million, is through projected savings, supposedly to be attained through the National Performance Review, IG recommendations and other management improvements that VA says they will make. NCOA believes that this is creating a false impression, because historically savings projected are rarely achieved.

Of concern also is this supposedly off budget $1 billion to the health care investment fund. In regards to all of this on health care, let me state: The NCOA does not believe that the current system can be essentially forsaken while betting on a system that may never come, and that seems to be the implication in the 1995 budget.

We have many concerns with the full time employment reduction of 622 for the BVA. I won't belabor at this point the problems associated with BVA. They are well known to the committee and so forth.

As I indicated in my prepared statement, the Association fully believes that this committee will strive to do what is right for the Nation, not only on the committee but in view of the many other competing national priorities that you are confronted with. Our only request, as it has been for the last many, many years, is that this committee will strive to do what is right and fair to the veterans of this Nation.

We would specifically request that, as you undertake your difficult work, that you would be guided by a purpose and philosophy that would truly restore pride, honor, and dignity to the term veteran.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Rhea appears on p. 420.]

Mr. EVANS. Thank you, Larry. We appreciate your testimony.

John, if you can keep it to about 5 minutes, and I'm sure you'll be able to do that, we'll be able to finish up in time.

STATEMENT OF JOHN HANSON

Mr. HANSON. Yes, sir. I'll do it as quickly as I can.

Thank you, Mr. Chairman. As you will recall, last September National Commander Bruce Thiesen came before you and presented The American Legion's recommendation for fiscal year 1995. I won't go into all the details, but I wish we had been surprised by what we saw here on Monday, but The American Legion's request is about $2 billion more than the administration's, and for research we're looking at what we see as about a $70 million shortage.

So our detailed statement, what we consider to be the real needs for VA, has been submitted to you, and we know that will be accepted for the record.

I wanted to assure you that we understand that you're under a lot of pressure to save money wherever possible, and we understand the mandates you must operate under to achieve budgetary goals, but we can't accept this budget as a legitimate effort to address the problems facing the delivery of services to veterans and their families.

This budget, in fact, is only a very slight variation on a sadly familiar theme, and we think it's time to change the tune. For more than a year, The American Legion and some of our other colleagues have been working closely with the administration on what we consider to be a fair and honest plan for the delivery of health care to this Nation's veterans.

We thought we were working on a way for VA to become a competitive partner in a national health care reform package. While we appreciate the attention the administration's plan alone pays to VA, the numbers we see in this budget don't match the concern expressed by the Secretary and his representatives.

Maybe the personnel cuts are only an illusion, and maybe they are part of some accounting gimmick, but we don't think so. If VA can do what it needs to do to be a legitimate player in health care reform with fewer people and fewer real dollars, then we really have to wonder why we've been coming up here for so many years.

We're betting the VA really can't do it with less, and that would be a loss of a remarkable opportunity that may never come again;

and while we've been fiddling with the problem of health care reform, the benefit side of the house has been burning down.

The backlog of claims for earned eligibility, for earned disability benefits and pensions is just absurd. Now what should only be an inconvenient wait for benefits can stretch out until an uncomfortable situation might become desperate.

Of course, while a veteran is waiting for his or her benefits decision, the other parts of the VA puzzle are also missing. We wonder how it can be that a Nation that professes to treasure its service members can construct the artificial barriers of bureaucracy and budget constraints so high that many people just give up. I think we're better than that.

There are other problems in the budget, of course. The VA research budget request is more than $40 million less than what was approved last year, and nearly as low as VA's request from last year. We consider medical and prosthetic research to be critical to the success of VA's mission in delivering health care.

Periodic shortchanging has long term negative effects that really can't be undone later on. If VA research is going to continue to be a vital component of VA's health care effort, it can't be held hostage by the budget process.

The programs VA administers are often a lifeline, sometimes the only lifeline, to deserving people who might not have other options. If a veteran must wait for months to receive a check for an earned entitlement, that veteran may feel disregarded.

Veterans who are turned away from VA medical centers often don't come back until their situations are critical, and that cost to the system can be enormous. The people VA serves deserve better than the hollow promises and pledges of more efficiency. They deserve our thanks and our compassion, and this budget provides little of either.

Thanks again, Mr. Chairman, for permitting us to come before you again. We look forward to working with you and the committee to try to correct the situation.

[The prepared statement of Mr. Hanson appears on p. 424.]

Mr. EVANS. Thank you, John. Mr. Stump has been so patient waiting throughout all this today that I'll be glad to recognize him for a few comments.

Mr. STUMP. Thank you, Mr. Chairman. I'll be very brief. Larry, let me ask you again. You said, I think, that the VA should come forward with eligibility reform instead of waiting until the outcome of the national health care reform.

Mr. RHEA. Yes, sir.

Mr. STUMP. May I ask you the same thing, John?

Mr. HANSON. Whether the VA comes forward with a plan or not, certainly the planning should go forward and not wait on some plan to come up.

Mr. STUMP. I'd like to ask the same question I asked of the other panel. Do you believe that this budget will adequately let the VA compete in a national health care reform program?

Mr. RHEA. NCOA believes that this budget will not allow it.

Mr. HANSON. No, sir, it cannot.

Mr. STUMP. Thank you very much for all of your testimony and for your frankness.

Mr. EVANS. The gentleman from Texas.

Mr. EDWARDS OF TEXAS. No questions.

Mr. EVANS. I want to thank everyone for testifying today, and this panel, in particular, and the minority side for waiting throughout. We appreciate your being here, Mr. Stump, so long. We appreciate it very much, and we will dismiss you at this time.

[Whereupon, at 1:05 p.m., the committee was adjourned.]

APPENDIX

HONORABLE G. V. "SONNY" MONTGOMERY

FEBRUARY 10, 1994

The Committee will be in order.

Mr. Secretary, again I want to welcome you to the Committee. This is the third time in ten days you have been before us. I hope you're comfortable here.

The budget for veterans programs which you are presenting to us this year is a very tight one. We knew it would be. These are tough economic times and everyone wants to get the country's financial house back in order. We are fully aware that VA and all other government agencies must participate in deficit reduction. Veterans only ask that they be treated fairly in the process.

Based on a quick review of the budget for all departments, I question whether veterans' programs are given the priority they deserve.

For the first time in many years, health care employment levels would be cut substantially, which could do great harm to VA's ability to deliver timely services to veterans. In response to this, I introduced legislation on Tuesday to exempt VA from across-the-board federal workforce reductions. My proposal is not intended as a freeze on staff. It would buy VA time to gear up for its role in health care reform. Why make such deep cuts before VA can assess the demands on its health care system under reform?

Furthermore, the level of funding for the Veterans Benefits Administration and deep employee cuts there mean longer delays

and less service.

But perhaps the biggest disappointment is the failure to provide support for the VA's medical research program.

Mr. Secretary, I have been telling a lot of people what a great investment VA's research budget is. For each dollar we spend, we get back several dollars in better quality care for our veterans today and improved treatment for the veterans of tomorrow. In fact, everyone benefits from VA medical research. But this budget proposal ignores that message. It invests funds in the NIH research budget, in the drug treatment budget, in claims processing for Social Security, in programs for the homeless -- the list goes on and on, but there isn't any investment in programs for veterans. University-based research will increase to roughly $12 billion, a three percent increase over 1994, but VA research takes a $41 million cut.

The President has expressed the opinion that the veterans health care system is a national resource, and he has proposed an investment fund to make the VA a competitive provider under health reform. I support him in his efforts. But this budget taps into that investment fund to fund current budget needs. It robs Peter to pay Paul.

The National Performance Review made a big deal about making government "customer-oriented". The budget does not provide the means to meet veterans need for basic services in a timely manner. In over three out of five cases, a veteran calling the VA to ask a simple question gets a busy signal. Waiting times in

VA outpatient clinics continue to be a problem. A veteran in Louisiana complained bitterly to the President about this during the President's recent visit there to discuss health reform.

Mr. Secretary, for VA to be a customer-oriented agency, you need a customer-oriented budget.

While there are significant increases in discretionary spending for the Departments of Labor (up $1.1 billion), Education (up $1.7 billion), HUD (up $1 billion), Health and Human Services (up $1.1 billion), and Justice (up $2.8 billion), VA gets less than a quarter billion dollars.

In closing, Mr. Secretary, please don't take my remarks as critical of your performance. I am well aware that you did everything you could to get a better health care budget out of OMB. However, it is clear from this budget proposal that OMB's priorities are not in line with what this Committee and the Congress would expect for our veterans and their families.

STATEMENT

HON. BOB STUMP

Thank you Mr. Chairman.

I join you in welcoming our good friend Jesse Brown, Secretary of Veterans Affairs, who over the years has done great things for veterans of our nation.
Last year there was not much to say about the budget, it closely resembled the previous Bush Administration budgets.
We could not be too critical of the new Administration, despite wanting to see more resources provided to the VA.
But there are no two ways about this budget, the first real Clinton budget.
It is an outrage and a travesty for veterans and the VA.
The only thing more tragic for veterans than this budget would be enactment of the Clinton Health Security Act.

This budget is severely lacking in resources necessary to make the VA health care system competitive with the private sector under the Clinton Health Security Act.
It undermines all claims to maintaining a separate independent system which could credibly be expected to compete for veteran patients.

The almost cavalier attitude toward making any significant progress on the claims processing backlog invites future litigation for denial of due process as delays get ridiculously long.

o This budget claims a $500 million increase in health care funding, yet VA's own conservative estimate of what it needs to even provide a current services level is $611 million.

o This budget claims that VA can compete and survive in national health reform, yet this budget expects VA to treat 27,000 MORE veterans with LESS than current services dollars and 3,680 FEWER employees.

o Last year, we were told the FY 94 budget decrease of $26 million to VA's Research account was a one-time thing, "a short term measure," but the FY 95 budget cuts VA's Research program by $41 million.

O Last year, we were told that VA would begin to shift resources over to ambulatory care so that the Department could become competitive in national health reform. The Clinton budget reduces major medical construction by 45%. Of the few medical projects funded, 3 add to VA's inpatient bed capacity and the remaining 2 add research projects at two sites that were never even on VA's Five Year Facility Development Plan. They literally popped out of no where and superseded all other projects in the pipeline. Political pork-barrelling appears to have completely taken over any logical national prioritization methodology.

o Instead of demonstrating a commitment to making VA health care competitive, this budget includes 8 ambulatory care projects but shamelessly holds them hostage to passage of the Clinton Health Security Act.

o The budget requests a Veterans Benefits Administration decrease of 622 employees, yet timeliness on compensation and pension claims processing continues to slip.

o The reduction of 29 employees for Vocational Rehabilitation and Counseling is completely inconsistent with the stated goal of providing the highest quality counseling and rehabilitation services.

Furthermore, the budget request acknowledges "a demand for services exists which exceeds our capability for service delivery."

o The budget request states "BVA ensures that appellants are afforded due process of law and that they receive on a timely basis all benefits to which they and their dependents are entitled." However, BVA's processing time by the end of FY 95 could be an incredible 2500 days, we are told by VA officials, and yet BVA would receive only 3 more employees (446 to 449 employees).

Mr. Secretary, this Committee worked long and hard to turn the VA into a cabinet level Department. This budget surely does not do that effort justice.

Statement on the Department of Veterans Affairs
FY 1995 Budget Request

Congressman Lane Evans
February 10, 1994

Mr. Secretary, I want to join my colleagues in extending a warm welcome to you and the other representatives of your department who are here this morning.

Your job this morning is to explain and discuss the President's proposed budget for VA for fiscal year 1995. Please realize that any misgivings which I or the other members of the Committee have with the proposed budget is not a disagreement with you personally or any other VA representative. We have no doubt about your commitment to America's veterans. Throughout the past twenty-seven years, you have certainly distinguished yourself as a veteran's advocate.

Nevertheless, I must tell you that I am very disappointed by this budget. It could, and should, have been more generous. The men and women who defended this nation should not now, or ever, be forced to sacrifice because the past two Administrations increased the deficit.

Initial analysis indicates that this budget will not maintain current service levels in either veterans health care or veterans benefits. If these services were now first-rate that would be one thing, but we all know that they are not. Real improvements, not reductions, are needed in VHA and VBA if veterans are ever to get the quality service that they deserve.

With reductions in the current service levels for both veterans health care and benefits, this budget appears to be a retreat from our nation's commitment to those who answered the call to arms.

I am also concerned that many veterans may view this budget as the first step towards killing the VA health care system. Rather than providing VA with the resources necessary to ensure that it can eventually compete under national health care, this budget reduces VHA's staffing, support for VA research, and the Department's construction program.

This budget may also delay VA plans to develop new community primary care facilities. These facilities are needed to improve services to veterans by making VA health care more accessible and user-friendly. And they would give the VA health care system a better chance to succeed in a more competitive marketplace.

Mr. Secretary, as Marines, we were both taught never to leave anyone behind. Today, it's our duty to ensure that not a single veteran is forgotten or left behind. The deficit is a real problem that requires tough choices, but veterans should not suffer because of it. I know that we agree on this point and look forward to hearing your testimony today and continuing to work with you on behalf of veterans.

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STATEMENT OF JOSEPH P. KENNEDY II
DEPARTMENT OF VETERANS AFFAIRS FY 1995 BUDGET HEARING
FEBRUARY 10, 1994

Good Morning. I would like to thank Chairman Montgomery and Ranking Member Bob Stump for calling today's hearing to take a look at the VA's budget for FY 1995. Never before, have we embarked upon such serious efforts at cutting our nation's deficit. Setting priorities with limited federal dollars has never taken on greater significance.

Any way you look at it, tight budgetary times will have serious implications for already strapped VA programs. I would like to point out that the $37.8 billion budget represents a mere $225 million increase in real discretionary spending.

With the national health care reform debate is front and center stage, the VA's medical care budget receives only a $500 million increase above last years level -- at this rate, VA cannot even meet current health care needs not to mention prepare to compete in national reform. This insufficient budget request is compounded by rigid cutbacks of nearly 4,000 VA health employees, and will further imperil VA's ability to care for veterans today and exist in health care competition of tomorrow.

Employee cuts will also severely impede the VA's ability to process veterans claims. Our goal must be to erode the projected backlog of 900,000 unprocessed claims and process them sooner than the average 235 days it now takes.

Last year, we found the $211 million VA research budget request inadequate and funded this vital program at $252 million. Again, this budget request resurfaced at $211 million. By VA's own estimation, this would mean no new research projects and a cutback of as many as 500 current research projects. I am deeply concerned about the dim prognosis this casts on important new research areas, particularly on Persian Gulf research. Amid all the recent talk of a Persian Gulf Coordinating Board and Advisory Committee, the VA budget speaks for itself. There are no targeted funds for critical Persian Gulf research efforts.

President Clinton and VA Secretary Brown have rightly pledged to make tackling our homeless program a priority. The VA should be the place to start delivering this promise, with over one-third of all homeless in this country are veterans. Why then should the VA receive baseline funding for homeless programs when government-wide homeless programs increase by 50%. We cannot stand for our veterans to be shortchanged in this landmark opportunity to conquer homelessness. On the positive side, I am encouraged that VA has recognized the value of the new community-based homeless programs by requesting funds for this program for the first time. But, this $8 million request -- the level appropriated by Congress last year -- is just the beginning.

I am deeply concerned by signals in the VA construction budget. Expanding outpatient services and veterans' access to health care are essential. But, these are not the projects that turned up in the budget. Many of these important projects were relegated to a investment fund tied to the health care reform plan. For many years, improvements at the Boston VA Medical Center have been identified as a priority. These projects are clearly needed independent of health care reform. While I support health care reform and think we will achieve it this Congress, these projects should and must be funded in FY 1995.

In many respects the choices we make in the FY 95 budget will chart the very future of the VA -- and the turning point for future services for those who served our nation. I look forward to working with you, Secretary Brown, and my colleagues on the committee to make sure we serve our veterans well.

Clifford Stearns
6th FL.

Veterans' Committee
February 10 ,1994
VA BUDGET

Thank you, Mr. Chairman.

Mr. Chairman, there is virtually nothing in the VA budget presently before that should give any reasonable assurance that this Administration considers the veterans of this country a cherished population.

It is correct to say the VA is held hostage to the passage of the President's Helath Care bill which releys on taxes increase, rationing of medical care and price controls. Not the kind of stuff the American people want.

After working through the numbers I see, not a $1 billion increase in funding but an increase in funding of under $300 million.

I have more concerns:

Medical research comes in at $211 million. This at the very least signals that the President has essential ignored that calls of Congress to invigorate this area of the VA. For example, how can we expect fully and through research regarding Desert Storm Syndrome at this level?

Construction funds. The VA has allotted $115 million for construction and 80% of that goes for seismic construction in Tennessee. The last know earthquake there was in 1800! Meanwhile in my home state of Florida we languish for veteran psychiatric care, hospitals and nursing homes.

On top of this we see a broad reduction in VA personnel. This will effect, for example, the VA Court of Appeals, which may with this budget be looking at a delay of action on veteran claims by as much as 7 years.

Typically budgets show the direction a President sees a particular department moving to towards. I call upon every veteran to seriously ponder whether this VA budget does not send a signal that the future is not a bright one.

STATEMENT OF THE HONORABLE JESSE BROWN
SECRETARY OF VETERANS AFFAIRS

FOR PRESENTATION BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
FEBRUARY 10, 1994

Mr. Chairman, members of the committee, I am grateful for the opportunity to be here today to discuss the President's 1995 budget request for the Department of Veterans Affairs. Let me begin by reaffirming VA's commitment to excellence in providing direct benefits to America's veterans through its three administrations--the Veterans Benefits Administration (VBA), the Veterans Health Administration (VHA) and the National Cemetery System (NCS).

As you know, the Omnibus Budget Reconciliation Act of 1993 capped discretionary spending government-wide. This Act established five year discretionary spending limits that are essentially frozen at the 1993 spending level. The combination of the spending caps and the President's commitment to reduce Federal employment by 252,000 requires agencies to examine each program and every aspect of their operations in order to determine how their customers, which in our case are veterans and their dependents and survivors, can best be served.

VA's 1995 budget request of $37.8 billion is $1.3 billion above the 1994 level. VA is one of only seven cabinet departments whose 1995 budget request for both budget authority and outlays exceeds its 1994 levels. We will use these resources judiciously to serve veterans while effectively responding to the many challenges facing our operations.

VA's challenges include meeting the continuing changing needs of a veteran population that is both declining in size and aging; providing timely benefits and counseling to the many new veterans entering our system as a result of the military downsizing; and adjusting our operations so that we can continue to provide veterans with quality health care.

In order to respond to these challenges, VA must examine and, if necessary, be ready to change the way it does business. Health care must be provided in a manner which continues the current shift from inpatient care to outpatient and other appropriate care settings. In 1995, we plan to implement a new field management structure designed to improve the efficiency and effectiveness of our health care system; expand collaboration with community health care services; and consolidate, merge, and realign hospital functions. Our goal is to achieve greater efficiency without ever sacrificing quality of care.

In addition to modernizing our benefits delivery system, we will also streamline claims processing and test various methods of delivering benefits. Successful methods will then be implemented throughout the benefits delivery system. Our goal is to have a well-trained staff using a modernized, streamlined system to provide veterans the benefits to which they are entitled in a timely manner.

A total of $20 billion of this request is for mandatory programs. I am pleased to say that this budget provides full cost-of-living increases to compensation and pension recipients and does not propose any changes in eligibility for veterans benefits.

A total of $16.1 billion, which is over 90 percent of VA's discretionary funds, will be used for our health care delivery system. This level of funding, which represents a $500 million increase over 1994, will support over 1 million hospital, nursing home and domiciliary inpatient episodes and 24.9 million outpatient visits. We estimate that our system will provide quality medical care to 2.8 million individuals in 1995, an increase of over 27 thousand over 1994.

The strength of our ability to provide quality care relies largely on our medical care infrastructure. Our 1995 request includes resources to open a new medical center in Palm Beach, Florida, five new nursing homes and make many outpatient and infrastructure improvements.

The 1995 budget recognizes the importance of the benefits delivery system. VBA is facing a backlog in its adjudication workload as a result of the downsizing of the military, the increased complexity of claims and the impact of the Court of Veterans Appeals. The Court's interpretation of VA's statutory duty to assist claimants, and the mandate that we be more inclusive and explanatory in decisions, while the right thing to do, does necessitate longer, more carefully worded decisions. We recognize that we must improve the timeliness of benefits delivery, while ensuring the quality of the service we provide. To that end, we will continue to pursue our three-part strategy of reengineering, training and modernization. We will combine business reengineering practices with VBA's modernization program to reduce the backlog of pending claims and improve our benefits delivery system. The Blue Ribbon Panel recommendations on compensation and pension claims processing will serve as a basis for the development of action plans and implementation schedules to meet increased workload demand. Although employment is decreasing due to the expected decrease in workload associated with the savings provision of OBRA, employment funded by direct appropriations will remain stable in the compensation, pension, education and loan guaranty programs.

The 1995 budget for the National Cemetery System (NCS) is supportive of VA's continued efforts to provide compassionate and dignified services to our Nation's veterans and their families. It includes an increase in employment and expansion of the system through initiation of construction of a new national cemetery in Seattle, Washington. VA will also proceed with land acquisition for three new national cemeteries in Albany, New York; Chicago, Illinois; and Dallas, Texas.

Reductions in VA staffing levels in 1995 may create situations where normal attrition might not provide sufficient staff reductions. In that event, it will be necessary to employ tools such as special placement programs within and outside the Department, voluntary early retirements and buyouts, if available.

Finally, I wish to close by reaffirming our commitment to quality health care and timely benefits delivery. VA remains a dedicated advocate for veterans and as such will take every measure possible to ensure that their needs are met. I will now briefly summarize the 1995 budget request for VA, highlighting significant budget issues for our major programs:

BENEFIT PROGRAMS

The VA benefits programs reflect a grateful Nation's obligations to those who have unselfishly served in the protection of their country. These programs constitute the major portion of a safety net which allows a disabled, homeless or unemployed veteran to return to a productive life after separation from service.

An appropriation of $17.6 billion is requested to support the Compensations and Pensions (C&P) account. In 1995, 2,218,300 veterans and 311,448 survivors will receive benefits under the Compensation program. The Pension program will provide benefits to 425,600 veterans and 356,000 survivors. Under the Burial Benefits and Miscellaneous Assistance program, 102,700 burial allowances, 84,500 plot allowances and 318,100 headstones or markers will be provided.

We have also included appropriation language in the C&P accounts that would eliminate the end-of year funding shortages experienced in the past.

Proposed in this budget, is a three percent cost-of-living adjustment (COLA), based on the projected change in the Consumer Price Index, to be paid to all compensation beneficiaries including Dependency and Indemnity Compensation (DIC) spouses and children. This would equal the COLA that will be provided, under current law, to veterans' pension and Social Security recipients. The COLA increase will be effective December 1, 1994 and will cost an estimated $347 million during FY 1995.

An appropriation of nearly $1.3 billion is requested for the Readjustment Benefits program to provide education opportunities to veterans and eligible dependents as well as various other special assistance programs for disabled veterans. Education benefits will be provided for over 502,000 trainees in 1995.

In 1995, VA's Home Loan Guaranty program anticipates approving 320,000 loans totaling $30.3 billion at a loan subsidy value of $357 million. The "Veterans Home Loan Program Amendments of 1992" authorized a new direct loan program for Native American veterans for dwellings located on trust land. This program is now fully underway, with 150 direct loans projected in 1995 through existing Memorandums of Understanding (MOUs). Further MOUs are under negotiation and additional loans under this program are expected.

Currently, the associated administrative operating costs for three insurance programs (National Service Life, U.S. Government Life and Veterans Special Life) are funded out of the General Operating Expenses (GOE) appropriation. The 1995 budget proposes to have the GOE appropriation reimbursed for these administrative costs. Legislation is included in the Administrative provisions of the 1995 Appropriation language to have these costs funded from the insurance funds' excess reserves. This proposal is estimated to save $29.4 million in 1995.

MEDICAL PROGRAMS

Medical Care

This is a time for great change in our Nation's health care system. So too is it a time for change within VA's own health care system. We are identifying ways to better meet the changing needs of our veteran population within tight fiscal realities. Additionally, we fully intend to be an active participant in the new health care environment.

The 1995 medical care budget request of $16.1 billion represents a 3.2 percent increase over the 1994 appropriated level. VA is also requesting 201,508 FTE in 1995. With these resources VA will care for 2.8 million individuals, resulting in over 1 million inpatient episodes, 944,000 acute care and 124,000 long-term care, and 24.9 million outpatient visits. This funding level will enable VA to maintain the current service level of care as well as open newly constructed and leased facilities. In 1995, VA will open a new medical center in West Palm Beach, Florida. Nursing homes will open in West Palm Beach, Florida; Pittsburgh, Pennsylvania; Marlin, Texas; Oklahoma City, Oklahoma and northern California. We will also open a new outpatient clinic in Wichita Falls, Texas; Decatur, Illinois; and San Jose, California.

VA has planned several management improvement initiatives designed to enhance VA's ability to compete in the new health care environment, improve the efficiency and effectiveness of the services provided to veterans and achieve savings. These initiatives include replacing the current regional field management structure with a Veteran Service Area (VSA) concept. This shift enhances field level responsibility and authority as well as accountability for meeting established goals and policies.

VA will contract for some administrative, clinical and clinical support services with affiliated medical schools, community health organizations, and private sector companies. Such arrangements will allow VA to more fully utilize its existing capabilities and benefit from the resources that community providers have to offer. We are also looking inward at means of achieving greater efficiency. As part of that effort, VHA is planning to consolidate support and clinical functions where geographically feasible.

Medical and Prosthetic Research

A total of $211 million and 3,430 FTE is requested to support VA's medical and prosthetic research program. This funding represents a sixteen percent reduction in appropriated funding from the 1994 level. Given the importance of the research program to VA, this decision was not an easy one to reach. Nonetheless, it is in keeping with our commitment to focus our scarce resources on those areas that provide direct service to veterans. 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 1995, 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 and veterans, Persian Gulf War veterans, former prisoners of war and female veterans.

Medical Administration and Miscellaneous Operating Expenses (MAMOE)

We are requesting $69.4 million for the Medical Administration and Miscellaneous Operating Expenses (MAMOE). This level of funding will support 804 FTE and continue the effective administration of VA's medical and construction programs. In 1995, the Construction Management staffing will be reduced by 30 FTE. This reduction is due to increased project delegation to the medical centers and a restructuring of the Office of Construction Management. This restructuring will improve efficiency and customer service.

Medical Care Cost Recovery (MCCR)

A total of $103.9 million and 2,172 FTE is requested to collect over $668 million from third parties, copayments, and receipts. While employment will remain the same in 1995, collections are estimated to increase by $90 million over the 1994 level.

Health Professional Scholarships

The 1995 budget request of over $10 million for the Health Professional Scholarship program will help support approximately 520 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.

CONSTRUCTION PROGRAMS

In 1995, a total of $269 million is requested in new budget authority for the Major and Minor construction programs.

Major Construction

A program level of over $115.5 million is requested for the Major Construction program. The 1995 Major Construction budget emphasizes increased access to care for veterans and seismic corrections.

Joint ventures with the Air Force will enable VA to expand access to medical care for veterans in East Central Florida and northern California. A total of $17.2 million is requested for the design of a new medical center and nursing home in Brevard County, Florida. East Central Florida has long been identified as an area in need of greater VA presence due to its growing veteran population. Additionally, $7.3 million is requested to begin construction of a new medical center to replace the former Martinez Medical Center in California that was closed due to seismic deficiencies in 1991.

Funding of $62.3 million is also requested for the first phase of a seismic correction project at the Memphis VAMC which is located in the high seismic risk zone of the New Madrid fault. This project is critical to the safety and well-being of the medical center's patients and employees and will result in complete seismic structural correction. Life safety, privacy and handicapped accessibility deficiencies will also be addressed.

In 1995, VA will initiate construction of a new national cemetery in the Seattle, Washington area. This will be the first national cemetery in the State of Washington.

Additional funds are included in the request to remove asbestos in Department-owned buildings and for VA's share of costs related to the clean-up of hazardous waste sites that pose a health threat. Funding is also provided for VA to reimburse the Judgment Fund for the payment of settled claims.

We propose to direct $26 million of previously appropriated funds in 1995 to the expansion of research space at the Portland, Oregon and Huntington, West Virginia Medical Centers. These additions will address the growing needs of the research programs at the two facilities.

Minor Construction

A total of $153.5 million is requested for the Minor Construction program. Primary and preventive care in an ambulatory care setting is the cornerstone of VA managed care. With that in mind, VA has earmarked $18 million in the 1995 minor construction budget for outpatient improvements.

Our request includes $127.5 million for Veterans Health Administration projects that emphasize the conversion of acute care beds to nursing home beds and improvement to infrastructure, outpatient and other clinical areas. Also included is $9.5 million for National Cemetery System projects designed to alter, extend or improve existing national cemeteries.

Non-Recurring Maintenance and Repair

A total of $283.5 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, 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 newly defined requirements to control the potential spread of tuberculosis.

GENERAL OPERATING EXPENSES

A total of $847.2 million is requested for the General Operating Expenses (GOE) appropriation in 1995. This funding level, combined with the $132.2 million of administrative costs associated with VA's credit programs (funded in the loan program account per Credit Reform provisions), and $25.8 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), together with other reimbursable authority, will provide $1.085 billion to support operations funded in the GOE account.

Veterans Benefits Administration

The 1995 budget request for the Veterans Benefits Administration (VBA) is $629.5 million with an average employment level of 13,203. This request, combined with $126.9 million associated with Credit Reform and funded in the loan program accounts, will result in an increase of $22.7 million over the 1994 level. Average employment will decrease by 622 from the 1994 current estimate, although 464 of this FTE reduction is due to expected decreasing workload associated with provisions of OBRA.

The adjudication backlog remains one of the foremost concerns in VBA. Direct funded FTE has been maintained at the 1994 level in this budget for the C&P program. The employment reduction reflected in these activities is due solely to the reduced workload associated with the OBRA cost-savings provisions. Claims completed will decline due to the increased complexity of original claims filed and the many mandates of the Court of Veterans Appeals. However, in 1995 the C&P programs will utilize recommendations of the Blue Ribbon Panel on Claims Processing to address problems related to the adjudication process. In addition, emphasis will be placed on reengineering adjudication divisions and implementing time-saving ADP Modernization initiatives in order to provide more timely service to our veterans.

This budget also includes $25.5 million for award of Stage three modernization which will result in the acquisition of equipment and systems to support centralized applications and data exchange with VA organizations and other government agencies. A primary goal of VBA's Modernization effort is to clarify and maintain the alignment of information systems to VBA's business goals and work procedures. To achieve this goal, VBA is using business-oriented information engineering principles to thoroughly review the delivery of benefits. The Compensation and Pensions program will be the first to transition to the new model of business and ADP integration. As the first benefit program to be redesigned, C&P will provide the foundation for further redesign efforts, including the initiation of a veteran-centered, integrated database.

General Administration

The General Administration 1995 request of $217.7 million and 2,975 FTE is a $1.2 million and 75 FTE reduction from the 1994 level. This activity provides support for VA's mission. It 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.

Judicial Review

VA faces an enormous challenge in its management of changes resulting from the Court of Veterans Appeals decisions. Legislation is currently under consideration that would allow one-member decisions by the Board of Veterans' Appeals in an effort to reduce the Board's backlog. This legislation would increase the Board's appeals decided by 27 percent.

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 $5.3 million for this initiative.

Performance Measurement

VA is actively involved in the implementation of the Government Performance and Results Act of 1993. The Department submitted three pilot project proposals to OMB relative to the development of annual performance plans and performance reports during the 1994-1996 time frame. These pilot proposals cover our loan guaranty program, New York Regional Office, and national cemetery operations. VA is also pursuing the identification and development of selected performance measures that will be used to enhance our budget submissions for 1996 and beyond. This is part of our larger effort to link more directly VA's strategic planning, performance measurement and budgeting activities. During 1995, we will continue to expand our corporate performance measurement system in order to give field and Central Office representatives easy and quick access to a wide variety of information on the performance of our various program operations.

Prospectus Project

The General Services Administration (GSA) has announced plans to initiate a "prospectus" renovation of the Lafayette Building in Washington, DC, which houses many VA headquarters elements. The project will replace building systems such as heating and air conditioning, electrical, fire and safety. Plans also call for the abatement of any asbestos that is encountered. Construction funding will be provided by GSA, and the financial responsibility for space planning lies with VA. The Central Office renovation project is on schedule with employees already returning to the renovated building.

National Cemetery System

A total of $72.7 million and 1,340 FTE are requested in 1995 for the National Cemetery System. This represents an increase of $2,156,000 and 25 FTE over the 1994 current estimate. The budget request provides resources for the interment of an estimated 73,000 veterans and their dependents. Construction will begin on a new cemetery in Seattle, Washington. NCS will continue to make progress with the Burial Operation Support System (BOSS) and other automated record keeping and management information systems. BOSS will be integrated with other data systems, including VBA systems, to provide VA offices with timely death notifications. We will also upgrade the Automated Monument Application System (AMAS) used to process over 300,000 applications each year for headstones and markers.

Office of Inspector General

The Office of Inspector General (IG) requests $32.6 million and 409 FTE in 1995. This is an increase of $1.2 million and a decrease of 4 FTE below the current estimate for 1994. Funds requested will provide for continuing audits of financial statements and continued focus on high pay-off areas that are most vulnerable to fraud, waste and inefficiency. We note that the requested FTE level is eight below the current statutory floor for the IG. However, legislation in support of the National Performance Review (H.R. 3400) includes a provision that removes the floor from the IG's authorizing statute.

Health Care Investment Fund

In addition to the appropriation requests for 1995 in our health care programs, the President's Health Security Act will provide VA with $1 billion in new spending through the Veterans Health Care Investment Fund. This investment will continue through 1997 and will total $3.3 billion over three years. The Investment Fund will help ensure that VA can compete effectively under health care reform. Specifically, in 1995 we have already begun planning to fund eight ambulatory care projects to improve access and provide much needed ambulatory care capacity from the Investment Fund. The projects will be located in Bay Pines, Florida; Boston, Massachusetts; Brevard County, Florida; Columbia, Missouri; Gainesville, Florida; Hampton, Virginia; San Juan, Puerto Rico; and West Haven, Connecticut. These projects represent initial use of the Investment Fund resources. Other uses of the Investment Fund will be determined as we continue to evaluate our needs in reaching the goal of competing effectively under health care reform.

CLOSING

Mr. Chairman, the challenges before us are great but so too is our commitment to ensuring the best possible service to our Nation's veterans. While our resources are limited, I believe that by continuing our efforts to meet the most immediate needs of our veterans we can provide compassionate, quality health care and efficient benefits delivery. I know we all agree that we owe our veterans nothing less. 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 PRESTON M. TAYLOR, JR.
ASSISTANT SECRETARY FOR
VETERANS EMPLOYMENT AND TRAINING
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

FEBRUARY 10, 1994

Mr. Chairman and Members of the Committee:

It is with great honor and appreciation that I appear before you as Assistant Secretary for Veterans' Employment and Training to present the Fiscal Year 1995 Department of Labor budget as it pertains to veterans' employment and training programs.

On this first opportunity for me to testify before you regarding VETS' budget, I would like to preface my remarks by providing a brief statement of my vision for this agency, followed by a sampling of the agency's recent accomplishments that I have learned more about during the two months I have served as Assistant Secretary. It has become clear to me that VETS has not done enough in the past to make those interested in veterans aware of the outstanding work that this agency does on behalf of veterans. I believe a brief listing of some of VETS' recent successes will provide compelling support for the presentation of VETS' FY 1995 budget request which I will provide today.

First, please allow me to explain my vision for VETS. I want VETS to be recognized as a "world class" organization ensuring employment and training services to our veterans. The agency must keep pace with the demands and rewards of putting the customer--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 its employees. The emphasis within the agency is on total quality management (TQM) and the teamwork principles underlying this philosophy.

During FY 1993, VETS achieved many significant accomplishments that will have a continuing impact both on the agency's operations and on the veterans being served.

- **1.8 million**[1] veterans registered with State disabled veterans outreach program specialists (DVOPs) and local veterans' employment representatives (LVERs), and **561,587**[2] veterans were helped into jobs through VETS funded staff and State Employment Security Agencies (SESAs).
- **145,092** military men and women and their spouses were trained at **3,424** Transition Assistance Program (TAP) workshops on how to find employment in the civilian labor force.[3]
- **8,415** homeless veterans are being assisted by the VETS Homeless Veterans Reintegration Project (HVRP) and its **32** grants, with over **3,800** expected to find jobs.[4]
- Over **5,800** service-connected, Vietnam-era or recently separated veterans will have received training under Job Training Partnership Act Title IV-C (JTPA IV-C) grants, with over **3,900** of these veterans expected to be placed in jobs upon completion of their training.[5]
- Over **3,500** State employment service agency staff, Department of Labor (DOL) staff, and Department of Veterans' Affairs (DVA) staff were trained in the implementation procedures for the new Service Members Occupational Conversion and Training Act (SMOCTA) program, through "train-the-trainer" instruction developed by VETS through the National Veterans' Training Institute (NVTI) over a period of less than 90 days. Enacted in FY 1992, with implementation in the 4th quarter of FY 1993 and ending in FY 1996, the SMOCTA program develops on-the-job training agreements between unemployed

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[1] Source: Program Year (PY) 1992 VETS 200 report.

[2] Source: National summary, PY 1992 ETA 9002 report, produced by the Employment and Training Administration.

[3] Source: Monthly reports filed by VETS field staff.

[4] Source: Grant award data compiled for grants awarded during the period.

[5] Source: VETS tracking data base, from grant awards for Program Year 1992.

veterans and employers, focusing on job development in stable and/or growth industries.[6]

- **2,206** veterans' service providers were trained at NVTI. A new initiative was the NVTI training of **110** Native American veterans' service providers, representing **70** different tribes and **23** States, to provide training and employment services to Native American veterans.[7]
- **1,560** Veterans' Reemployment Rights (VRR) cases were closed, with **$332,700** having been recovered for claimants through litigation and **$810,000** having been recovered through VETS' compliance activity.[8]
- Long-range planning was completed during FY 1993 by VETS' Automation Steering Committee to improve VETS' automation systems capacity over the next five years. Plans developed should increase both staff productivity and the efficiency of intra-agency communications and data transmission. During FY 1993 VETS also completed acquisition of new equipment and software for every State and Regional Office, as well as for the National Office, positioning VETS to participate fully in the new Information Resource Management environment being developed by the Department. The agency also entered into an agreement with the Employment and Training Administration (ETA) to participate in their development and testing of a wide area network.

FY 1994 has also produced numerous highlights in VETS' operations.

- During FY 1994, VETS is streamlining its Job Training Partnership Act Title IV, Part C (JTPA IV-C) grants process through recommendations developed by an internal ad hoc committee, including elimination of the

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[6] Source: NVTI data base.

[7] Source: NVTI data base.

[8] Source: VETS field staff reports via VETS Quarterly Reporting System.

existing regulations and the phasing in over the next several years of a revamped process to administer fewer, larger-valued grants over multi-year grant periods (subject to satisfactory annual performance by the grantees). The improved operational efficiency of these plans is one example of how VETS plans to cope effectively with the impact of staffing level reductions while also maintaining and improving direct client services.

- Also in progress during FY 1994 are three other VETS projects designed to reach specific agency goals. Three separate ad hoc committees within VETS are involved in planning fundamental changes in the DVOP/LVER programs; conducting customer satisfaction surveys and increasing employer participation in VETS programs; and reviewing and changing as appropriate VETS' internal operations and organizational structures. These far-reaching projects are designed to change and improve significantly both VETS' delivery of services through its delivery systems and the operations of the agency itself.

  The potential impact of the agency's ad hoc committees' work is illustrated by the Loaned Executive Program (LEP) currently under development by the committee responsible for increasing employer participation in VETS' programs. This initiative will provide for a loaned executive from the business community to work with VETS as an advocate and spokesperson for job-ready veterans. With public relations and marketing efforts, as well as the executive's established business network, the loaned executive will enhance VETS' efforts to enlist the support of employers and employer groups nationwide to promote the hiring and training of veterans--marketing the advantages of employing veterans to improve and

increase veteran employment opportunities. The individual will represent VETS in advocating the employment of veterans to the business community, identifying ways to raise employer awareness of the skills and attributes of veterans and helping to dispel any negative misconceptions about veterans. In addition to marketing veterans, the loaned executive will enhance VETS' understanding of employers' needs, wants, and concerns (e.g. skill needs). The LEP initiative will enhance VETS' ability to develop a national policy to meet employer needs while promoting the labor market competitiveness of veterans.

- Over 25,500 veterans have applied for SMOCTA services since the August 1, 1993 implementation date. Through January 28, 1994, 1,352 veterans have been matched with employers to pursue SMOCTA on-the-job training programs. VETS and its State DVOP and LVER staff have continued to assist the Department of Veterans' Affairs in the implementation of the SMOCTA program.
- VETS is in the process of developing training through NVTI for SESA and VETS' staff in case management, and in the successful management and oversight of the case management process. Case management enables the DVOPs and LVERs providing veterans with direct employment and training services to facilitate effectively the development and achievement of the veterans' employment goals. The two case management training courses being developed will improve skills in this function, which is so critical to effective client service in SMOCTA and other VETS programs. NVTI will begin delivery of the case management training curricula in April 1994.
- VETS' total quality management (TQM) program will begin in FY 1994 with the identification of the initial functional component(s) to be targeted. TQM will then be implemented in a vertical manner, i.e., throughout

the agency's entire hierarchy for the identified component(s). Appropriate training will be a prerequisite for those involved in this initial phase (and all later phases) of VETS' TQM program.

- Improvements in VRR case processing procedures have been developed by another VETS ad hoc committee in FY 1994. These procedures include provisions to increase the quality of investigation in VRR cases while continuing to emphasize timely case resolution.
- A second generation of VETS' Automated Reporting System (VARS) is being implemented in FY 1994. This will include elimination of duplicate reporting by manual (hard copy) methods for all essential information reported by VARS. VETS has also established the Computer Support Team (CST), consisting of front-line VETS employees in each VETS region who receive hands-on "train-the-trainer" training before implementation of each new VARS module. In this training, each CST member will receive copies of the training materials that the member will need to be able to pass on this VARS training to computer users within their region. The CST will also become a training resource for each region to provide all its VETS staff computer/automation training in off-the-shelf software applications, with additional extensive training to be made available to VETS staff from NVTI and other qualified training vendors to meet their individual needs.
- A comprehensive assessment of the types of training needed by VETS and SESA staff will be completed during FY 1994 under the direction of VETS' Training Needs Assessment Committee. This needs assessment will focus on the training needs of specific audiences within NVTI's training universe by defining the knowledge, skills, and abilities (KSAs) for each training group, followed

by delineation of specific training needs for each group relevant to one or more of the group's KSAs. The results of this needs assessment, the first undertaken since 1988, will be used both to facilitate decision-making regarding new NVTI course(s) to be developed and to provide guidance in the development of VETS' Annual Training Plan for NVTI courses to be delivered in FY 1994.

- The agency has signed a Memorandum of Agreement with the Department of Defense to help identify and assist military personnel separating to pursue a teaching career, targeted to low income schools. A grant will fund a pilot program to connect military personnel with teacher certification training options and assist with placement in low income schools. The agreement is in support of the "Troops to Teachers program."
- VETS is in the process of implementing the requirement which establishes the Advisory Committee on Veterans' Employment and Training (38 U.S.C. Section 4110). The agency's current plans call for the Advisory Committee to meet before the end of FY 1994.

For FY 1995 VETS is requesting a total of $190.276 million to fund 272 Federal positions and 3,167 State positions by the end of that fiscal year. This amount is comprised of $165.795 million for grants-to-States, $21.495 million for administration, and $2.986 million for the National Veterans' Training Institute. This budget includes a 2.1% increase over the FY 1994 funding levels for grants-to-States, a 0.7% increase in administration funding, and a 2% increase in NVTI funding.

Services to veterans by the front-line providers in VETS' delivery system--tne DVOPs and LVERs--will continue to include all legislatively prescribed services in FY 1995, with priority to be given to special disabled and other disabled veterans. State DVOP staff will continue to provide outreach and other legislatively prescribed services to veterans. LVER staff will

continue to monitor the provision of priority services to veterans by all State Employment Service staff and will promote veterans' participation in Federally-funded programs. The DVOP/LVER grants, JTPA IV-C grants, and VRR programs will be maintained at funding levels sufficient to support their integrity and to enable VETS' staff to perform critical functions, including conducting on-site local Employment Service office evaluations and follow-up reviews, opening and resolving VRR cases, conducting JTPA IV-C grant reviews, and processing grant applications and modifications.

Other areas of emphasis in VETS' FY 1995 budget request include an increase in responsibility for the DVOPs and LVERs in presenting Transition Assistance Program (TAP) workshops. Budgetary constraints required VETS to look at ways of providing TAP services more efficiently. The population to be served is relatively stable (an estimated 300,000 separatees worldwide in FY 1995 as compared with the FY 1994 estimate of 317,000). Now that TAP is fully integrated into the organization, fewer oversight and monitoring visits and fewer workshop facilitator training classes at NVTI will be necessary. To reduce the costs of hired workshop facilitators, DVOP/LVER staff will assume greater responsibility for presentation/facilitation of TAP workshops, making DVOP/LVER staffing levels a critical factor. Despite the budgetary constraints, VETS' efforts to improve efficiency will mean that only a small reduction in TAP coverage is expected (from 46 percent of separatees in FY 1994 to 43 percent in FY 1995).

It is tentatively planned that VETS' reduced staffing level for FY 1995 (272 FTE positions, or four fewer than in FY 1994 and 13 fewer than in FY 1993) will be accommodated through elimination of all ten (10) of VETS' assistant regional administrator (ARA) positions, along with reductions from other field staff and from among National Office staff over the FY 1994-1995 period. The elimination of ARA positions, two of which are presently vacant, will preserve essential front-line

positions in the field, including all those statutorily required. To ameliorate the impact of these Field and National Office reductions, the agency will enhance its management information systems for Veterans' Reemployment Rights cases, grants management, and quarterly reporting, and will achieve efficiencies through cross-training and expanded utilization of remaining staff.

The nature and scope of all FTE reductions in the Field Offices and the National Office will be specifically determined through the deliberations of VETS' FY 1994 ad hoc committees, currently engaged in planning VETS' organizational restructuring as part of their work on the agency's FY 1994 goals.

The case management approach to services has been identified as a key operational cornerstone in the agency's efforts to improve service delivery in its programs. I therefore believe that the establishment of standard case management procedures and the delivery of comprehensive case management training for LVER and DVOP staff through NVTI, as quickly as possible, will be of utmost importance in FY 1995.

NVTI's other FY 1995 training priorities will be determined through the comprehensive needs assessment project to be completed during FY 1994. This will help VETS prioritize its training efforts over the next several years in order to determine both new course offerings and needed revisions to existing courses. Development of at least two new training courses is anticipated as a result of this comprehensive needs assessment.

FY 1995 will be the third year of implementation of the Service Members' Occupational Conversion and Training Act (SMOCTA) program. The LVERs and DVOPs will provide participating veterans with case management services and will be helping to develop on-the-job training agreements between eligible veterans and prospective employers.

VETS' current efforts to reinvent the JTPA IV-C grants process include plans to eliminate the present IV-C regulations,

which will allow flexibility throughout FY 1995 and thereafter in serving the statutory groups through appropriate multi-year service delivery strategies. It is also expected that Program Year (PY) 1995 IV-C funds will be competitively awarded, resulting in 12-16 grants nationwide. This is a departure from awarding grants to States by formula and is expected to result in a more cost effective program.

The Homeless Veterans Reintegration Project (HVRP) will serve approximately **8,500** homeless veterans in FY 1995, resulting in about **4,200** placements in unsubsidized jobs. A competition for HVRP funds is expected to result in approximately **24** urban and **6** rural projects being funded at a level of $5.055 million. These projects provide homeless veterans comprehensive services, linkages with other service providers, and placement assistance. Grantees also have the option of replicating a StandDown event in their area with assistance from the grant.

Mr. Chairman, I appreciate the opportunity to begin discussion of change within the Veterans' Employment and Training Service. I look forward to working closely with the Committee, as has already been occurring at the staff levels on several recent occasions with respect to our reinvention efforts and the NPR recommendations. I now will be pleased to answer any questions you might have. Thank you.

SERVING WITH PRIDE

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INDEPENDENT BUDGET

Mr. Chairman, AMVETS would like to thank you for requesting our views on VA's budgetary needs. And once again, we are pleased to cosponsor the Independent Budget for the Department of Veterans Affairs with the Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars.

This is the eighth year the veterans service organizations have presented the Independent Budget to Congress as our assessment of what VA needs to accomplish its mission. We were asked to comment on the administration's request, but unfortunately, we must limit those comments because of the very short time between its submission and this hearing.

As in the past, each VSO has contributed a major section of the Independent Budget. DAV develops the GOE and Benefits section of the Independent Budget, while PVA authors the Medical Programs section which addresses the VA medical care system, its research program and other medical accounts. VFW builds the Construction Programs section and AMVETS develops recommendations for the National Cemetery System section. Each organization comment on its section.

Perhaps the most pressing issue in VA's future is the initial employee reductions being made to meet VA's share of the National Performance Review goals. Over the next five years, the administration proposes to cut nearly 27,000

employees from VA's payroll. At a time when VA must transition from a government-funded healthcare provider (and all its attendant baggage), VA must now accomplish a radical shift in culture and operating practices to compete for veterans' healthcare dollars. To downsize the workforce and at the same time remake VA in the image of a private sector provider may be asking too much - despite all good intentions of VA management.

To ensure adequate medical care, AMVETS national resolutions call for a separate appropriations committee dedicated solely to VA funding matters. Next, AMVETS calls for funding VA medical care benefits from mandatory spending accounts. We realize that enlarging entitlement spending is not popular politically, but it is illogical to provide an entitlement, and fund the staff that delivers those benefits from discretionary accounts.

We also call for improvement of substance abuse and PTSD treatment as well as improvement of adult day care and Alzheimer's disease programs. The veterans of the Persian Gulf War and their families are suffering from a yet-poorly-understood syndrome and VA must get to the root causes regardless of origin. We thank this committee for the efforts you have made on their behalf. Finally, we call for extension of VA care to veterans exposed to foreign nuclear tests.

To accomplish these goals, as well as those enumerated in the legislative portion of the Independent Budget, we fully support funding VA medical care in the amount of $20.1 billion. That is $3.7 billion above the level requested by the president.

As with medical care, it does not make sense to fund entitlement programs administered by the Veterans Benefits Administration from non-mandatory spending accounts. We fully support restoration of burial and plot allowances to their pre-OBRA 90 levels and instituting regular increases to account for inflation. To accomplish these and other legislative provisions contained in the Independent Budget, AMVETS fully supports $19.5 billion for VBA programs. The president has requested $19.5 billion. Construction is always a popular topic on the Hill. This year the Independent Budget calls for $933 million to replace or modernize VA facilities that no longer conform to safety or community standards. We note the emphasis on renovation vice new construction. It is time to admit that of all the resources available to VA, the least important - in terms of veterans health care - is the physical plant. VA must stop thinking of itself as a collection of buildings, and while doctors and nurses and patients need safe, modern facilities to conduct their business, there is no magic in ownership. AMVETS is convinced that continuing to

define VA medical care in terms of maintaining and enlarging its current inventory of medical centers will only cripple VA's ability to survive.

As an example of the direction VA must move to make itself more available to veterans, we applaud VA's recent initiative in northeastern Texas to provide healthcare at contracted outpatient facilities now affiliated with VAMC Amarillo. If VA must become more grassroots-oriented to survive - and it must - AMVETS urges Congress to provide - even mandate - a greatly increased reliance on a network of local providers. Accomplishing that, VA will be able to improve and expand its core business of the very special medical treatment they do so well.

The National Cemetery System

The National Cemetery System has its origins in the Civil War when President Lincoln signed legislation formally establishing national cemeteries for "soldiers who die in the service of the country." Initially, the government established cemeteries in areas that were the sites of significant Civil War battles, such as Antietam, Maryland, or near large military bases, hospitals, or POW camps such as Keokuk, Iowa.

Over the years, Congress increased the eligibility for burial in national cemeteries, and various government agencies had the responsibility of caring for the growing number of cemeteries established to accommodate veterans of subsequent conflicts. In 1920, Congress passed legislation that entitled all who died in the service at any time to free burial in a national cemetery. Shortly after World War II, Congress set the general eligibility rules entitling those who died in service, those who received an honorable discharge as well as the widows, widowers or minor children of an entitled veteran to burial in a national cemetery. In 1993, Congress extended the benefit to members of the National Guard and Reserves who were eligible for retirement benefits.

From the first 12 sites established in 1862, the Department of Veterans Affairs system has grown to a network of 114 cemeteries and 34 soldiers plots and memorial areas. Other cemeteries, such as Arlington National Cemetery and Gettysburg are still the responsibility of the Army or the National Park Service.

In addition to providing burial space, VA also provides grave markers headstones, Presidential Memorial Certificates (when requested) and grants to states wishing to establish new or improve existing state veterans cemeteries.

Today, the authors of the Independent Budget view the National Cemetery System with

both pride and concern - pride in the historically fine job VA has done to maintain the system as national shrines; concern about the future of the system. Our concern can be described in two phrases - static (at best) resources, and peaking demand.

Of the 114 cemeteries, only 59 remain open to initial casket burial. The remaining 55 are either closed to all burials or open only to cremations and second family member casket interments. Today VA maintains nearly 2.1 million graves plus another 150,000 cremains/columbaria on 10,000 acres of cemetery space split evenly between developed and undeveloped land. There are currently about 273,000 available casket, cremain-in-ground and columbaria gravesites available on developed land and VA estimates room for another 1.7 million gravesites in its undeveloped property.

The IBVSO's see several issues facing the National Cemetery System. First, the continued underfunding of NCS programs has not allowed NCS to expand its system to provide sufficient national cemeteries within reasonable commuting distance to most veterans. Underfunding may well have created a suppressed demand for benefits that could overtax the system's ability to respond in a timely fashion. Annual appropriations have remained nearly constant and the system cannot continue to absorb the negative effects of flat funding and increased demand without degrading the level of service and the high standards to which national cemeteries must be maintained.

Second, VA will need more space and a better distribution of facilities. It is evident the location of the cemeteries projected to be open after the year 2000 will not provide a burial site that is reasonably convenient to many veterans and their families. OMB has shelved VA's previous policy of developing new sites to achieve an open cemetery within 75 miles of 75% of veterans, but has decided to allow VA to pursue planning for new cemeteries around Albany, Cleveland, Chicago and Dallas. Since it now takes 10 years to plan, build and open a new cemetery, VA faces an uphill battle to meet the approaching peak demand and must immediately pursue appropriations for any new sites. As pointed out earlier, VA now has space for less than 2 million veterans in all the developed and undeveloped space it now owns. VA statistics show the median age of all veterans to be nearly 56 years with the World War II population now in its 70's. The next large veteran population bulge - the Vietnam era veteran - is reaching the mid-forties. Consequently, the total number of veterans 65 and older will peak at over 9 million in 1999 and again in 2015 at over 8.6 million. Historically, about 10% of veterans opt for burial in a national cemetery and spouses usually choose interment with the veteran. With the recent addition of a large number of new beneficianes as a result of the entitlement of National Guard and Reserve retirees, it is clear VA will face a sharp

increase in demand for burial benefits over the next several years.

A related issue is the improvement of the VA grant program to state veterans cemeteries. While our strong support for this highly cost-effective program does not imply support for shifting the responsibility from the federal government to the states, the IBVSO's recognize and appreciate states' willingness to recognize their veterans.

Third, VA faces a serious equipment backlog. NCS currently has over $6 million in old equipment - over 50% of which was 5 years beyond replacement age in 1990. With looming FTEE cuts, modern equipment is absolutely necessary to provide timely interments and maintain cemetery grounds in an appropriate manner.

Fourth, NCS' infrastructure is badly in need of maintenance. Recent extreme weather and natural disasters in many parts of the country has caused unanticipated damage to many cemeteries that create funding requirements beyond the normal maintenance cycle.

In addition to a hundred miles of aging roads in need of upkeep, many of cemetery system buildings are on historic registers, which prevent these structures from being razed despite being in a rundown - and sometimes dangerous - condition. While the IBVSO's support preservation of historic landmarks whenever possible, such maintenance and rehabilitation must not come at the expense of keeping burial grounds in top condition and timely service. Congress must give serious attention to funding NCS for renovation of its historic buildings or provide relief from statutory historic preservation requirements.

Fifth, the growth of the workload cannot be allowed to outpace resources. As a result of chronic underfunding, the effect of flat funding rates have been difficult in terms of cemetery workload vs. cemetery employees. The authors of the IB estimate a 250 FTEE shortfall for NCS. We urge Congress and the administration to resist the urge to shift equipment funds to personnel accounts to make up the deficit. Rather, it is incumbent upon Congress and the administration to adequately fund both accounts. This year we recommend an additional 90 FTEE as an incremental increase towards filling personnel requirements.

Finally, the IBVSO's recommend accelerated deployment of the Burial Operations Support System (BOSS). This system will allow cemetery directors to keep up-to-date information on operations and automate authorization of burial benefits. It will also help ease the FTEE shortage at field sites.

There are now over 2 million veterans and their family members interred in VA's national cemetery system. To ensure proper maintenance and the park-like beauty of these national shrines and timely response to request for burial benefits, the IBVSO's recommend a total budget of $81 million and 1405 FTEE. While this is an increase over last year's appropriation, in terms of actual dollars, it is a small price to retain the highest quality service to those veterans receiving the nation's final symbol of gratitude.

Recommendations:

- Accelerate planning and construction of new cemeteries;
- Fully fund FTEE requirements;
- Eliminate equipment backlog;
- Resolve the repair/demolition dilemma for historic buildings;

Mr. Chairman, once again, AMVETS would like to thank you and the members of this committee for the interest all of you take in veterans programs. We at this table are honored to represent all veterans, not just those on our membership rolls, and we take pride in the title veteran - a title acquired not by accident of birth, but by honorable service in war and peace. That completes our testimony.

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 '95 DEPARTMENT OF VETERANS AFFAIRS BUDGET

WASHINGTON, D.C. FEBRUARY 10, 1994

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

The VFW is appreciative for being invited to participate in this morning's hearing on the Department of Veterans Affairs Fiscal Year 1995 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, and the likelihood that some form of national health care will be implemented, we are particularly concerned that VA have physical capabilities of providing care to an expanded veteran population and be competitive with respect to a national health care program.

Meeting The Challenge

The VA construction program was re-organized in FY 1994 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 $3.8 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 timeline 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.

A policy memorandum is awaiting approval to delegate authority to facility directors to lease up to 10,000 square feet of space, at up to $300,000 cost, to meet outpatient clinic needs. Should the Secretary grant such authority, facility directors will have more control in meeting their patients needs for accessible ambulatory care, better positioning facilities to compete as health care reform is implemented.

Additional Management Improvements Needed

The National Institute of Building Sciences (NIBS) carried out 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 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.

The Dilemma of FY '95

Perhaps the most difficult problem facing CM is the coordination of mission and program planning for facilities and the Facility Development Program (FDP). IBVSOs continue to believe the FDP program should be discontinued until the VA National Health Care Plan is

adopted and specific missions and types of facilities within the VA system's health plans are determined. VA and Congress are likely to commit to an inappropriate structure from plans based on the present delivery system and mission if the current FDP remains in place. For example, a hospital authorized in FY 1995 may not be activated until 2001 or 2002. This is likely to result in a hospital with too many beds and support services. The U.S. already has too many hospitals and too many beds. VA should not compound the problem.

If VHA is to be competitive in health care reform, it must practice acute and some extended care medicine as the private sector does—substituting more appropriate care in community and ambulatory care settings for inpatient care. The *Independent Budget* co-authors believe VHA needs to begin extensive primary care outreach through more remote and satellite clinics in this fiscal year and in FY 1995. In the short-run, clinic activities must move closer to patients and potential patients. In keeping with the government's "one stop service" concept the IBVSOs believe some primary care clinics should be sited contiguous to or within veterans outreach centers (or "vet" centers). Expanding leasing authority is an essential, immediate need to allow VHA to reconfigure its delivery system expeditiously. In certain situations with smaller veteran user populations far from VA facilities, VA hospital directors should be granted authority to contract with private sector providers.

The present outreach and community clinic criteria in VA's facility sizing model need to be reviewed to determine if distance and travel time from home to care site are too great. The VA's two hour driving time criterion is not competitive with the 30 minute criterion established in other proposals. Ultimately, enactment of legislation for both national health care reform and VA eligibility expansions will facilitate a more realistic approach to setting priorities for future construction projects for the system.

VA should also revise its planning models and guidelines to account for veteran demographics. Current and future populations' needs should determine system priorities and the allocation of construction resources. Added emphasis should be given for 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 population is declining, the strategic and facility development plans must include alternatives to provide needed care in different settings or organizations. The IBVSOs recommend revisions to strategic planning models and FDPs be started now, and completed as soon after legislative decisions on health care reform are accomplished.

FY '95 Budget

The IBVSOs are aware that the Administration has proposed a five year "appropriated" construction budget plan with annual targets of, on average, $165 million per year for major construction starting with FY 1995 and ending with FY 1999; the plan proposes average targets for VA Major Construction to be $175 million per year after FY 1997. Minor construction appropriations will average $154 million per year over the same time period.

The Administration plans to use money from the investment fund, a fund proposed by the *American Health Security Act*, to supplement resources for construction projects needed to improve the infrastructure. Because the legislation which contains the investment fund has yet to be enacted, the IBVSOs consider assurance of receiving it to rest on a tenuous base. As in the case of the ill-fated Economic Stimulus Package, desperately needed correction of infrastructure deficiencies is held hostage to an uncertain date. Because VA has committed its limited construction funds to building or replacing hospitals, if funds are not made available from the investment fund, it will not be until FY 1998 that construction funds are available for outpatient, infrastructure improvements and other needs. The IBVSOs consider the high priority of new hospital construction and replacement problematic. It prevents resources from moving to primary care and its support at a most crucial time. Emphasis on primary care, remodeling hospital beds to nursing home care and correction of infrastructure should be the highest priorities and projects should be funded immediately. Unless this happens, VHA cannot effectively compete in any kind of health care reform. VA's need for enhanced outpatient and extended care facilities and improvements in infrastructure far outweigh the need for additional hospital beds.

If VA decides that there is a significant need for new hospital beds, it should consider different alternatives to new construction to create them. Existing VA hospitals have empty and unused beds which could be activated—a least one hospital has yet to be activated in the VA system; acquisition and conversion of closed military facilities, like Orlando, is possible and far less costly than ground-up construction; and, leasing beds from underutilized facilities in the military system or the private-sector may allow VA to make beds available to veterans on a much speedier timeline than they are now activated. These options for increasing inpatient capacity should be carefully considered before major construction projects resulting in additional hospital beds are undertaken.

The Administration also plans to designate funds from the investment fund — if and

when the it becomes available — for infrastructure needs such as patient privatization, including private and semi-private bathrooms. The IBVSOs believe this is commendable, but population need and facility mission must determine priorities for system remodeling. VA should allow flexibility in determining the needs of individual VA medical centers and service areas.

Independent Budget Funding Recommendations for FY 1995

Major Construction

The *Independent Budget* recommends a $294-million Major Construction appropriation for FY 1995. To achieve less funding in FY 1995 would be catastrophic given the extended replacement cycle for facilities, rapidly changing clinical requirements, and the existing plant's excessive age. The majority of the *Independent Budget* recommended appropriation is for leases for outpatient clinics and nursing homes. In these uncertain times, the *Independent Budget* co-authors believe leasing is preferable to new construction. Leasing offers an affordable, expedient and non-permanent 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 twelve nursing homes, approximately $12-million. It also accommodates annual leasing costs for approximately 100 outpatient clinics at approximately $100-million. Funding for leased clinics complements *Independent Budget* recommendations for grants to VA medical centers in states with active reform schedules which offer alternatives for enhancing ambulatory care capacity; plans to expand VA in-house capacity; and plans to 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. Orlando and other facilities available for acquisition offer VA an opportunity to realize substantial savings and activate beds more quickly than a "ground-up" construction project would. Should VA acquire Orlando funds will be needed to make it handicap accessible and improve infrastructure. The IBVSOs recommend that other selected replacement and modernization projects that provide natural hazard mitigation and modernize and upgrade the physical plant be dictated by an established set of priorities based on probable competition under health care reform plans impacting facilities and mission conversions for facilities in new veterans service areas.

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. Indeed, the aging veteran population necessitates nursing home construction through the 1990s. The *Independent Budget* 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 veterans 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. In the immediate future, VA must enter into 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 proposal also includes $16-million to acquire land for national cemeteries in states that have no available grave sites. 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 1995 *Independent Budget* recommends a $412-million appropriation for Minor Construction, which funds smaller facility construction projects. As Table 1 shows, the *Independent Budget's* FY 1995 recommendation significantly exceeds the FY 1994 appropriation. The requested increment reflects the IBVSOs' growing concern about VA facilities' urgent updating and repair needs. Most VA facilities were constructed during the 1950s and, therefore, update 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 as VA medical centers enter into competition with private-sector providers. Of the total Minor Construction appropriation, $300-million should be allocated to these types of projects. Also within this allocation, VA should select residential sites to purchase for compensated work therapy programs.

VA should use $80-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* co-authors emphasize conversion as the principal means of making nursing home care

available to veterans. The IBVSOs recommend that VA convert the remaining 30 beds from its FY 1993 plan, accomplish those it plans for FY 1994, and convert 25 120-bed wards in FY 1995. While this strategy represents a tremendous rate of conversion, it is the only way VA can hope to keep pace with the demands of the aging veterans' community.

IBVSOs have requested $14-million within the Minor Construction appropriation to support VA regional office projects, such as recurring maintenance projects, collocation when it improves services, and improvement of handicapped accessibility. The FY 1995 *Independent Budget* recommends $18-million for existing National Cemetery System construction projects.

Parking Garage Revolving Fund

The FY 1995 *Independent Budget* recommends a $20-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. Currently, however, only a few revenue-producing projects exist, so VA needs limited new appropriations. Future funding requirements should diminish.

Grants for the Construction of State Extended Care Facilities

The state home program adds to VA's extended care workload capacity. The Grants to State Extended Care Facilities are mutually beneficial to the states and VA. Congress should fund any State agreeing to participate in these programs.

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 1995.

Mr. Chairman, this concludes the testimony of the VFW and I will be pleased to answer any questions you may have at this time. Thank you.

STATEMENT OF
JOSEPH A. VIOLANTE
LEGISLATIVE COUNSEL
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
FEBRUARY 10, 1994

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 wish to thank you for this opportunity to present DAV's views on the Independent Budget for Veterans Affairs for Fiscal Year 1995 and President Clinton's budget.

Mr. Chairman, this is the eighth consecutive year that American veterans of World War II, Korea and Vietnam, Disabled American Veterans, Paralyzed Veterans of America and Veterans of Foreign Wars have joined forces to formulate a needs-based budget for the Department of Veterans Affairs (VA). As in prior Independent Budget's, DAV has drafted the Benefits Programs and General Operating Expense (GOE) portion of the Independent Budget.

The Independent Budget Veterans' Service Organizations (IBVSO) appreciate the recognition and praise our efforts have received from the Veterans Affairs and Appropriations Committees in the past. We once again submit the Independent Budget to the Congress for its careful consideration of our collective analysis of the funding needed to provide adequate benefits and services to our nation's veteran population. Highlights of the Independent Budget appear later in this statement.

Mr. Chairman, as you are aware, President Clinton's Fiscal Year 1995 budget for VA was submitted to Congress on February 7, 1994, the day before our written testimony was due. The information we have received thus far shows funding levels for the VA will reach $37.8 billion in FY 1995, an increase of $1.3 billion above the FY 1994 budget. While we take comfort in knowing that VA was one of only a handful of Cabinet departments to receive an increase, we must ask ourselves what this increase really means -- a below current services budget. The realities of this budget provide us with a very bleak picture of the VA's future.

President Clinton's budget calls for:

- Increasing Veterans Health Administration's (VHA) direct health care budget authority $500 million above FY 1994 while reducing employment by nearly 3,700;

- Overall spending on Veterans Benefits Administration (VBA) is increased by $21 million, however, an employment reduction of 622 employees will take place in FY 1995.

- The budget authority for Compensation, Pension and Education (CP&E) is $4 million below current appropriated level and reduces CP&E level by 342 employees below FY 1994 appropriated level;

- Employment levels in VBA Support Services will decline by 169;

- Veterans Services (VS) will lose 33 employees;

- The National Cemetery System (NCS) will have a budget authority increase of $2.2 million and an increase of 25 FTE above the FY 1994 authority;

- Vocational Rehabilitation and Counseling will lose 29 employees;

- The employment level for Loan Guarantee Services for FY 1995 will remain unchanged;

- The proposed budget for VA construction calls for spending $253 million less on construction in FY 1995; and

- Medical research has also been targeted for a $41 million decrease below the FY 1994 budget authority including the elimination of 514 research projects and the loss of 830 employees.

Additionally, the President's proposal includes three legislative proposals with budgeting impact:

- Cost-of-living (COLA) increase of 3.0 percent, effective December 1, 1994;

- Administrative allowance authority for BVA Chairman or Vice Chairman; and

- Payments to GOE from Insurance administrative costs.

Mr. Chairman, a revealing chart, compiled by the Congressional Research Service (CRS) and entitled "Federal Outlays for Social Welfare Programs," displayed federal outlays in constant 1992 dollars for six major categories of domestic spending over the past 27 years. It is interesting to note that while the VA budget made up only 15.6 percent of the total outlay for social welfare programs in 1965, **in FY 1992 it dropped to 4.4 percent, the lowest of all six programs.** In FY 1998, it is estimated that VA will drop a whole percentage point to 3.4 percent of the total outlays. In dollars, this equates to a budget of $24.5 billion in FY 1965, $34.1 billion in FY 1992, and the estimated figure for FY 1998 is $33.6 billion. Total outlays for all social welfare programs during FY 1965 were $256.7 billion, in FY 1992 it was $772.4 billion and, in FY 1998, it is estimated that it will be $995.2 billion. **Simply stated, while total spending on all social welfare programs will increase by nearly $145 billion between 1994 and 1998, VA appropriations will decline by $2.5 billion.**

To us, the conclusion revealed by the chart is dramatic. During a time when expenditures for other federal programs were increasing at an extraordinary pace, **the cost of veterans' benefits was held to a virtual straight line.**

For over a quarter of a century, while meeting the needs of aging veterans from World War I, World War II and Korea, and new veterans coming out of Vietnam -- our country's longest and most costly war -- and the military campaigns in Lebanon, Granada, Panama and the Persian Gulf, the VA and all of its programs were continually required to do more with less. Certainly by comparison, federal expenditures for veterans cannot be viewed as anything but a model of fiscal restraint.

Mr. Chairman, in underscoring the fact that veterans' programs have not fueled our deficit problems, my purpose is not to introduce a basis for claiming "sacred-cow" status, even though advocates for other federal beneficiaries have done so with, in our opinion, far less justification. But I do wish to

emphasize our view that VA expenditures are not included among those entitlements at the root of the deficit.

In the past, the attrition rate affecting the disability compensation rolls, for the most part, exceeded the number of new recipients and the compensation program was able to absorb the cost-of-living adjustment (COLA) authorized without a rise in overall program expenditures. If all other programs could make this same claim, our deficit dilemma would be significantly less. (This trend has had a recent, slight reversal due to the downsizing of the military.) Despite this fact, and notwithstanding the special claim of service-connected entitlements, the veterans of this country do expect, and they have every right to demand:

> That VA be provided with adequate resources to enable it to fulfill its mission to veterans, their families and survivors in a timely manner. Unfortunately, the current Administration's budget proposal does not provide for sufficient resources to accomplish this task. In fact, the current budget proposal is below current services levels.

For the first time in its long history, Mr. Chairman, the VA has a Secretary FOR Veterans' Affairs. Secretary Brown, a combat wounded veteran of the Vietnam War, has dedicated his adult life to ensuring that all veterans, including their dependents and survivors, obtain the benefits and services to which they were entitled. Secretary Brown knows the system and he knows the needs of this country's veterans. However, without sufficient resources, Secretary Brown will not be able to accomplish the VA's stated mission -- "to care for him who have borne the battle and for his widow, and his orphans."

We would like to recognize Secretary Brown and the VA and express our appreciation to them for their efforts with respect to ADP modernization and the innovations in the claims adjudication process that are being implemented at Regional Offices around the country. These programs will certainly help to improve the claims adjudication process; however, these innovations and ADP modernization will not make up for the thousands of employees lost over the years.

Mr. Chairman, as you know, VA's discretionary spending is frozen at FY 1993 levels for the next five years. This spending freeze, coupled with the nearly 252,000 government-wide employee cut mentioned by the Vice-President's report of the National Performance Review, quite simply, will further erode VA's ability to provide quality benefits and services. It is interesting to note what the General Accounting Office had to say with respect to the mindless across-the-board cuts proposed in this report. As quoted in the Washington Post, Friday, December 3, 1993, the GAO stated, "across-the-board reductions that do not recognize the differing capabilities of agencies to absorb such cuts could significantly exacerbate existing gaps in agencies' abilities to meet their missions."

The freeze in discretionary spending will further exacerbate the long delays in the delivery of compensation, pension, vocational rehabilitation and other VA benefits to America's veterans and their families. As pointed out in the Independent Budget, without a significant increase in the number of employees available to adjudicate veterans' benefits claims, claims backlogs will increase beyond the already unacceptable levels. Veterans who are now required to wait nearly a year for a determination on their compensation claims will wait even longer, rendering Congressionally authorized benefits meaningless and causing even more hardships for those who depend on VA compensation payments to provide for their basic daily necessities.

Currently, VBA has a 535,000 case backlog, plus an additional 25,000 claims dealing with Agent Orange. At current staffing levels, VA is predicting that the claims backlog will increase to 709,000 at the end of FY 1994 and 867,000 in FY 1995.

Mr. Chairman, last year the VA estimated that it would take approximately 1,050 additional FTE to reduce the claims backlog to 200,000 claims. Yet the President's budget calls for a reduction of 622 FTE for VBA. In addition, should the Congress reject the Administration's proposal to provide GOE with some of the administrative costs of VA's insurance program from insurance reserves, VBA will be faced with an additional loss of 546 employees, for a total of 1,168 FTE less for FY 1995 than are currently available to provide services to veterans and their families.

We believe, Mr. Chairman, that a crisis situation -- approaching a state of emergency -- currently exists in VA's Compensation and Pension Service. Drastic measures are necessary if this nation's veteran population is to receive some semblance of timely and quality benefit determinations.

Additionally, delays at the Board of Veterans' Appeals (BVA) have become unconscionable and intolerable. Currently, the average response time is 660 days. Based on the first quarter figures for FY 1994, it is predicted that the response time will increase to just under 1,700 days if no changes are made in the way appeals are processed. This would mean that a claimant would have to wait more than 4.5 years for his/her appeal to be decided by the BVA. For FY 1995, the wait increases to six years and seven months.

Mr. Chairman, it is estimated by the VA that, based on current projections, the BVA will decide only 12,000 cases in FY 1994. Considering that the present remand rate is almost 50 percent, that would mean that there will only be 6,000 final determinations.

Additionally, the BVA, as of April 30, 1994, will not be conducting any further travel hearings until the backlog is reduced. There are approximately 40,300 cases physically located at BVA. It does not take a mathematician or a Rhodes Scholar to figure out that with only 6,000 final determinations per year, the current backlog will only continue to grow at an alarming rate.

Mr. Chairman, we do not understand how anyone can justify a cut of 33 employees from Veterans Services (VS) at a time when veterans' demand for information about benefits and services are increasing.

VS's basic problem has been, and it continues to be, 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.

For example, 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 9.3 million calls received, approximately 1.3 million callers, or 12.5 percent, hung up before talking to a counselor. Abandoned calls result from insufficient telephone circuits or employees to respond to veteran's calls. Additionally, the waiting time has tripled in the last two years

from 1 minute to 3.2 minutes a caller must wait before he or she can talk to someone.

Yet, the President's budget proposal is based, not on increased demand, but on a decrease in demand for veterans' services. The workload analysis contained in the submission to Congress shows decreasing demand from the FY 1993 actual figures for FY 1994 and, more importantly, FY 1995. It is projected in FY 1995 that telephone interviews will be down 215,402 from the FY 1993 actual figures. Similar, at-office interviews are predicted to decrease more than 38,000 from actual FY 1993 figures and away-from-office interviews show a 6,500 drop. Quite frankly, we are puzzled by the estimated decline for services.

Mr. Chairman, we view the President's recommendations as neither fair nor equitable or in the best interest of our nation's sick and disabled veterans and their families.

MEDICAL CARE

Mr. Chairman, for FY 1995 the President has requested a budget of $16.122 billion to fund the Veterans Health Administration provision of direct health care services to our nation's veterans.

As we have stated earlier, Mr. Chairman, we do recognize the constraints included in discretionary spending and also recognize current budgetary pressures, and appreciate Secretary Brown's commitment to and struggle for adequate funding.

However, what is immediately apparent in this budget proposal is the immense inadequacy of funding to permit VA to provide quality and timely health care to veterans.

Mr. Chairman, the President's request represents a $500 million increase over the FY 1994 enacted level. In fact, the proposed increase for rising payroll costs for existing employees ($265 million) and the cost for inflationary factors ($288.7 million) in and of themselves amounts to $553.7 million. Immediately, VA has spent $53.7 million more than their professed budget increase.

This does not bode well for VA or, more importantly, disabled veterans seeking VA medical services.

Mr. Chairman, we recognize and applaud Secretary Brown for proposing innovative management improvements which assume significant savings and efficiencies. These include:

- Move from the current regional management structure to a more locality based Veterans Service Area (VSA) concept;
- Closer collaboration with community health care providers;
- Consolidate certain administrative support functions;
- Reassessment of health care facility missions;
- Expand the use and concept of electronic commerce;
- Phase out VA supply depots while moving to a procurement process of direct vendors.

It is clear VA is again being expected to do more with less. It appears to us, Mr. Chairman, this budget proposal sets a tone of creating poor public policy.

Clearly, this represents an inadequate budget in the face of VA preparing to embark down the road toward reforming their health care delivery system in context with the President's overall health care reform proposal for the nation.

Mr. Chairman, although DAV has not and will not take a position on, nor endorse the President's overall health care proposal, we are generally in agreement with and supportive of the role identified for the VA in the context of national health care reform.

Having so stated, however, we are not confident that VA will be able to proceed down the path of meaningful and sustainable reform unless and until an adequate budget is enacted that will permit them to do so.

A reduction of some 3,700 FTE in Fiscal Year 1995, as proposed by the Vice-President's report of the National Performance Review, seems to fly in the face of saying VA may operate in an independent, competitive health care delivery system. VA will be faced with a multitude of new challenges -- some contemplated, some not -- in an era of reform. The overall tasks of functioning in a labor intensive business with an arbitrary reduction of FTE seems to do no less than set the stage for failure.

Mr. Chairman, it is our belief that VA has every attribute necessary to successfully compete in the coming era of health care reform. The task will not be an easy one. Operational as well as cultural changes need to occur, and need to occur swiftly. We believe, however, that the potential does exist to permit these changes to occur, if VA is provided adequate resources and relief from many existing constraints.

While our colleagues and partners in the Independent Budget will present the specific details in funding requests felt necessary for the VA health care delivery system, we urge, in the strongest possible terms, this Committee to report an adequate budget request for the VA health care delivery system.

MEDICAL AND PROSTHETIC RESEARCH

Mr. Chairman, the primary purpose of the VA research program is to support the clinical mission of the Veterans Health Administration (VHA) and is reflected in its research mission statement:

> "To develop and conduct research representing a continuum of programs (medical research, health services research, and prosthetics and rehabilitation research and development) that integrates clinical needs and research inquiry to enhance the quality of health care delivery to veterans."

The FY 1995 proposal of $211 million -- a dramatic decrease of $41 million from the FY 1994 enacted level -- is woefully inadequate to meet its stated mission.

The research program, in addition to being a proven recruiting incentive for quality health care professionals, and an integral part of quality care, conducts research of particular importance and relevance to veterans. For example, virtually nowhere else does a vigorous program of prosthetic and rehabilitation research exist. Were it not for VA, the many

innovations that improve the quality of life for disabled veterans, and Americans in general, simply would not exist. Clearly, VA should be proud of its many accomplishments.

Mr. Chairman, this request would reduce employment levels by 830 and reduce the total number of projects by 514.

We ask the Committee's careful consideration of the IB's research request and urge adequate funding for VA's research programs.

CONSTRUCTION

The IB recommends a $932,000,000 construction appropriation request which consists of:

- $294,000,000 major construction;
- $412,000,000 minor construction;
- $20,000,000 parking garage revolving fund;
- $200,000,000 for grants for construction of state extended care facilities; and
- $6,000,000 for grants for construction of state veterans' cemeteries.

As is so clearly evident, Mr. Chairman, the IB request is radically different from the VA's total request of $296.4 million broken down as:

- $115.5 million major construction;
- $153.5 million minor construction;
- $1.4 million parking garage revolving fund;
- $37.4 million for grants to state facilities; and
- 5.4 million grants to state cemeteries.

Mr. Chairman, at this point we would voice our concern regarding the critical need for VA to move forward with adequate funding for meaningful construction projects that address serious infrastructure issues. As VA proceeds down the path of health care reform, foremost in the minds of some, will be the adequacy of and attractiveness of VA's facilities to potential veteran enrollees.

Recognizing that deficiencies exist, and have existed for a long period of time, we urge adequate funding be assured VA in order that they may address the most compelling infrastructure issues that will enable them to prepare for an era of health care reform.

DEPARTMENT OF LABOR VETERANS' EMPLOYMENT AND TRAINING SERVICES (VETS)

Mr. Chairman, as we know, Title 38 USC Section 4103A mandates that the Department of Labor (DOL) make available sufficient monies to support a minimum number of Disabled Veterans Outreach Program specialists (DVOP) on a formula basis. The current formula requires the DOL to provide sufficient funding to staff at least 1,968 such positions. The FY 1995 budget request only provides enough money for 1,701 positions -- 267 below the mandated level.

Section 4104 Title 38 USC mandates DOL to provide sufficient monies to appoint 1,600 full-time Local Veterans Employment Representatives (LVER). The 1995 budget request falls short of that by 134 positions.

Mr. Chairman, the law is very explicit in its language and provides no discretionary authority to deviate. Section 4103A states, in part, "The amount of funds ... shall be sufficient .... " (Emphasis added.)

Section 4104 likewise uses the same "shall be sufficient" language. Webster's New World Dictionary defines shall in this context as "compulsion, obligation, or necessity."

Mr. Chairman, if the Administration wishes to request funds less than an amount needed to fill statutorily mandated positions, it should seek legislative change through the legislative process, not through the budgetary process. We believe that this is a direct affront to the authorizing committees -- in this case, the House and Senate Veterans Affairs Committees.

Mr. Chairman, not only does the 1995 budget request fall significantly short of the statutory mandate, it reverts back to levels approximating or less than the 1992 levels.

At a time when we are downsizing our military forces and the need for employment services for veterans is ever increasing and the fact that this Administration has placed the issue of homeless veterans as a high priority, we believe that it is incongruous that the Administration would have the temerity to submit a budget request that fails so far below the mandated level. Mr. Chairman, such a budget request impacts directly on the service delivery system affecting the individuals' lives -- not just the administration of such a system.

We hope that you will work closely with the Appropriations Committees to assure a restoration of the mandated levels.

HIGHLIGHTS OF THE INDEPENDENT BUDGET RECOMMENDATIONS

During the past several years, we have seen a dramatic increase in the time it takes to adjudicate virtually all categories of veterans' claims. While we acknowledge that the increased delay in processing veterans' claims results, in part, from decisions of the United States Court of Veterans Appeals and from the downsizing of our military, we do believe, however, VA reacted slowly to the increased demands the Court placed upon it, and, at times, has had a knee jerk reaction to some court decisions.

The cornerstone of the Independent Budget funding recommendations is an entitlement's inseparability from its timely delivery. This principle should also be the basis for VA management's budgetary planning. Now is the time to link veterans' entitlements and their timely and accurate delivery. With proper equipment and sufficient numbers of trained employees, VA management has the talent and dedication to meet reasonable timeliness and accuracy standards cost-effectively.

Our budget analysis, contained in the Independent Budget, performs two main functions:

(1) it assesses the level of service provided to veterans; and

(2) it recommends authorizing and appropriations legislation to restore adequate benefits and services delivery to veterans.

Our discussion will focus mainly on the latter.

VETERANS BENEFITS ADMINISTRATION (VBA)

- Congress should authorize funding of VBA's personnel costs for Veterans Services; Compensation, Pension and Education; and Vocational Rehabilitation and Counseling through transfers from mandatory spending entitlement accounts.

- VBA's budget should have a line item for training. For FY 1995, Congress should appropriate $8 million to fund VBA wide training.

- As VBA's workforce becomes more skilled and productive, management should re-examine and revise position descriptions, with a view toward increasing their grade levels.

Information Resources Management (IRM)

- We urge Congress to ensure that VBA moves forward with a realistic, comprehensive plan to provide much needed ADP improvements for VBA;

- We urge VA to give VBA both the authority and responsibility for all ADP systems activities that relate to program delivery, including equipment acquisition.

Veterans Services (VS)

- The IB VSO's recommend 2,440 FTEs, so that VS may begin to satisfy reasonable service levels.

- We also recommend that VS update its telephone equipment to take full advantage of automated systems such as VAATS.

Vocational Rehabilitation and Counseling (VR&C)

- Add 600 employees to VR&C because, from a purely economic standpoint, it is sound public policy and cost-effective to return disabled veterans to meaningful employment as soon as practicable following an injury or onset of a disease.

- Increase the cap on contract counseling funds.

- Provide sufficient funding for vocational rehabilitation revolving fund loans.

- Authorize non-pay training/work experience in the private sector.

Insurance and Indemnities

- It is estimated that an employee level of 455 will be required during FY 1995 to support VA's insurance activities.

Compensation, Pension and Education (CP&E)

- Without the necessary equipment, training, and employees to adjudicate veterans' claims, little progress can be made to reduce the overwhelming backlog of claims; therefore, we recommend an increase in CP&E employment level to 4,700.

Loan Guaranty

- Rarely do the goals of deficit reduction, program integrity and efficiency, and good service to veterans coincide so exactly, as they do in improving loan servicing. Accordingly, an additional 50 employees specifically for loan servicing activities makes fiscal sense.

- Increase thé loan guaranty employee level to 2,180.

Support Services

- VBA Support Services needs 3,214 employees.

GENERAL ADMINISTRATION

Board of Veterans' Appeals (BVA)

- Based on current staffing levels, it is projected that BVA's response time would be more than 6.5 years at the end of FY 1995 -- which is totally unacceptable; therefore, BVA should be provided with adequate resources to accomplish its goals of providing quality, timely appellate decisions.

- An appropriation of $200,000 should support BVA's FY 1995 training activities.

- Congress should increase board members' salaries so that they have pay equity with administrative law judges.

General Counsel

- Increase employee level to 720 for FY 1995.

Office of the Inspector General

- For FY 1995, employee level should be increased to 530.

Mr. Chairman, this concludes my statement. I would be pleased to answer any questions you may have.

STATEMENT OF
RUSSELL W. MANK, NATIONAL LEGISLATIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING THE
INDEPENDENT BUDGET FOR THE DEPARTMENT OF VETERANS AFFAIRS
FOR
FISCAL YEAR 1995
FEBRUARY 10, 1994

Good morning, Mr. Chairman and members of the Committee. I am honored to present testimony on the fiscal needs of the Department of Veterans Affairs' Medical Programs on behalf of Paralyzed Veterans of America and the *Independent Budget* co-authors.

Mr. Chairman, we have made strong appeals in the past to patriotism, to fairness and to the common-sense of maintaining a medical system dedicated to veterans. Today, we voice a more plaintive truth. Without your intervention, veterans are fearful they may lose their health care system.

PVA believes we have the makings for a crisis with the Administration's FY 1995 budget request for VA medical programs, but that's not the worst of it. VA staffing levels are proposed to be cut drastically, but that's still not all. VA is now being forced to compete with its hands tied behind its back in many states which, as I am speaking, are implementing major health care reform initiatives. Many of these states offer eligible VA beneficiaries a richer benefits package than VA is able to make available to them under current eligibility rules. But the action in the states is still not the end of it because if the combined impact of all of these factors doesn't kill the VA system, comprehensive national health care reform under these conditions will.

Funding is not the only requirement to solving the VA medical system's problems, but it is certainly a precursor to successful system reform. The Administration has requested a $16.1 billion appropriation from Congress for the VA medical care system. This request is $2.3 billion less than the *Independent Budget's* recommendation for current services and $3.6 billion less than its full recommendation, including critical initiatives, for the Medical Care account. The Administration's request amounts to a *de facto* cut in real dollars from the FY 1994 funding level.

The VA research program staff has been demoralized over their ongoing dogfights for funding in recent years. VA research is subject to a $41 million cut from the FY 1994 level in FY 1995 resulting in a $211 million appropriation if the Administration's request is enacted. This level of funding will be devastating to the survival of a VA research program. Few new projects were undertaken last year with a far greater funding level. VA is not likely to be able to fund any new projects in FY 1995 if Congress appropriates the requested amount. The result will be direct-care providers and extra-mural funding for veterans' research lost to the system as clinician-investigators depart for better research opportunities.

VA has demonstrated its inability to support its medical services workload base even in the years of the billion-dollar increases.

The *Independent Budget* uses FY 1988 as a baseline for its workloads and programs. Since that time, workloads in virtually every health care setting—even fee-based outpatient care and contract nursing home care—have decreased. Without having the alternative for ambulatory care that private sector providers offer their patients, VA's inpatient workload indices are dropping precipitously. This at time when the aging of the veteran population would dictate a workload increase. Growth in outpatient care workloads does not indicate that, like in the private-sector, ambulatory care is serving as a "substitute" for inpatient hospital care. Rather, access to outpatient care is still so fettered by eligibility criteria for most veterans, that there would be no way for this substitution to occur. The only conclusion that the IBVSOs can draw is that VA is basing its medical decisions on funding availability, in effect, rationing care. Underfunding impacts other aspects of quality health care delivery. Equipment and repair backlogs have not been diminished. Both still approximate the billion dollar mark we have addressed in many past *Independent Budgets*. VA has not been able to meet its own workload targets for critical program enhancements, not to mention the *Independent Budget's* optimal goals.

Staffing cuts poised to be levied on VA and other domestic discretionary programs also pose a threat to VA's continued viability. The *National Performance Review* recommends that VA cut approximately 25,000 positions over the next few years. VA staff to patient ratios are already low in comparison to private-sector providers and most of the cuts the Administration proposes will come from positions devoted to direct patient care. As monitors of VA medical care, the veterans service organizations worry that quality will suffer.

Reductions in staff and funding will also prohibit VA from developing services it needs to be competitive under a comprehensive health care reform plan. Although some might say it is premature to predict the impact of health care reform should it be enacted, the IBVSOs take the position that it is better for VA to plan proactively for the changes that must be made than to be blind-sided.

Reform is not remote—it is occurring at the state level today. VA medical centers that have not yet been affected by state or national reforms should heed the experiences of VA's in states with active reform agendas. VA must be liberated from restrictive legislation so it can compete as necessary. Of greatest concern to the *Independent Budget* co-authors is VA's restrictive eligibility criteria. VA's eligibility criteria are its greatest obstacle to delivering cost-effective and appropriate care. The Administration claims this problem will be settled once VA is able to deliver a standard benefits package to its enrollees like other providers. In states where reform is emerging, enactment of comprehensive national reform will come too late. The *Independent Budget* outlines a grant program for VA hospitals in states where reform is underway which offers limited funding and authorizes exemption from restrictive eligibility which we believe would ameliorate the immediate problems faced by the VA hospitals in these states.

In tomorrow's more competitive medical care market, VA must have a more accessible ambulatory care system in place. VA cannot begin to develop this capacity with less money and staff. Even the proposed investment fund in the President's reform proposal will not be enough if VA must replace these dollars for those it loses in appropriations. Unfortunately, Congress continues to overlook the connection between strategic investments and long-term savings opting instead for quick fixes for the VA system which too often result in unfunded initiatives VA must absorb. It <u>will</u> cost money to balance the system, now overly reliant on inpatient health care. It <u>will</u> cost money to bolster the aging buildings and create accessible venues of care in the community. It will ultimately <u>save</u> VA money to be able to deliver care to its veterans in the

most cost-effective setting. But Congress and the Administration must be willing to make the initial investment to get this result.

Mr. Chairman, we realize "things are tough all over" and we want to be constructive whenever possible. The VSOs have been criticized in the past for always having their hand out. Although staff and funding are critical system needs, there are ways medical centers can achieve desired change by redirecting resources or better managing services which involve minimal investment. We outline a "realistic marketing plan" for VA based on innovation occurring in the hands of resourceful VA managers right now. Sadly, these success stories are not well disseminated throughout the VA system. We hope that we can be instrumental in sharing some worthwhile case studies with VA managers through the dissemination of the *Independent Budget*. Some effective changes can occur in VA facilities in today's legislative and fiscal environment. We realize better management must accompany funding initiatives and increased staff levels.

Regardless of the outcome of the legislative efforts of the Clinton Administration and the 103d Congress on health care reform, VA's future depends on being able to deliver medically necessary services to veterans in convenient settings. We end where we have so often begun with our testimony to Congress—with the *Independent Budget* co-authors' urgent plea to amend eligibility criteria which are trapping VA in an anachronistic practice style which is overly reliant on inpatient care. Private-sector providers have demonstrated that patients can be served more cost-effectively by using appropriate venues of care. Veterans also need accessible care. Without adequate access to primary and preventive care and beneficiary travel funds, any veteran with cost-competitive local health care available is most likely to choose that care. VA needs to be enhancing ambulatory care clinics now to prevent veterans from leaving the system in droves should these cost-competitive options come available. We are relieved to hear that VA apparently sees things our way. We are very heartened by the fact that VA is now drafting legislation which may give VA medical centers in up to five states a fighting chance to compete. From what we understand, their proposal will closely resemble our own proposal for grants to VA hospitals in states where reform is implemented.

Finally, Mr. Chairman, the veterans service organizations have been asked to support, in concept, the President's health care reform proposal. We have done so with the promise that the VA health care system would remain a viable, quality, independent, health resource. If the conditions are right, the President's proposal could offer VA a chance to come out ahead in health care reform. But this can only happen if the system is given the tools, the staff, the funding and the motivation to accomplish that goal. The Administration's FY 1995 budget request is a blueprint for disaster. If approved intact, it will send the VA, already bankrupted by a decade of underfunding, out to compete in a reformed national health care environment with both hands tied behind its back. The President's health care reform bill promises $3.3 billion for VA at some point down the road to help the system prepare itself to be more competitive. But promises of future support provide little comfort to a system facing an unprecedented fiscal crisis right now.

Veterans organization have also been asked to help in recruiting and retaining a strong veteran patient base under the reformed health care plan. We plan on helping promote the "new" VA, but VA has to show that it is willing to rededicate itself to, in its own words, "putting veterans first." VA must learn to be the provider of choice and not the provider of last resort.

Veterans will not be blind to inadequacies in their system. Health care reform will create other health care options for veterans. For the first time, many veterans will be able to "vote with their feet" for the health care they need. For VA to come out a winner,

or even a survivor, of health care reform, it must be an acceptable, practical choice for the veteran patient. The tangle of rules that have grown around a federal health care provider must be loosened for VA to compete more effectively in a private sector environment. And, VA must have the resources, the facilities and the image to become a viable provider for the veteran population.

This concludes my testimony, Mr. Chairman. I will be pleased to respond to any questions you might have.

FY '95 INDEPENDENT BUDGET — PROLOGUE

SECOND DRAFT - January 3, 1994

This is the eighth year that the AMVETS (American Veterans of World War II, Korea and Vietnam), Disabled American Veterans (DAV), Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars of United States (VFW) have collectively formulated and presented to Congress a detailed budget designed to meet veterans' needs through programs administered by the Department of Veterans Affairs (VA).

Beginning with the initial issue, the *Independent Budget (IB)* has carried the candid statement that our publication is predicated on a loss of confidence that the Office of Management and Budget's (OMB) has any interest in understanding or responding to a consumer perspective of veterans needs. Last year there was transient evidence this perception might change.

Members of Congressional committees had been suggesting that we try to establish a direct rapport with OMB to argue for a more realistic construction of VA's budget. In the Spring of 1992 we were encouraged by the OMB staff's willingness to prospectively receive and comment on the issues under consideration for the Fiscal Year 1994 edition of the *IB*. Welcoming that opportunity, we provided them a preliminary draft of the FY 1994 *IB* document. Still waiting for a response at the time of its publication, we expressed our appreciation in the *IB* Prologue and our hope that this opening would yet set a precedent for the new Administration.

Accordingly, the *IB* staff more recently submitted a request to meet with the Clinton OMB staff regarding current budget issues. Word was indirectly received not to expect a reply. In retrospect, we can assume it was a dubious OMB pledge only made in anticipation of a presidential election. We particularly regret this riposte, for never, in the eight year history of this *IB* publication, has the resolution of VA budget issues addressed on these pages related so directly to the destiny of the VA health care system.

It has become abundantly clear, notwithstanding a delayed national implementation of health care reform, that meaningful renovation and reorganization of the VA health care system must begin *now* if it is to be

successful in tomorrow's competitive medical market. The current proactive implementation of reform initiatives at the state level underscores this need. Immediate supplemental resources are required for this purpose. In this document that estimated funding has been kept separate from the numbers needed to maintain what we continue to call current services.

We have never accepted a definition of "current services" as that level of appropriation needed just to maintain a previous year's workload plus coverage of inflation—as implied in the budget term "cost plus". As in the past, this is a needs based budget proposal and as such makes no pretense at compensatory reductions to maintain budget neutrality. To do so would lose all tract of veterans true health care need, although much of it has long since been suppressed. We have been assured that Congress has interest in knowing the cumulative consequences of VA's perennial budget shortfalls. Since 1988 was the last year budget resources accommodated stability in VA's patient workload, we have continued to use that year's data as a baseline from which to calculate the appropriations needed to maintain that same level of health care services while also providing coverage for all subsequent unavoidable cost increase. We have also each year requested several much needed additional programs and services along with the augmented dollars required for their implementation. Ignoring any such growth potential, the FY 1994 VA Medical Care budget is short some $1.5 billion from even providing that earlier level of current services, a situation very similar to that prevailing the previous year, and again perpetuated in the Administration's FY 1995 VA budget proposal.

The theme carried throughout last year's *IB* document was in recognition of the health care industry's imperative for change. Pending impacts from the nation's health care reformation on the VA's system mandate that it too must change. Predicated on the conviction that the VA health care system is a national resource worth saving, our theme was that VA, in its effort to change, *must be provided every opportunity and support* — a requirement that is validated in the Administration's *American Health Security Act of 1993*. Dynamic events in the health care industry are now overtaking that concern. The VA medical care system's future is now.

The FY 1995 *IB* will again address the critical resource needs of the General Operating Expenses account. This account funds administrative costs of the

Veterans Benefits Administration and Veterans Services. Problems with timeliness in the administration of veterans' entitled benefits have been an ongoing travesty. VA has an urgent need for adequate staffing and for modern automated data processing and telecommunications systems necessary to eliminate claim backlogs and enforce an appropriate timeliness standard.

Frankly, the new budget reality is frightening. The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), requires veterans' benefits programs to once again come under the deficit reduction axe. OBRA 93, which incorporates all legislation designed to reduce the federal deficit by $500 billion over the five year period FY 1994-1998, contains a number of decremental provisions directly affecting veterans' benefits programs. Discretionary spending is frozen at the FY 1994 level over the next five years. This means that regardless of the rate of inflation, VBA will have to operate with the same funding in 1998 as they had in 1994. The House and Senate Committees on Veterans' Affairs were also instructed to find savings of $266 million in FY 1994 and $2.6 billion over FY 1994-1998. **As the IBVSOs have continued to point out, VA entitlements do not contribute to the deficit's rate of growth.** For the most part, the attrition rate affecting the disability compensation rolls far exceeds the number of new recipients. By comparison, federal expenditures for veterans can be viewed as a model of fiscal restraint; VA has continually been required to do more with less.

Retaining these themes from past *Independent Budgets*, this FY 1995 *IB* is, with renewed conviction, directed toward the solicitation of Congressional concurrence in the full achievement of these goals.

SIGNATURES:

ENDORSERS OF THE 1995 *Independent Budget*

February 4, 1994

1. Air Force Sergeants Association
2. Alliance For Aging Research
3. American Academy of Ophthalmology
4. American Association of Dental Schools
5. American Association of Spinal Cord Injury Nurses
6. American Association of Spinal Cord Injury Psychologists & Social Workers
7. American Defenders of Bataan & Corregidor (ADBC)
8. American Ex-Prisoners of War
9. American Military Retirees Association
10. American Nurses Association
11. American Optometric Association
12. American Paraplegia Society
13. American Physiological Association
14. American Podiatric Medical Association (APMA)
15. American Psychiatric Association
16. American Security Council
17. Arthritis Foundation
18. Association for Health Services Research
19. Association of American Medical Colleges
20. Association of Professors of Medicine
21. Association of Schools of Public Health
22. Association of the United States Army
23. Association of University Radiologists (AUR)
24. Blinded Veterans Association
25. Catholic War Veterans, USA, Inc.
26. Chief Petty Officers Association (CPOA)
27. Diabetes Action Research & Education Foundation
28. Enlisted Association National Guard of the U.S.
29. Italian American War Veterans
30. Jewish War Veterans of the U.S.A.
31. Juvenile Diabetes Foundation International
32. Legion of Valor of the U.S.A., Inc.
33. Marine Corps League

34. Marine Corps Reserve Officers Association (MCROA)
35. Military Order of the Purple Heart
36. National Alliance for the Mentally Ill
37. National Amputation Foundation
38. National Association of Uniformed Services
39. National Association of VA Chiefs of Staff
40. National Association of VA Physicians & Dentists
41. National Association of Veterans' Research and Education Foundations
42. National Council of Senior Citizens
43. National Multiple Sclerosis Society
44. Navy League of the U.S.
45. Non Commissioned Officers Association of the United States of America
46. Nurses Organization of Veterans Affairs (NOVA)
47. Ohio Veterans' Home
48. Society of Medical College Directors of CME (SMCDCME)
49. Surgical Infection Society
50. The Military Chaplains Association of the U.S.A.
51. The Polish Legion of American Veterans, U.S.A.
52. The Retired Enlisted Association
53. Thomas Fitzgerald Veterans' Home
54. U.S. Merchant Marine Veterans of World War II (U.S.M.M.V.W.W.II)
55. Veterans Affairs Physician Assistant Association
56. Vietnam Era Veterans Association of Rhode Island

TABLE OF CONTENTS

CHARTS AND TABLES

TABLE 1

VA APPROPRIATIONS BY ACCOUNT (In thousands)				
	FY 1994 APPROPRIATION	FY 1995 IB CURRENT SERVICES LEVEL	FY 1995 IB RECOMMENDED APPROPRIATION	FY 1995 ADMINISTRATIVE REQUEST
GENERAL OPERATING EXPENSES (GOE)				
General Operating Expenses	826749	1224222	1350522	847153
Office of the Inspector General	31436	32065	37915	32596
National Cemetery System	70507	81000	81000	72663
TOTAL GENERAL OPERATING EXPENSES	$928,692	$1,337,287	$1,469,437	$952,412
BENEFITS PROGRAM				
Compensation, Pension, and Burial Benefits	17527146	17627592	17627592	17627592
Readjustment Benefits	1050600	1286600	1286600	1286600
Veterans Insurance & Indemnities	15370	24760	24760	24760
Veterans' Job Training Fund	0	0	0	0
Loan Guaranty Program Account	95852	78035	78035	78035
Guaranty and Indemnity Program Account	522423	433520	433520	433520
Direct and Other Loan Program Accounts	3874	2059	2059	2059
Native American Veteran Housing Loan Program Account	156	218	218	218
TOTAL BENEFITS	$19,215,421	$19,452,784	$19,452,784	$19,452,784
MEDICAL PROGRAMS				
Medical Care	15622452	18441157	19651884	16122452
Medical & Prosthetic Research	252000	328583	346583	211000
Medical Admin and Miscellaneous Operating Expenses	68500	79225	79225	59380
Health Professionals Educational Assistance Programs	10386	10905	15905	10386
TOTAL MEDICAL PROGRAMS	$15,953,338	$18,859,870	$20,095,597	$16,413,218
CONSTRUCTION PROGRAMS				
Construction, Major Projects	369000	294000	294000	115465
Construction, Minor Projects	153540	412000	412000	153540
Parking Garage Revolving Fund	1353	20000	20000	1400
Grants for Cons. of State Vet. Cemeteries	5242	6000	6000	5378
Grants for Cons of State Extended Care Facilities	41080	200000	200000	37387
Grants to the Republic of the Philippines	500	500	500	500
TOTAL CONSTRUCTION PROGRAMS	$570,715	$932,500	$932,500	$313,680
TOTAL APPROPRIATION	**$36,668,166**	**$40,582,441**	**$41,950,318**	**$37,132,094**

Table 2
BENEFITS.XLS

APPROPRIATIONS		
BENEFITS PROGRAM		
	FY 1994 Appropriation	FY 1995 IB Recommended Appropriation
Compensation, Pension, and Burial Benefits	17527146	17627592
Readjustment Benefits	1050600	1286600
Veterans Insurance & Indemnities	15370	24760
Veterans' Job Training Fund	0	0
Loan Guaranty Program Account	95852	78035
Guaranty and Indemnity Program Account	522423	433520
Direct and Other Loan Program Accounts	3874	2059
Native American Veteran Housing Loan Program Account	156	218
TOTAL BENEFITS	**$19,215,421**	**$19,452,784**

TABLE 3

GENERAL OPERATING EXPENSES (GOE)	FY 1995 Independent Budget Recommended Current Services Level	FY 1995 Independent Budget Recommended Appropriation
Veterans Benefits Administration (VBA)		
Executive Direction	32,355,000	36,555,000
Veterans Services	95,170,000	109,370,000
Compensation, Pension and Education	197,888,000	207,638,000
Loan Guaranty	85,879,000	92,779,000
Insurance	14,471,000	16,371,000
Vocational Rehabilitation and Counseling	38,928,000	68,928,000
Information Technology	107,780,000	107,980,000
Support Services	237,979,000	267,279,000
Program-wide Training		8,000,000
Reimbursements	190,470,000	190,470,000
Total VBA	$1,000,920,000	1,105,370,000
General Administration (GA)		
Board of Veterans Appeals	27,981,000	37,281,000
General Counsel	40,894,000	43,944,000
Assistant Secretary for Finance and IRM	130,781,000	131,881,000
Assistant Secretary for Human Resources and Admin.	52,935,000	58,735,000
Consolidated Staff Offices	21,933,000	24,533,000
Reimbursement	-51,222,000	-51,222,000
Total GA	$223,302,000	$245,152,000
General Operating Expenses (GOE)	**$1,224,222,000**	**$1,350,522,000**
National Cemetery System (NCS)	**$81,000,000**	**$81,000,000**
Office of Inspector General	**$32,065,000**	**$37,915,000**
TOTAL GENERAL OPERATING EXPENSES (GOE)	**$1,337,287,000**	**$1,469,437,000**
Office of Acquisition and Material Management: Supply Fund	**$794,919,660**	**$794,919,660**

Independent Budget
Recommended Full-Time Employee Equivalents
GENERAL OPERATING EXPENSES (GOE)

	FY 1995 Independent Budget Recommendation	FY 1994 Enacted	Additonal Staff Recommended by Independent Budget
Veterans Benefits Administration (VBA)			
Executive Direction	473	389	84
Veterans Services	2,440	2,156	284
Compensation, Pension and Education	4,700	4,505	195
Loan Guaranty	2,180	2,042	138
Insurance	455	417	38
Vocational Rehabilitation and Counseling	1,314	714	600
Information Technology	978	974	4
Support Services	3,214	2,628	586
Total VBA	15,754	13,825	1,929
General Administration (GA)			
Board of Veterans Appeals	632	446	186
General Counsel	720	659	61
Assistant Secretary for Finance and IRM	1,325	1,303	22
Assistant Secretary for Human Resources and Admin.	500	384	116
Consolidated Staff Offices	310	258	52
Total GA	3,335	3,050	285
General Operating Expenses (GOE)	**19,089**	**16,875**	**2,214**
National Cemetery System (NCS)	**1,405**	**1,315**	**90**
Office of Inspector General	**530**	**413**	**117**
Office of Acquisition and Material Management: Supply Fund	720	702	18
TOTAL GENERAL OPERATING EXPENSES (GOE)	**21,744**	**19,305**	**2,439**

82-758 O - 94 - 5

Table 5

BVA Decisions

FY	Decisions	Allowed	Remanded	Denied	Other
1990	46,556	13.4%	23.5%	62.0%	1.1%
1991	45,308	13.8%	29.7%	55.4%	1.2%
1992	33,483	15.7%	50.5%	32.7%	1.1%
1993	26,400	16.9%	44.0%	36.9%	2.2%

Board of Veterans' Appeals Table 6

BVA Operating Statistics

	FY90	FY91	FY92	FY93	Estimated FY94
Decisions	46,556	45,308	33,483	26,400	24,350*
Appeals Received	43,808	43,093	38,229	38,147	39,000
Pending (EOY)	19,450	17,235	21,981	33,728	48,378
Hearings - VACO	1,244	1,502	1,394	1,172	1,000
Hearings - Field	440	873	1,258	3,533	4,000
Decisions per FTE	114.7	110.2	81.5	59.9	54.2
BVA FTE	406	411	411	441	449
Response Time	152	139	240	466	725
Cost per Case	$421	$486	$684	$1,046	$1,127

* Estimated decision production does not assume enactment of single member decision-making legislation currently under consideration

TABLE 10	
MEDICAL CARE	
INDEPENDENT BUDGET	
RECOMMENDED APPROPRIATION	
FY 1994 Current Services Level	**$17,131,963,000**
FY 1995	
Payroll Related Increases	
Retirement Programs	65,086,000
Annualization of 1994 Locality Pay	111,244,000
Annualization of 1994 Federal Employee Health Benefit Program	6,331,000
Pay Raise 1995	121,580,000
Within Grade Pay 1995	77,375,000
Federal Employee Health Benefit Program 1995	15,323,000
Workday Change	(38,586,000)
Other Personnel Costs	50,000,000
Inflation	216,075,000
Compensation for Inadequate Inflation from FY 1993	19,034,000
Facility Activations (Including Capital Investments)	200,000,000
Property Rental	1,254,000
Recurring Funding for FY 1994 Administration and Congressional Initiatives	120,000,000
Adjustments to FY 1994 Program Base	218,957,000
Adjustments for Rate Changes	
State Nursing Homes	73,789,000
State Home Hospitals	2,345,000
State Home Domiciliaries	9,194,000
Community Nursing Homes	27,691,000
Contract Hospitals	12,502,000
FY 1995 Current Services Level	**$18,441,157,000**
Additional Initiatives 1995	
Inpatient Workload Increase	11,678,000
Outpatient Workload Increase	66,271,000
Extended Care Programs Increase	558,036,000
Community Psycho-Social Programs	22,000,000
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	85,000,000
Equipment Backlog	168,269,000
Non-Recurring Repair and Maintenance Backlog	161,523,000
Pharmaceutical Unit Dose Program	10,000,000
Facility Activations for Leased Clinics	35,000,000
Facility Activations for Leased Nursing Homes	31,500,000
FY 1995 RECOMMENDED APPROPRIATION	**$19,651,884,000**

TABLE II

Selected Comparisons of VA Medical Care Activity Volume
Inpatients Treated and Outpatient Visits
FYs 1988-1993

ACTIVITY	FY 88	% CHANGE FY 88-89	FY 89	% CHANGE FY 89-90	FY 90	% CHANGE FY 90-91	FY 91	% CHANGE FYs 91-92	FY 92	% CHANGE FYs 92-93	FY 93	%CHANGE FY 88-93
Total Hospital	1116681	-5.8%	1053942	-3.8%	1018430	-4.2%	974085	-1.8%	956315	-1.5%	942129	-15.6%
Non-VA Hospital	27377	-13.6%	23655	-11.4%	20968	-1.7%	20618	-8.9%	19193	3.3%	19827	-27.6%
State Home Hospital	2846	-5.0%	2708	-11.2%	2404	-2.9%	2335	-13.1%	2030	-1.9%	1991	-30.1%
VAMC Patients Treated	1086456	-5.4%	1027581	-3.4%	993058	-4.2%	951112	-1.7%	935092	-1.6%	920311	-15.3%
VAMC Psychiatric	214512	-8.1%	201432	-4.9%	191469	-5.5%	181004	2.6%	185788	1.6%	188818	-12.0%
VAMC Surgical	290569	-6.2%	272630	-3.7%	262442	-3.6%	253081	-1.4%	249590	-3.5%	240848	-17.1%
VAMC Medical	581375	-4.8%	553518	-2.6%	539147	-4.1%	517027	-3.3%	499718	-1.6%	490647	-15.6%
Total Nursing Home	83676	-12.7%	73081	-2.6%	71028	1.6%	72145	-1.0%	71422	5.6%	75404	-9.9%
VAMC Nursing Home	27220	-2.4%	26561	1.9%	27067	4.8%	28378	7.1%	30404	4.2%	31668	16.3%
Community Nursing Home	42232	-23.7%	32209	-10.4%	28851	-1.4%	28450	-11.9%	25062	7.3%	26887	-36.3%
State Home Nursing Home	14224	0.6%	14311	5.6%	15108	1.4%	15318	4.2%	15956	5.6%	16849	18.5%
Total Domiciliary Care	24018	3.4%	24825	3.4%	25670	0.3%	25735	-0.9%	25501	-1.8%	25034	4.2%
VAMC Domiciliary	16607	7.3%	17822	6.0%	18896	0.0%	18897	2.6%	19384	-2.1%	18982	14.3%
State Home Domiciliary	7411	-5.6%	7003	-3.3%	6775	0.9%	6838	-10.5%	6117	-1.1%	6052	-18.3%
Total Inpatients Treated	1224375	-5.9%	1151848	-3.4%	1113126	-3.7%	1071946	-1.7%	1053238	-1.0%	1042567	-14.8%
VA Staff Outpatient Visits	21473403	-2.1%	21013928	1.8%	21396334	2.5%	21932426	3.0%	22788431	1.6%	23144398	7.8%
Fee-Basis Outpatient Visits	1758492	-8.0%	1603456	-26.0%	1203198	-8.4%	1102090	1.0%	1113394	-1.9%	1091699	-38.0%
Total Outpatient Visits	23232895	-2.6%	22617382	-0.1%	22599532	1.9%	23034516	3.6%	23901825	1.4%	24236095	4.3%

TABLE 12

ACTUAL AND PROJECTED INFLATION RATES

Economic Assumptions Used to Formulate VA Budgets Actual Economic Rates

	Medical CPI	Non-Pay Deflator	Medical CPI	Non-Pay Deflator
FY 1995 OMB	4.9%	2.0%		
FY 1994 OMB	5.4%	2.5%		
FY 1993 OMB	5.8%	3.7%	5.7%	2.7%
FY 1992 President's Budget	6.4%	4.1%	7.0%	2.7%
FY 1991 President's Budget	5.7%	4.2%	7.8%	4.0%
FY 1990 President's Budget	5.9%	3.6%	8.8%	3.6%
FY 1989 President's Budget	6.1%	3.9%	7.2%	4.4%
FY 1988 President's Budget	5.3%	3.7%	6.3%	2.0%

Differences in Estimated Inflation Rates Used in VA Budget and Actual Inflation

	Medical CPI	Non-Pay Deflator
FY 1993	.1%	1.0%
FY 1992	-0.6%	1.4%
FY 1991	-2.1%	0.2%
FY 1990	-2.9%	0
FY 1989	-1.1%	-0.5%
FY 1988	-1.0%	1.7%
AVERAGE	-1.3%	0.6%

TABLE 14

		VA MEDICAL CARE WORKLOAD DISTRIBUTIONS			
	Actual FY 1988 (Baseline)	Actual FY 1992	Estimated FY 1993	IB Target FY 1994	IB Target FY 1995
VA Sponsored Programs					
Community NH ADC	12405	7821	8418	8832	14040
Community Hospital ADC	571	352	338	355	600
State Home NH ADC	8666	10145	10601	12522	14040
Fee Outpatient Visits	1759492	1113394	1091699	1113000	1880000
VA-Operated Programs					
Hospital Inpatients	1086456	935092	920311	964665	1086456
Nursing Home ADC	11344	13111	13476	14632	18720
Domiciliary ADC	6061	6441	6197	6718	7600
Outpatient Visits	21473403	22788431	23144396	23748000	24000000
Other VA Programs					
Hospital Based Home Care	68	75	75	75	75
Adult Day Health-VA	15	15	16	16	40
Adult Day Health-Contract	35	28	28	28	60
GEMs	80	118	113	121	171
GRECCs	12	16	16	16	25
Respite Programs	1	127	136	136	171
Hospice Programs	2	171	171	171	171
Community Residential Care	125	127	135	135	171

TABLE 15

Actual and Budgeted VA Workloads
FY 1993

ACTIVITY	FY 93 (budgeted)	FY 93 (actual)	Difference (budgeted v. actual)
Total Hospital	989085	942129	-4.7%
Non-VA Hospital	18739	19827	5.8%
State Home Hospital	2346	1991	-15.1%
VAMC Patients Treated	968000	920311	-4.9%
Total Nursing Home	78407	75404	-3.8%
VAMC Nursing Home	29496	31668	7.4%
Community Nursing Home	30627	26887	-12.2%
State Home Nursing Home	18284	16849	-7.8%
Total Domiciliary Care	27314	25034	-8.3%
VAMC Domiciliary	20023	18982	-5.2%
State Home Domiciliary	7291	6052	-17.0%
Total Inpatients Treated	1094806	1042567	-4.8%
VA Staff Outpatient Visits	22697000	23144396	2.0%
Fee-Basis Outpatient Visits	1090000	1091699	0.2%
Total Outpatient Visits	23787000	24236095	1.9%

TABLE 21

MEDICAL AND PROSTHETIC RESEARCH	
INDEPENDENT BUDGET	
RECOMMENDED APPROPRIATION	
FY 1994 Current Services Level	**$317,832,000**
FY 1995	
Payroll Related Increases	
Retirement Programs	993,000
Annualization of 1994 Locality Pay	1,794,000
Annualization of 1994 Federal Employee Health Benefit Program	105,000
Pay Raise 1995	1,876,000
Federal Employee Health Benefit Program 1995	254,000
Within Grade Pay 1995	678,000
Inflation	5,051,000
FY 1995 Current Services Level	**$328,583,000**
Aging Initiatives	5,000,000
Women's Issues	4,000,000
Spinal Cord Medicine	1,000,000
Health Services Research	10,000,000
FY 1995 RECOMMENDED APPROPRIATION	**$348,583,000**

TABLE 22

MEDICAL ADMINISTRATION AND MISCELLANEOUS OPERATING EXPENSES (MAMOE) INDEPENDENT BUDGET RECOMMENDED APPROPRIATION	
FY 1994 Current Services Level	**$88,781,000**
FY 1995	
Reduction in CM FTEE Level	-12,114,719
Payroll Related Increases	
Retirement Programs	340,000
Annualization of 1994 Locality Pay	535,000
Annualization of 1994 Federal Employee Health Benefit Program	24,000
Pay Raise 1995	642,000
Federal Employee Health Benefit Program 1995	58,000
Inflation	960,000
FY 1995 Current Services Level	**$79,225,281**
FY 1995 RECOMMENDED APPROPRIATION	**$79,225,281**

TABLE 23

CONSTRUCTION PROGRAMS
INDEPENDENT BUDGET
RECOMMENDED APPROPRIATION

FY 1995 Major Construction	
Medical Care Program	
Replacement and Modernization	100,000,000
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
Regional Office	6,000,000
Other	10,000,000
TOTAL	**$294,000,000**
FY 1995 Minor Construction	
Medical Care Program	
General Fund	300,000,000
Nursing Home Care	80,000,000
Regional Office	14,000,000
National Cemetery	18,000,000
TOTAL	**$412,000,000**
FY 1995 Parking Garage Revolving Fund	
TOTAL	**$20,000,000**
FY 1995 Grants for State Extended Care Facilities	
TOTAL	**$200,000,000**
FY 1995 Grants for Construction of State Veterans Cemeteries	**$6,000,000**
TOTAL FY 1995 CONSTRUCTION PROGRAMS RECOMMENDED APPROPRIATION	**$932,000,000**

INTRODUCTION

For the last eight years the four Congressionally-chartered veteran service organizations (VSOs), coauthors of the *Independent Budget*, collectively representing more than 5 million veterans, have presented to Congress a needs-based budget proposal for the Department of Veterans Affairs (VA), as a counterpoint to that of the administration. As in past years, the motive for this project is defined in the foregoing Prologue.

Never before have the implications of the *Independent Budget* contrasted with those of the administration's budget in such bold relief. This is a pivotal time in VA. The FY 1995 federal budget, once enacted, will have a lasting impact in terms of both enabling VA to continue delivering entitled benefits to veterans and allowing it to embark upon the extensive structural and functional changes required for successful delivery of veterans' health care in tomorrow's competitive medical market.

Although much has occurred since the publication of the FY 1994 *Independent Budget*, events have largely fulfilled our expectations. The new administration has now been in office one year, pushing forward a sweeping agenda of change. Implementation of two major reform efforts—President Clinton's American Health Security Act of 1993 (HSA) or any of Congress' competing comprehensive health care reform plans, and the recommendations in the Vice President's *Report of the National Performance Review*—will fundamentally affect the Department of Veterans Affairs.

This fall, the president and the first lady delivered the administration's comprehensive health plan to Capitol Hill. The *Independent Budget* veterans' service organizations, support, in concept, the administration's national health care reform proposal; that proposal assigns a strong, independent participatory role for the veteran-dedicated VA health care system. Other national reform proposals, some less devoted to veterans, will surely be an influential part of the coming congressional health care debate. We have commended the Clinton administration for the inclusiveness it exercised in crafting its proposal, the architects of which included many VA staff experts. Considerable concerns remain, however, about how the integrity of the VA system will be maintained under the proposal and how VA will actively compete for veteran patients' enrollment

against a currently better funded and staffed private medical sector.

Those concerns are fueled by such ironies as the administration's FY 1995 VA budget request, the level of which would again fail to maintain even the previous year's workload, and the 12 percent VA personnel reduction recommended in the *Report of the National Performance Review*. The latter, purportedly attainable through further improvement in management, would indicate the loss of 25,080 FTEs from VA health care provision over five years. Paradoxically, preparation for a competitive role under national health care reform will require additional personnel to support enhancement of VA health care services.

In an *IB* telephone survey, referred to later in this document, VA medical center directors, in states where implementation of health reform programs is already underway, reported that delays for outpatient clinic appointments commonly extend from three to nine months. They explained that their inability to make any increased commitment to ambulatory services or the promotion of primary care is due primarily to the lack of required personnel. Contrary to what is commonly claimed, the inevitable price of sizeable staff reductions is a loss of clinical workload capacity—one more barrier to veterans' access to VA health care.

The FY 1995 *Independent Budget's* primary theme deals with the resource needs and legislative changes required to enable VA successfully to restructure and respond to the challenge of these turbulent times. This year's *IB* focus on issues and admonitions differs from that of last year only in the profound urgency of that focus. This phrase from last year's publication is all the more cogent:

> There is a pervasive aura of change provoking both the discomfort of uncertainty and the fervor of opportunity. The shape and substance of this year's federal budget will be heavily influenced by the turbulent dynamics in the nation's medical, economic, and political environment.

We continue to be encouraged by some of the constructive changes recently underway in VA in contrast to the dilatory response to recommendations from former VA Secretary Derwinski's Commission on the Future Structure

of Veterans Health Care (Mission Commission). Many of the recommendations contained in this issue of the *IB* are now being addressed by the National Health Care Reform Project under the deputy undersecretary for the Veterans Health Administration (VHA). We like their agenda! And we are in accord with the VA's belated realization of the immediate need for such accomplishments as

- a comprehensive reorganization of the VHA
- realignment of its facilities and missions
- decentralization of management authority
- shift to non-institutional venues
- enhancement of primary care
- legislative authorization for advertising, marketing and facility-centered control and management of personnel.

We look forward to the outcome of this more purposeful strategic planning by VHA while continuing to insist that the VSOs should be accorded an active collaborative role in that effort. Similarly, in this era of consumer representation, the composite membership of health alliances proposed by the Clinton administration includes delegates from government, business, insurers, providers, and consumers of health care.

Differences remain between the VSO and the VHA planning agendas. They are of two categories: one consists of proposals that VA has yet to embrace, and the other involves matters of degree. In the latter category, for example, we are inclined to doubt that VA is contemplating the degree of management decentralization that the VSOs consider necessary to provide VA medical center directors with a level of authority comparable to that enjoyed by their competing counterparts in the private medical sector. Similarly, VA appears to accept complacently the continued inadequacy of access to VA health care, although full, adequate access is provided for in the American Health Security Act of 1993 (HSA).

The IBVSOs, in contrast, make clear in this publication their belief that eligibility reform, under the Clinton plan, is more limited than that repeatedly proposed in past issues of the *IB*. Clinton's VA eligibility reform rests on a very tenuous base, tied as it is to the American Health Security Act's basic medical benefit package. The entitlement to VA health care will shrink

should Congress reduce the amount of medical services in the standard national benefit package. It is for that reason that the VSOs make clear their intention, and rationale, to monitor this issue closely during the coming congressional debate on health care reform. The *Independent Budget* veterans service organizations reserve the right to request separate legislation covering veterans' eligibility reform should that become appropriate.

VSO proposals not yet on the VA agenda are numerous and are presented in detail elsewhere in this issue of the *Independent Budget*.
Some examples of these proposals follow:

- To provide interim legislation for pilot studies to allow VA to compete by waiving the authority that currently restricts its competitive efforts in states where health care reform either is being implemented or is about to be implemented. The legislation would include grants to provide VA medical facilities the resource allocations to "move" with the rest of the state by funding the implementation of expanded access eligibility, enhanced primary care services, marketing, and contracting.

- To consider VA contracting for extramural "medical support services" as now planned for DOD's TRICARE.

- To clarify VA funding arrangements under the HSA proposal. VSOs advocate capitation budgeting for VHA; the full retention of reimbursements at the local providing facility; and a clear commitment by Congress to providing all care for service-connected veterans through appropriated funding.

- To place special emphasis—in the realignment of VA health care facilities—on the continued provision of the specialized services in which VA excels (i.e., geriatrics and long-term care, mental health care, treatment of post-traumatic stress disorder, spinal cord dysfunction care, care for the blind, prosthetics and orthotics and all variety of rehabilitation).

- In this transition period, to protect the integrity of VA/academic affiliations and restore the full viability of VA medical and prosthetic research.

The nation's veterans are depending on Congress for assurance that, in the course of the pending debate on national health care reform, the destiny of the VA system will not be left to arbitrary afterthought. From this point on, VA's ability to adjust successfully to change and to meet the challenge of a competitive medical market is largely up to Congress.

America's veterans and their families are also depending on Congress to provide meaningful resources to VA to enable them to reduce the long delays in the delivery of compensation, pension, vocational rehabilitation, and other VA benefits. As pointed out in past *Independent Budget*s, without a significant increase in the number of employees available to adjudicate veterans' benefits claims, claims backlogs in the future will increase beyond the already unacceptable existing levels.

Veterans who are now required to wait nearly a year for a determination on their compensation claims, and another two years if the case is appealed to the Board of Veterans' Appeals, will wait even longer if more resources are not forthcoming. These challenges pose a serious threat to the VA's ability to provide high-quality, timely benefits and services. While the IBVSOs are encouraged by innovative programs being conducted at some Regional Offices, these programs should not be considered a panacea for all the VA's problems.

A new VA needs an imaginative congressional design, relief from perennial budget shortfalls, provision of the tools and authority to move in different directions, and, most important, a firmer congressional commitment to sustained support. Both a strengthened benefits delivery system and the success of a competitive VA medical system rely upon the satisfaction of these needs.

GUIDING PRINCIPLES

This FY 1995 INDEPENDENT BUDGET is based on a set of principles to which the four sponsoring Congressionally chartered veterans service organizations have agreed. Few changes have been made from last year's listing since these are for the most part enduring precepts reflecting a shared underlying philosophy regarding veterans programs.

Veterans who receive VA medical care should be entitled to the full range of VA medical services.

Once admitted to the VA health care system, veterans should receive care in the most appropriate setting. The choice of location of care — inpatient, outpatient, nursing home or home care — should be made by physicians and facility administrators according to principles of proper patient management. The establishment of assured access to a full continuum of medical care for entitled veterans, including certain nonservice-connected patients, is essential to high-quality care, rational planning, and efficient operation. It will also be an imperative for success in the recruitment of patients under any competitive enrollment system.

Assuming, under national health care reform, the VA system is assigned a participatory role in the nation's competitive medical market with multiple sources of funding, Congress must retain ultimate responsibility for VA solvency.

VA's financial structure should feature capitation budgeting with annual carryover of funds, retention of third party reimbursements by the local VA facility service provider, and appropriated funding to cover services to all service-connected veterans, supplemental services not otherwise funded by third party reimbursement, and maintenance of all facility infrastructure. Congressional appropriation is also required to restore the VA health care system through repair of the damage of a decade of budget shortfalls.

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 itemized in the

accompanying section titled ***"A REALISTIC MARKETING STRATEGY FOR VA".*** VSOs' prescription for change places emphasis on four elements — decentralize, regionalize, specialize and share.

Veterans service organizations should have 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 regarding mission changes, construction plans, new program location and implementation, program closing, and affiliations. The strongest political advocates of VA medical care programs' continued integrity are veterans service organizations; their participation in planning can be essential to success.

VA should site and staff its facilities in areas of the country with the greatest need of veterans services.

The time has come to adjust the missions of VA facilities. For both health care facilities and regional offices, this means a geographic reconfiguration to bring VA resources into conjunction with the veteran population. Realignment may require few facilities and expansion or modification of existing ones. Construction funding should ensure the integrity of VA's physical plant. There must be no covert downsizing of system capacity by allowing facilities to deteriorate.

The VA medical care program is, and has always been meant to be, a health care system dedicated to veterans.

While the IBVSOs endorse and favor the enhancement of VA's structured sharing programs with DOD, academic affiliate and community medical facilities, veterans must be assured inviolable priority to access their health care system.

Women veterans are entitled to the same access, level and quality of health care 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 female care must be enhanced.

VA must better prepare to meet the special needs of aging veterans.

It should 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 geriatric and long-term care.

VA's affiliations with medical school are essential to 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 should make every effort to improve communication and coordination among its facilities and their affiliates. Affiliates should have an advisory 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 committee's 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 by current limitations of VHA's research capability could undermine the quality of care available to veterans.

New appropriations must fund Congressional mandates.

Statutory mandates without adequate appropriations are empty promises. Adequate funding should accompany legislation that creates new service initiatives — otherwise, implementation should be at the Department's discretion. Congress should categorically exempt appropriations for patient care programs from federal budget sequestration.

Entitlement, by definition, implies timely delivery of benefits.

Congress should legislate reasonable timeliness standards for benefit and service delivery. Such legislation must then mandate sufficient funding to meet those timeliness standards.

Veterans should 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, 12 states do not have open burial space.

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 in areas damaged by natural disasters.

SUMMARY OF RECOMMENDATIONS

I. Veterans Benefits Administration (VBA)

A. Compensation, Pensions, and Burial Benefits

Repeal the current restriction precluding Dependency and Indemnity Compensation 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 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.

II. General Operating Expenses

A. General Operating Expenses

1. Veterans Benefits Administration (VBA)

Authorize funding of VBA's personnel costs for Veterans Services; Compensation, Pension and Education; and Vocational Rehabilitation and Counseling through transfers from mandatory spending entitlement accounts.

Include a line item in VBA's budget for training. For FY 1995, Congress should appropriate $8 million to fund VBA-wide training.

Re-examine and revise position descriptions as VBA's workforce becomes more skilled and productive, with a view toward increasing their grade levels.

a) Information Resources Management

b) Veterans Services

Provide funding to staff 2,440 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.

Provide sufficient funding for vocational rehabilitation

revolving fund loans.

Authorize non-pay training/work experience in the private sector.

d) Insurance and Indemnities

e) Compensation, Pension, and Education

Increase Compensation, Pension and Education employment level to 4,700 FTEE.

f) Loan Guaranty

Add 50 FTEEs specifically for loan servicing activities.

Increase loan guaranty FTEE level to 2,180 FTEE.

g) Support Services

Fund Support Services at a level which supports 3,214 FTEE staff.

2. General Administration

Increase FTEE level to 3,335 for FY 1995.

a) Board of Veterans Appeals (BVA)

Appropriate $200,000 to support BVA's FY 1995 training activities.

Increase board members' salaries so that they have pay equity with Administrative Law Judges.

b) General Counsel

Increase FTEE level to 720 for FY 1995.

c) Consolidated Staff Offices

Increase FTEE level to 310 for FY 1995.

d) Office of the Assistant Secretary For Finance And Information Resources Management

Provide 1,325 FTEE in FY 1995.

e) Office of the Assistant Secretary for Human Resources and Administration

Increase FTEE level to 500 for FY 1995.

B. Office of the Inspector General

Increase FTEE level to 530 for FY 1995.

C. National Cemetery System

Appropriate $81 million and a FTEE level of 1405 to meet the burial needs of veterans and their families.

Fast track the development of new cemetery sites to address the burial needs of the aging veteran population.

Provide funding to address the growing equipment backlog, and aging infrastructure of the National Cemetery System.

Address workload growth through the support of increased FTEE to the field.

Study the most appropriate organizational placement of burial related functions.

D. Other Accounts

1. Canteen Service Revolving Fund

No additional Congressional appropriation is necessary.

2. Office of Acquisition and Material Management: Supply Fund

Provide 720 FTEE in FY 1995.

III. Court of Veterans Appeals

Appropriate $9.5 million to support the Court's activities in FY 1995.

IV. Veterans Health Administration (VHA)

A. Medical Care

1. Human Resources Development

a) Nurses

Continue to monitor the implementation of amendments to the Nurse Pay Act and problems in the areas of salary compression and pay retention.

Recruit nurse practitioners to supplement primary and preventive VA providers.

b) Physicians

Extend tort claim protection to physicians contracted by VA when 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

Continue to strengthen VA-dental school affiliations and seek opportunities for sharing resources and facilities with dental schools.

Provide 50 dental residency stipends.

d) Physicians Assistants (PAs)

Take corrective steps to ameliorate retention problems and to improve recruitment of physician assistants by implementing more acceptable pay grades.

2. ***Independent Budget* Methodology**

b) Initiatives

i. Hospital Inpatient Care

Restore VA's inpatient capacity to the FY 1988 current services level of 1,086,500 inpatients treated in VA medical centers.

Accommodate an average daily census of 1,025 in non-VA hospitals.

ii. Intermediate Care

Re-examine the types of patients treated in VA intermediate care beds.

Structure resources to care for intermediate care patients in the most appropriate setting.

Remedy some veterans' misplacement in intermediate care beds through entitlement reform.

iii. Domiciliary Care

Expand the VA domiciliary program to accommodate an average daily census of 11,600 in FY 1995.

iv. Outpatient Care

Increase outpatient workload to achieve the *Independent Budget* FY 1995 target of 1,880,000 fee and 24,000,000 staff outpatient visits.

Fund 50 "storefront" clinics to provide outpatient care in Vet Centers.

a) Prevention

Add one women veterans coordinator at the 50 centers with the highest women's utilization rates for women's ambulatory care preventive services.

Add funding for approximately 10,000 fee visits for women's ambulatory care preventive services.

Add funding for direct care staff and equipment to implement preventive medicine program interventions.

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 intense treatment when necessary.

Continue to support the effective and importance activities of the Patient Health Education program.

c) Case Management of Outpatient Services

Eliminate restrictive entitlement criteria so that VA can manage its patients appropriately.

Expand managed care techniques to other programs, especially those treating veterans with specialized care needs, such as spinal cord injury and psycho-social impairments.

v. Long-Term Care

Appropriate funds to expand nursing home capacity and implement innovative long-term care programs.

a) Nursing Homes

1. VA Nursing Homes

Increase the VA nursing home average daily census to 16,724 in FY 1995 by converting hospital beds, leasing nursing homes, and entering enhanced use leases for additional capacity.

a) Hospital Bed Conversions

Convert 25 120-bed hospital wards to

nursing home use in FY 1995.

b) Nursing Home Construction

Fund four new 120-bed nursing homes in FY 1995.

Expedite VA construction project completion.

c) Nursing Home Leases

Lease 12 120-bed nursing homes for which VA personnel would manage care and equipment in FY 1995.

d) Enhanced Use Leases

Exploit enhanced use arrangements to add four 120-bed wards to VA's nursing home capacity.

Fund activation costs for leased facilities.

2. State Home Nursing Homes

Increase state nursing home average daily census to 14,000 for FY 1995.

Fulfill the obligation to compensate State Homes for one-third (1/3) 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.

3. Community Nursing Homes

Increase community-based nursing home census to 13,600 in FY 1995.

b) Non-Institutional Long-Term Care Alternatives

Continue to supplement institutional programs with more non-institutional types of care.

1. Hospital-Based Home Care

Activate Hospital-Based Home Care programs at the 96 remaining hospitals then currently lack them in FY 1995.

2. Respite Care Programs

Activate respite programs at the 35 hospitals that currently lack them in FY 1995.

3. Hospice Care

Expand the VA hospice program by creating community-based programs with existing HBHC teams.

4. Adult Day Health Care

Increase the number of hospitals with VA or VA-sponsored adult day health care programs from 43 to 60.

5. Community Residential Care

Establish community residential care program at the 36 VA medical centers that do not

offer such services now.

c) Accommodating the Long-Term Care Needs of Veterans

1. Multi-Level Long-Term Care Facilities

Establish four multi-level, long-term care facilities, one in each VA region, which is associated with a nearby VA regional referral center.

Develop geriatric treatment units to coordinate treatment of older veterans as they move through the VA system.

Expedite the integration of acute care and long-term care programs geared toward the elderly, thereby encouraging continuity of care for these veterans.

2. Geriatric Evaluation and Management (GEM) Programs

Activate GEM programs at the 40 remaining hospitals that currently lack them in FY 1995.

3. 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 1995.

iv. 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 psycho-social disorders in veterans.

a) Homeless Programs

Expand homeless veterans programs which focus on enhancing veterans' independent living skills. VA currently runs many innovative programs through its homeless chronically mentally ill programs, and should continue to utilize this venue.

Expand care at new and existing sites through the types of programs shown in Table MC-3.

Continue to develop drop-in centers in communities with unmet needs and metropolitan areas, and establish two new Homeless Chronically Mentally Ill programs.

b) Long-Term Psychiatric Care

Provide staffing and resource enhancements 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.

d) Veterans' Industries

Continue efforts to coordinate Veterans' Industries programs with private, non-profit organizations, and with the Department of Housing and Urban Development.

Focus on establishing 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 MC-6.

Establish PTSD Clinical Treatment team's in 30 additional VA medical centers.

Enhance treatment resources at existing facilities.

vii. Programs for Veterans' Specialized Care Needs

a) Women Veterans' Health Initiatives

Examine the special needs of women veterans in planning VA's future.

Increase publicity of women veterans coordinators, who facilitate women veterans' entry to VA facilities through outreach programs.

Continue implementation of the VA Advisory Committee on Women Veterans.

82-758 O - 94 - 6

Give coordinators direct access to facility directors to assist efforts to train and orient administrative staff to facilitate their women patients' access to gender-specific VA health care services.

Accommodate privacy standards for women's needs, 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 while on active duty.

Authorize funding for 50 new, dedicated FTEE for the Women Veterans Coordinators programs.

b) Programs for Gulf War Veterans

Extend authorization for VA coverage of Persian Gulf syndrome in veterans.

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, not only to benefit veterans, but to benefit the entire disabled community.

1. Prosthetics Users' Services

Fully implement the Prosthetics Improvement Implementation Plan, particularly those elements intended to expedite purchasing.

Coordinate reporting systems to enhance the availability of prosthetics to veterans.

2. 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.

Designate a GRECC dedicated to the study of spinal cord injury in aging veterans.

Establish a new SCI clinic.

Fully fund the Independent Living fund.

3. Blinded Veterans' Programs

Continue funding rehabilitation of blinded veterans through a centralized account.

Add funding for outpatient Specialists to treat blinded veterans at VA medical centers without dedicated rehabilitation facilities.

Establish one new blind rehabilitation program to expand VA's Blind Rehabilitation

capacity.

viii. Education and Training

a) Resident Training Programs

Maintain the additional FTEE level allocated to direct care in FY 1992-4.

b) Residents/Fellowships in High-Demand Specialties

Provide funds to support 160 FTEEs for residencies in high-demand specialties.

c) Tuition Reimbursement Program

Provide funding for nursing tuition reimbursement.

d) Career Field and Service Chief Development

Provide funding for expanded satellite television programming, requiring 15 FTEEs.

e) AIDS Related Training

Provide funding for AIDS related training

f) Satellite Television

Provide funding for expanded satellite television programming, requiring 15 FTEEs.

ix. Decentralized Hospital Computer Program (DHCP)

Continue to maintain a commitment to the DHCP as VA's primary hospital information system.

x. Pharmacy

Fund the remaining ten centers to implement the unit dose program.

Complete consolidation of VA mail service pharmacies.

xi. Equipment Backlog

Retire a newly prioritized equipment backlog within the next four fiscal years.

xii. Non-Recurring Maintenance and Repair Backlog

Retire the non-recurring maintenance backlog within the next four fiscal years.

B. Medical and Prosthetic Research

Appropriate $348.6 million for medical, rehabilitation and health services research. This amount includes $348.6 million to meet current services requirements.

1. Medical Research

Appropriate $269 million for biomedical, clinical and prosthetics research.

2. Rehabilitation Research

Appropriate $35 million for rehabilitation research.

3. Health Services Research

Appropriate $45 million for health services research activities.

4. Areas of Special Concern

Appropriate $20 million for special initiatives in priority ares of aging, women's health studies, AIDS, and spinal cord injury programs.

C. Medical Administration and Miscellaneous Operating Expenses (MAMOE)

Support a FY 1994 supplemental appropriation of $20 to cover short-fall.

Appropriate $79.2 million and fund 848 FTEE.

Conduct an in-depth study of the management, organization, funding, and role of MAMOE.

D. Health Professionals Educational Assistance Programs

E. Grant to the Republic of the Philippines

V. Construction Programs

A. Management Recommendations

Begin revisions to strategic planning models and Facility Development Programs now, and complete them as soon after legislative decisions on health care reform are accomplished.

B. Major Construction

Appropriate $294-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 an established set of priorities based on probable competition under health care reform plans.

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.

C. Minor Construction

Appropriate $412-million for Minor Construction projects.

Convert the remaining 30 beds from its FY 1993 plan, accomplish those it plans for FY 1994, and convert 25 120-bed wards in FY 1995.

Appropriate $18 million for existing National Cemetery System construction projects.

D. Parking Garage Revolving Fund

Provide a $20-million for this fund which finances VA facility parking garage construction and operation.

E. Grants for the Construction of State Extended Care Facilities

Provide $200 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 1995.

PROPOSED LEGISLATIVE INITIATIVES FOR FY 1995 *INDEPENDENT BUDGET*

1. **Eligibility Reform.** Require VA to provide the full continuum of VA health services, including long-term care, to Category A veterans.
2. **Catastrophically Disabled.** Include veterans who are or become catastrophically disabled as "Category A" veterans, for the purposes of entitlement to VA medical services.
3. **Procreative Services.** Include in the VA definition of "medical services" those services designed to overcome service-connected and non-service-connected disabilities affecting procreation.
4. **Medical Care/Mandatory Appropriation.** Provide that the VA medical care appropriation be designated as entitlement funding, and that sufficient funds be appropriated for the VA Medical Care budget to maintain a high-quality health care system and meet the needs of entitled veterans.
5. **Carry over authority.** Ensure that VA carry-over funds not spent by the end of the fiscal year to the following year.
6. **VA Physician Assistants.** Grant a pay increase or revise pay categories to offset salary compression and retention and recruitment problems.
7. **Medicare Reimbursement.** Authorize a demonstration project requiring Medicare to reimburse VA for treatment of Medicare-eligible vets.
8. **Timeliness Standards.** Provide resources to mandate minimum timeliness standards for processing compensation, pension, and adjudication claims and 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.
9. **Sequestration.** Legislatively provide total exemption from sequestration for VA Medical Care appropriation.
10. **Assistance for Providing Automobiles (and Adaptive Equipment).** Increase the monetary assistance provided veterans for purchase of automobiles from $5,500 to $11,000.
11. **"Whistleblower" Protection Act.** Repeal Title 38 exemption from the Whistleblower Protection Act to protect employees who report incidents of agency "wrong-doing" from retaliation.

12. **Compensation and Pension Examinations.** Give VA legislative authority to collect funds from the Compensation and Pensions account to cover the costs to the Medical Care account for examinations of these programs' beneficiaries.
13. **Immunity from Tort Liability for VA-contracted Physicians.** Extend to VA-contract physicians the same immunity from tort liability in medical malpractice claims that is accorded to regular VA physicians.
14. **Funding for Cemeteries.** Authorize funding for VA to build a veterans' cemetery in every state without an open site.
15. **Pay Equity for Board of Veterans Appeals Members.** Increase board members' salaries so that they have pay equity with administrative law judges.
16. **Dependency and Indemnity Compensation (DIC) Reform.** Provide DIC support for "killed in action" widows at the same level as widows of totally disabled veterans.
17. **Requirements for "contingent" provision of vocational rehabilitation.** Require VA to arrange vocational rehabilitation services for eligible disabled veterans by accredited non-VA agency if VA is unable to provide such services on a timely basis.
18. **Non-Pay Training/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.
19. **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.
20. **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. VA should be relieved of mandated compliance with the Buy America Act; the GSA regulations on management and disposal of federal property and acquisition of sites for construction

of public buildings; and, laws governing pre- and post-award disputes, contract disputes, and higher leasing authority thresholds.

21. **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 the VA, served as the primary peer review mechanism for the awarding of VA research grants. The *Independent Budget* urges the 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.
22. **Eliminate ceilings on full-time employee equivalents.** Grant VA medical center directors the discretion to hire necessary staff within funds allocated to their centers.

Regarding State Health Care Reform:

23. **Provide grant funding and waive restrictive legislation for VA medical centers in states with imminent comprehensive health reform.** Grant funding that will allow the VA to compete and waive authority that restricts competitive efforts in states where reform is either being implemented or about to be implemented.

Regarding National Health Care Reform:

24. **Provide a rich basic benefits package for all Americans.** Ensure that the American public is provided a rich basic benefits package in any Federally enacted health care reform plan. Allow VA to provide or fund these necessary services for all core-entitled veterans at no out-of-pocket expense.
25. **Provide asset protection from medical expenses for all Americans who are catastrophically disabled.** Ensure that health care reform protects veterans and other citizens from financial devastation in the event of catastrophic illness or injury.
26. **Protect the unique missions of the Department of Veterans Affairs.** Ensure that the VA medical care system be given a role in the national health care delivery system as a health care system

dedicated to veterans, as a clinical personnel training resource, as a premiere medical and prosthetic researcher, and as a back-up medical care provider to DoD in the event of national emergency.

27. **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:
    1. providing full funding support for a capitated risk-adjusted premium from a mandatory spending account and
    2. ensuring that appropriations adequately support additional services now offered to veterans under Title 38 (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 PTSD, treatment conditions related to AO/IR exposure, long term mental health services, domiciliary care, and nursing home care in excess of 100 days) that are not a part of a basic benefits package.
28. **Establish a formalized advisory role for VSOs.** Ensure that VSOs have a collaborative partnership with VHA in VA strategic planning efforts to prepare for national health care reform.
29. **Allow VA Health Plans to use funds from all sources for marketing purposes they deem appropriate for local community needs.** Prohibit restrictions on VA marketing efforts to prepare for health care reform.
30. **Allow a portion of reimbursements to remain in VA facilities.** Require the "Health Plan Fund" under the Clinton proposal to design a formula that would allow individual medical facilities to retain a specific share of reimbursements collected to encourage initiative and growth.

COMPENSATION AND PENSIONS

The Compensation and Pensions appropriation provides funds for payment of compensation, pension, and burial benefits, and some miscellaneous benefits described below.

Compensation: Compensation is paid to veterans for disabilities incurred during active military service or aggravated during 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 rank. DIC payments made to surviving spouses of veterans who die on or after January 1, 1993, and those who elect to receive payments under P.L. 102-568 are, effective December 1, 1993, $769 per month plus a payment of $169 monthly to spouses of veterans rated totally disabled for a continuous period of eight years immediately proceeding death. To be eligible for the $169.00 monthly add-on, surviving spouses must have been married to the veteran during the eight-year period of total disability. Effective January 1, 1994, survivors receive $150 per month for each dependent child. In addition, service-connected disabled veterans who use prosthetic or orthopedic appliances that tends to wear out clothing receive clothing allowances.

Pension: Pension benefits are paid to aged (65 or older) veterans who were receiving benefits prior to November 1, 1990, or disabled veterans of wartime service who have low income, 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, count almost all income in determining pension eligibility, and reduce pension amounts dollar-for-dollar for income from other sources. More than half of pensioners and more than four of every five pension dollars are paid under the improved law program. Older pension programs

have major income disregards, with little or no reduction of pensions for income from other sources, and no automatic annual increases.

Burial Benefits and Miscellaneous Assistance: The Burial Benefits program provides for (a) 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; (b) 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; (c) the payment of a burial allowance of up to $1,500 when a veteran dies as the result of service-connected disability; (d) a flag to drape the casket of an entitled deceased veteran; (e) headstones or markers for graves of veterans and, in certain cases, graves of eligible dependents; and (f) authority to provide graveliners for certain veterans interred in the National Cemetery System.

Miscellaneous Assistance serves 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.

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.

Mortgage Insurance - Mortgage protection life insurance (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) Remarriage Provision

The VSOs believe that the 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, Service Retirement System (CSRS), and the CIA Retirement and Disability System (CIARDS)--permit reinstatement of survivors' benefits when a surviving spouse's remarriage terminates. These programs also permit continuing eligibility while 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 terminates.

RECOMMENDATION: Congress should repeal the current restriction precluding DIC reinstatement for remarried surviving spouses or married children who become single.

DISCRETIONARY/MANDATORY SPENDING

The Omnibus Budget Reconciliation Act of 1990 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, the Omnibus Budget Reconciliation Act of 1993 caps discretionary spending through Fiscal Year 1998 at the Fiscal Year 1994 level. This "cap" does not allow for inflation.

With respect to veterans' benefits programs, however, the mandatory/discretionary spending distinction makes little sense. For example, the costs of administering compensation and pensions programs are considered discretionary even though compension and pension benefits are mandatory. The VSO's hold that a benefit entitlement and its accurate adjudication and timely delivery can not logically be separated. If there are no employees to adjudicate benefit claims, an authorized entitlement is rendered meaningless. Why then are the means needed to adjudicate

claims considered discretionary rather than mandatory?

The consequence, of course, is that entitlement-delivery resource needs 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 for the Veterans Benefits Administration (VBA) and, by any standard, adjudicative inaccuracy and tardiness.

The point is, of course, that budgetary categories should conform to reality. If authorizing legislation mandates a benefit or service, mandatory spending accounts should fund the costs of delivering 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 are credit reform and OBRA activities. Unfortunately, however, OBRA-related activities, for the most part, were geared toward eliminating entitlements. A most recent example of providing for the cost of VBA employees from mandatory spending 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 <u>all</u> 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 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.

<u>RECOMMENDATIONS</u>

With these considerations in mind, the VSOs urge Congress to:

o 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.

o 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 as a result of honorable wartime military service.

VA predicts an increased demand for headstones and 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.

READJUSTMENT BENEFITS

FY 1994 appropriations must fund the following Readjustment Benefits programs for veterans and certain eligible dependents and servicepersons.

o *All Volunteer Force Educational Assistance (veterans):*
Chapter 30, Title 38, USC. 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 assist Armed Forces members' readjustment 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 $100-per-month reduction on their military pay for the first 12 months of active duty. VA pays basic benefits and DOD pays supplemental benefits. Service persons 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.

o *All Volunteer Force Education Assistance (reservists):*
Chapter 106, Title 10, USC. This program provides educational assistance to persons who enlist, reenlist 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.

o *Educational Assistance (dependents):* Chapter 35, Title 38, USC. This program provides educational assistance benefits to children and spouses of veterans whose service-connected disability is rated permanent and total, and 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 have been interned by a hostile government

for more than 90 days.

o *Special Assistance to Disabled Veterans (vocational rehabilitation):* Chapter 31, Title 38, USC. This program provides benefits to disabled veterans enrolled in programs of vocational rehabilitation. Disabled veterans also receive payments for tuition, books, handling charges, supplies, equipment and beneficiary travel. The program also provides provisions for extended evaluation and independent living services for disabled veterans.

o *Special Assistance to Disabled Veterans (housing grants):* Chapter 21, Title 38, USC. 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 make necessary their service-connected disabilities. Veterans with service-connected blindness or the loss of (or loss of use of) both upper extremities may receive individual grants of up to $6,500.

o *Special Assistance to Disabled Veterans (automobile grants and adaptive equipment):* Chapter 39, Title 38, USC. 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 deemed necessary to ensure 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.

o *Workstudy:* A student pursuing rehabilitation, education, or training under chapters 30, 31, 32 and 35 of Title 38 USC and chapter 106 of Title 10 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 are 30 percent or more disabled from service-connected disabilities 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 (one-half time for Chapter 31 veterans) program who agrees to work up to 25 hours per week for the enrollment period receives the higher 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, which educational institutions and training establishments offer and in which veterans, dependents, or reservists enroll.

The VSOs would like to note here that a provision of Public Law 102-568, the Dependency and Indemnity Compensation Reform Act of 1992, indexed, beginning in FY 1994, future increases in MGIB with movement of the Consumer Price Index (CPI). However, Public Law 103-66, the Omnibus Budget Reconciliation Act of 1993, eliminated the MGIB COLA for Fiscal Year 1994 and reduced the Fiscal Year 1995 COLA by one half.

RECOMMENDATIONS

o Congress should authorize funding for all vocational rehabilitation benefits and services from the Readjustment Benefits entitlement account.

o Congress should legislate, as an entitlement, reasonable timeliness standards for VA's provision of vocational rehabilitation services to eligible veterans.

VETERANS INSURANCE AND INDEMNITIES

The Department of Veterans Affairs (VA) administers or supervises eight life insurance programs which provide more than $520 billion of insurance protection to 6.3 million veterans and members of the uniformed services. The amount of coverage provided by the VA-sponsored programs would make the VA the third largest life insurer in the country when compared to commercial insurance companies. Four of the VA administered life insurance programs are self-supporting; sufficient revenues have been invested in U.S. Treasury securities to ensure that these programs' liabilities are met without the need for any appropriated funds.

The Veterans Insurance and Indemnities (VI&I) fund is the only veterans' insurance fund that requires an annual appropriation. The appropriation subsidize: (1) providing service-disabled veterans with insurance protection at standard premium rates; and (2) 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 between 1946 and 1949 to veterans with service-connected disabilities. The VI&I appropriation also provides disability award payments to certain World War I veterans. These 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 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 policy holders who had mortgages in excess of $40,000; only 196 declined the additional coverage. As a result of this new increase, an additional $54 million in coverage was issued.

Except for VI&I payments, veterans' insurance benefits programs are entirely 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, 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) (effective 12/1/92)
- Veterans Reopened Insurance (VRI)
- Veterans Special Life Insurance (VSLI)

Standing legislation makes budget authority available to USGLI and NSLI funds automatically each year and therefore, Congress need not take action. Budget authority consists of net cash income in the form of premium

payments, interest on securities, and VI&I payments, which in FY 1994 amounted to just more than $1.4 billion.

As of September 30, 1993, approximately 3 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. In FY 1993, VA has collected approximately $70.3 billion in income from these policies, disbursed $55.7 billion to policy holders or beneficiaries, and currently holds $14.6 billion in reserve to cover future liabilities to these funds.

In 1992, VA paid annual cash dividends for NSLI, VSLI, VRI and USGLI in advance of 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 3, 1992, during which NSLI, VSLI and VRI policy holders could use their dividends credits to purchase paid-up additional insurance. During this "open season", approximately 101,000 policy holders 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. These 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

- Increase the maximum amount of VMLI from $40,000 to $90,000.

At the end of 1992, the VA introduced a new dividend option, called

net premium billing option, which allows policy holders to use their annual dividends to pay premiums. This option allows the dividend to automatically be applied to the premiums. If the dividend amount is less than the amount of the annual premium, the policy holder is billed for the balance. If the dividend amount is greater, the excess amount is refunded, used to buy additional insurance or reduce an outstanding loan balance. Approximately 30 percent of the eligible policy holders have elected to use this option.

HOME LOAN PROGRAMS

Congress created the Home Loan Guaranty Program in 1944 to assist returning veterans who were unable to maintain a suitable credit rating or achieve the necessary savings to afford a downpayment on a home. Originally, the legislation called for a sunset provision of five year; however, because of the program's popularity and success, Congress permanently codified it in Title 38 in 1970. The Loan Guaranty Revolving Fund financed the program's operation. Since its inception, VA has guaranteed 14 million loans, and approximately 3.48 million loans are outstanding.

For years, however, the Loan Guaranty Revolving Fund (LGRF) required substantial appropriations to maintain its solvency. High foreclosure rates caused LGRF deficits; however, as prior *Independent Budgets* described, misguided OMB policies, ineffective management practices and an inadequate number of employees to administer the program also contributed significantly to LGRF 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 to indemnify veterans who default on their home loans against liability to VA.

In the event of an insoluble default, VA, through its contract of guarantee, stands ready 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 percent to 1.25 percent (compensably-rated service-connected disabled veterans and spouses of veterans whose deaths are service-connected are exempt from the fee). For loans with 5- or 10-percent down payments, the loan fee was reduced 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-percent and 10-percent downpayment 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 were again in effect. However, under OBRA of 1993, P.L. 103-66, the fees borrowers pay to the VA for a VA-guaranteed home loan were increased by 0.75 percent of the loan amount (compensably-rated service-connected veterans and spouses of veterans whose death 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 amount of the loan for veterans who previously obtained VA-guaranteed home loans. The increased fee does not apply to veterans who make a downpayment of at least five percent of the price of the property. This increased fee applies in the case of second and subsequent loans closed between October 1, 1993, and September 30, 1998.

Under current law, the guaranty amounts are as follows:

- 50 percent of loans of $45,000 or less;
- The lesser of $36,000 or 40 percent (minimum of $22,500) of loans greater than $45,000, but not more than $144,000;
- The lesser of $46,000 or 25 percent for loans greater than $144,000, to purchase or construct a home.

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 non-credit transactions. The essence of credit reform is to separate the subsidy costs from the non-subsidized cash flows of credit transactions and to focus base budgeting and analysis on subsidy costs.

To accomplish the above objective, credit reform separated federal direct and guaranteed loan programs into the following new 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 after, are recorded in the direct loan financing account.

o Program accounts - These accounts record the subsidy costs for direct loans obligated and loan guarantees committed in 1992 or after, 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.

o Direct loan financing account - This non-budgetary account records all financial transactions to and from the government resulting from direct loans obligated in 1992 or after. The amounts in these accounts provide a means of financing and are not included in the budget totals.

o Guaranteed loan financing accounts - These accounts record all financial transactions to and from the government, resulting from loan guarantees committed in 1992 or after.

GENERAL OPERATING EXPENSES

INTRODUCTION

FY 1995 represents the seventh consecutive year for which the IBVSOs have prepared an independent budget for General Operating Expenses (GOE).

During the past seven years, we have witnessed a steady decline in VA's ability to adjudicate virtually all categories of veterans' claims. During Fiscal Year 1993, the average processing time for original claims stood at more than six months (188.7 days) and there were more than 530,000 claims backlogged in the C&P service at the end of Fiscal Year 1993. This represents a significant increase over last year. VA predicts this number will continue to grow and could reach more than 720,000 by the end of Fiscal Year 1994.

If the continuing decline in VA's ability to provide quality benefit determinations in a timely manner is to be reversed, there must be an honest and thorough assessment of VA's employee and equipment needs. This assessment, we believe, will demonstrate the critical need for a significant increase in the number of employees needed to accomplish this goal as well as the need to move rapidly forward on VBA's planned ADP modernization program. This, together with a continued emphasis on employee training and increased innovation in the way Regional Offices adjudicate benefit claims, will promote improved productivity and is the only way to maintain the well-motivated, efficient workforce necessary to improve the quality and timeliness of veterans' benefits and services delivery.

In the *Independent Budget*'s "Benefits Programs" section, the IBVSOs have stressed an entitlement's inseparability from its timely delivery. This principle is the cornerstone of the IBVSOs' funding recommendations. It also should be the basis for VA management's budgetary planning. VA should set goals for timely, accurate benefits and services delivery and direct resource planning toward meeting those goals. Previous *Independent Budgets* have stressed this theme. We have also gone a step further by recommending that Congress mandate, as an entitlement, minimum timeliness standards for adjudicating benefits claims and providing vocational

rehabilitation.

We doubt that anyone disagrees with these recommendations in principle; however, discretionary spending limits have inhibited their implementation. As the "Benefits Programs" section describes, funding from mandatory spending accounts could provide the resources to restore good service to veterans. We still believe that simply authorizing administrative cost transfers from mandatory entitlement accounts is only a partial solution. Such transfers are meaningless unless, as a condition of the entitlements, Congress sets and VA meets standards for timely benefits and services delivery.

Once Congress sets such standards, VA could utilize the budget process to determine the resources needed to meet them cost-effectively. We hasten to add that this in no way would diminish OMB's responsibilities or Congress's oversight role. Veterans must, however, have a guarantee that VA will meet minimum standards as a condition of the entitlement, and that they will be protected if, for any reason, administrative resources are inadequate to deliver benefits and services as Congress mandates.

The IBVSOs believe that now is the time to link veterans' entitlements and their timely and accurate delivery. With proper equipment and enough employees, VA management has the talent and dedication to meet reasonable timeliness and accuracy standards cost-effectively. The stability that mandatory spending account funding provides will ensure that it has the resources to do so. With all these pieces in place, the IBVSOs are confident that the ratio between entitlement payments and their administrative costs will decrease in future years. This ratio, of course, is the true measure of productivity, and the IBVSOs recommend that VA and Congress adopt it as a primary resource management tool.

In discussing GOE's two major components, Veterans Benefits Administration (VBA) and General Administration, we follow the same format as in previous years. Our budget analysis performs two main functions: (1) it assesses the level of service provided to veterans; and (2) it recommends authorizing and appropriations legislation to restore adequate benefits and services delivery to veterans. Our FY 1995 budget estimate for GOE is in Table ____.

THE CHALLENGE

As in prior years, this year's challenge is to persuade Congress to authorize a stable, cost-effective funding mechanism for delivering veterans' entitlements timely and accurately.

GENERAL OPERATING EXPENSES

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 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 simply seek 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". As an example, we note that VA cannot refuse to take and adjudicate benefit claims or arbitrarily deny vocational rehabilitation services to eligible disabled veterans. Therefore, personnel costs for delivering these entitlements are therefore unquestionably mandatory.

The IBVSO's continue to believe that the resources needed to purchase the equipment and technologies needed to support employees' performance should come from mandatory spending as these resources are indispensable to entitlement 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.

If our recommendations were implemented, we would not expect VBA's funding to rise dramatically. In fact, once systems are fully modernized, we expect personnel and administrative costs in general to stabilize or actually decrease, after allowing 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.

In recent years, VBA has made some strides in training, most notably in establishing the VBA Training Academy in Baltimore, Maryland. Such centralized training ensures better uniformity in employees' understanding of the training topics which help to ensure uniform and improved service nationwide.

During FY 1993, three new Veterans Benefit Counselors' (VBC) training sessions were held. Two of these sessions were held at the Academy in Baltimore and the other was held at the Regional Office in Oakland. In each of the next two years, two Academy classes for new VBCs have been scheduled.

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, enhance work skills, at least once a year. We also encourage the use of training technologies such as video-taping, video-conferencing, 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 VSOs believe that VBA should continue to have a budget line item for training. A small staff should develop, and coordinate VBA-wide training activities.

As we have in the past two *Independent Budgets*, we once again recommend $8 million for VBA training in FY 1995. This equates to less than $600 per VBA employee, a modest amount compared to amounts that large, private-sector corporations invest in training.

Training and systems modernization assuredly will generate more innovation, improve work quality and timeliness, and allow VBA to broaden outreach efforts, so that more eligible veterans receive quality, timely VA benefits and services. As this occurs, VBA should reward its workforce by updating and revising position descriptions and, when appropriate, increasing their grade levels.

VBA RECOMMENDATIONS

o Congress should authorize funding of VBA's personnel costs for Veterans Services; Compensation, Pension and Education; and Vocational Rehabilitation and Counseling through transfers from mandatory spending entitlement accounts.

o VBA's budget should have a line item for training. For FY 1995, Congress should appropriate $8 million to fund VBA-wide training.

o As VBA's workforce becomes more skilled and productive,

management should re-examine and revise position descriptions, with a view toward increasing their grade levels.

ASSESSMENT OF VBA SERVICE TO VETERANS

VBA MODERNIZATION PROGRAM

The benefits and services VBA delivers impact the lives of millions of Americans. Effective and timely delivery of these benefits and services requires a sophisticated information processing environment. The primary goal of VBA's Automated Data Processing (ADP) Modernization Program is to use modern technology to improve the delivery of benefits and services to veterans, their dependents and survivors.

The VBA's modernization goals were developed during a number of interactive workshops. These goals include:

- o providing faster, better service;
- o improving communications and information access;
- o streamlining processing; and
- o providing a system built with the user in mind.

Modernization will be the result of three progressive stages involving the procurement of major information technology. In Stage I, VBA will acquire equipment and software to support Regional Office operations. These components include sector computers, operating systems, data base management systems (DBMSs), workstations and peripherals. In Stage II, VBA will procure specialized technologies to support Regional Office Operations. These components may include imaging hardware and software, automated cards and enhanced local area networks. Finally, in Stage III, VBA will acquire computers, operating systems and DBMs to

support centralized applications and data exchange with VA organizations and other government agencies. Centralized applications include mission-critical payment systems, accounting functions and systemwide directories/locators.

The Modernization Program will improve services to veterans, provide cost savings to the government, allow changes in organization and program structures, and improve the productivity of the VBA staff. Clearly, this is a win-win situation for both veterans and the VA.

If VBA is to achieve its stated goal of providing timely benefits to America's veterans, VBA must complete its modernization plan in a timely fashion. We urge Congress to ensure that VBA moves forward with a realistic, comprehensive plan to provide much needed ADP improvements for VBA.

VETERANS SERVICES

In last two *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.*

In assessing VS's FTEE and equipment needs, it is important to note the scope of the activities of this critically important information link between VA and America's veteran population.

In FY 1993, Veterans Services responded to more than 9.3 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; conducts personal hearings and field examinations to appoint and audit incompetent veterans' fiduciaries. Veterans Services' outreach activities assist homeless veterans, woman veterans, former POWs, 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 pilot program at approximately 22 military facilities. By the end of 1992, the program expanded to include 178 military installations and now is available at 250 military installations.

In late 1991, VS developed and implemented a significant expansion of its military services program. A Military Services Coordinator (MSC) was designated at each Veteran Service Division (VSD) nationwide, with some coordinators outbased to locations strategic to large military populations. (There are 14 MSCs with primary offices on military installations and 13 who are outbased in community offices adjacent to major military facilities). 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.

Additional responsibilities include liaison functions with education 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 following represents workload accomplished during FYs 1992 and 1993:

	FY 1992	FY 1993
Briefing Sessions	6,162	6,995
Attendance at Sessions	323,932	311,628
Personal Interviews	116,026	114,913

Examining VS's telephone services probably best illustrates its ability to meet demand for its services. A 1991 US Sprint study for 800-service lines at 47 stations and local telephone company studies for 23 stations reveal the large demand VS does not satisfy. These studies show that blocked calls (busy signal) represent 25.1 percent of local line calls to 35.5 percent of 800-service line calls.

In 1990, a similar study revealed a blocked-call rate of 9.7 percent for local lines, 11.6 percent for 800 lines and 27.5 percent for foreign exchange lines (VA phased out foreign exchange calls in 1992). Current VS estimates of blocked telephone calls project no relief. For FY 1993, the blocked call rate doubled, jumping to 6 million blocked calls.

VA implemented (effective October 26, 1992) a single, toll-free 800 number (1-800-827-1000) that individuals can call from any location in the fifty states, Puerto Rico or the Virgin Islands. Unfortunately, VA's new nationwide 800 number utilizes no routing enhancement features for overflow traffic. Therefore, veterans now have one number, rather than several, at which they cannot reach VA.

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 9.3 million calls received, approximately 1.3 million callers, or 12.5 percent, hung up before talking to a counselor.

Abandoned calls result from insufficient telephone circuits or employees to respond to veteran's calls. Additionally, the waiting time has tripled in the last two years from 1 minute to 3.2 minutes a caller must wait before he or she can talk to someone. Inadequate staffing in FY 1995 will result in an increase in blocked and abandoned calls due to inadequate telephone coverage. Installing additional telephone circuits, with enhanced routing features for overflow traffic during peak calling times, and adding additional employees to answer veterans calls or the use of interactive voice response technology would solve the blocked-and abandoned-call problem.

The VA cannot do more than it is currently doing without additional FTEEs or automated systems. 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 will be able to obtain general information about benefits and services. The long range goal of VAATS is to enable claimants to access their individual account information (Compensation, Pension, Education, Insurance, Loan Guaranty, and Vocational Rehabilitation).

In last year's *Independent Budget*, we recommended a return to the FY 1985 staffing levels as a conservative estimate to meeting Veterans Services' FTEE needs. Unfortunately, Veterans Services' projected 2,152 FTEEs for FY 1993 represent 41 less than FY 1992. If Congress intends VA to meet the information and outreach needs of veterans and individuals soon to be veterans, it must provide VA with the resources to do so.

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 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 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.

- We also recommend that VS update its telephone equipment.

VOCATIONAL REHABILITATION AND COUNSELING (VR&C)

Previous *Independent Budgets* have discussed the problems confronting VR&C at length. As the FY 1993 *Independent Budget* predicted, VR&C's workload has increased substantially.

In FY 1991, Congress provided appropriations for 69 additional vocational rehabilitation specialists (VRS), reducing their average workload from 256 veterans to 229 veterans by the end of FY 1992. In FY 1993, the average workload increased to 230. It is projected that the average workload will increase to 295 cases in FY 1994 and, in FY 1995, it will increase to 315 cases. Ideally, 125 cases per VRS would be a manageable workload.

The average amount of time from the point that a veteran filed his application for vocational rehabilitation with VA to the veteran's first appointment decreased from 86 days in FY 1991 to 74 days by the end of FY 1992. This downward trend continued in FY 1993, when the figure dropped to 71 days. Projections for FY 1994 and 1995 show a 60 day wait, still double the goal of 30 days.

Likewise, VA expects VRS workload to increase to an average of 353 veterans in FY 1993, an increase of 124 over FY 1992 and 227 beyond VR&C's goal of 125.

FY 1994 projections are dismal. 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 will leap to 433 days, and applicant status time will increase to 129 days. This trend must not continue. Congress must provide VR&C with enough employees to restore timely vocational

rehabilitation services to deserving veterans.

The FY 1994 *Independent Budget* recommended that an additional 568 employees be added to provide the level of service VR&C provided in 1992. The 1994 President's Budget reduced VR&C staffing by 18 employees.

More disabled veterans need VA's Vocational Rehabilitation Services in 1995 than 1994. Congress must provide VR&C with enough employees to meet the existing workload, which VA estimates is 330 employees.

Experts agree that, to be effective, rehabilitation counseling and training must begin as soon as practicable following injury or disease onset. Over the past several years, VR&C has been unable to provide vocational service in a timely fashion. 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:

- o the 3,083 disabled veterans total annual income before entering vocational rehabilitation was $11.9 million;
- o 66 percent had no income when they entered vocational rehabilitation;
- o 84 percent were at or below poverty level entering training;
- o following vocational training, these veteran's aggregate income increased to approximately $60 million--a 402-percent increase;
- o after completing vocational rehabilitation, these veterans paid an estimated $3.7 million to Social Security; and
- o following vocational rehabilitation, these individuals paid $13 million in total estimated state and federal income taxes.

From a purely economic standpoint, it is sound public policy to return disabled veterans to meaningful employment following injury or onset of disease. To do this, it is estimated 600 additional employees will be needed just to provide the level of services VR&C provided in FY 1992.

Additionally, VA ran out of money to contract for counseling cases in 1993. Complaints from around the country were received by VA that veterans had counseling sessions canceled for lack of funds. No change is expected in 1994. Legislation must be proposed to increase the $5 million dollar cap on contract counseling. This will enable VA to spend more resources on providing services to disabled veterans.

VA also ran out of money in 1993 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 legislation be proposed which would make these loans available to all disabled veterans.

It is also recommended that VA propose legislation which would authorize non-pay training/work experience in the private sector. This type of program has been in place in Federal agencies for almost 20 years, and in State and local governments for 3 years, and has been successful.

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-pay 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 FY 1993, 3 million policies were in effect, with a total face value of 26.2 billion. In addition, VA also supervises the Servicemans' Group Life Insurance (SGLI) and the Veteran's Group Life Insurance (VGLI) programs which, by the end of FY 1993, provided $495 billion of insurance coverage to 3.4 million veterans and servicepersons. The Service Disabled Veterans' Insurance and Veterans' Mortgage Life Insurance programs are the only VA administered insurance programs that are still open to new issues. SGLI and VGLI are also open to new issues.

VA has two insurance centers (located in Philadelphia, Pennsylvania, and St. Paul, Minnesota) that have provided excellent service to America's veterans and their families through the years. Due to increased telephone inquiries, the dividend credit for paid-up additions mailing that Public Law 102-86 mandated and an increase in death awards, VA anticipated a substantial backlog by the end of FY 1993. However, the average time to process an insurance claim remained at the
FY 1992 level of four days in FY 1993, due to FTEs working overtime. The outlook for FY 1994, based on a projection of 417 FTE without any consideration of overtime pay, is an average processing time of about 19.5 days.

At the end of 1992, the VA introduced a new dividend option, called net premium billing option, which allows policy holders to use their annual dividends to pay premiums. This option allows the dividend to automatically be applied to the premiums. If the dividend amount is less than the amount of the annual premium, the policy holder is billed for the balance. If the dividend amount is greater, the excess amount is refunded, used to buy additional insurance or reduce an outstanding loan balance. Approximately 30 percent of the eligible policy holders have elected to use this option. It has been estimated that the net premium billing option has eliminated approximately 1.1 million pieces of mail (checks) from coming into the collection department. This has allowed personnel to be used elsewhere when needed.

The Insurance Service is also in the process of obtaining interactive voice response technology, which would allow policy holders to access their accounts through a touch-tone phone to obtain information on their account. It is hoped that this new system will not only free up personnel from answering routine policy status questions, but that it will also help to eliminate the number of blocked calls.

Finally, there has been significant progress in modernizing the ADP system in the Insurance Service. The computer programs have been rewritten for greater flexibility and easier programming. By the end of January 1994, all workstations will have these improvements available. In March or April, the Insurance Service will be providing annual policy statements to all policy holders. This statement will provide them with information on the status of their policy and it will enable the policy holder to keep better informed about his policy. By providing this statement to each policy holder, it is believed that this will eliminate many calls from policy holders regarding the status of their policy. This will also help to reduce the number of calls coming in and the number of blocked calls.

COMPENSATION, PENSION AND EDUCATION

As noted earlier, during the past year we continued to witness an increase in the time it takes to adjudicate veterans' compensation claims. While there are many reasons for this
dramatic increase-for example, US Court of Veterans Appeals decisions and the military draw-down, VA's compensation and pension service simply does not have enough employees or the necessary equipment to complete action on veterans' claims promptly.

Congress must have a complete assessment of VA's needs in order to provide the funding necessary for VA to complete its benefits delivery mission. As stated previously in this *Independent Budget*, congressionally authorized benefits are rendered meaningless if there are no employees to deliver them. Therefore, the IBVSOs continue to recommend that Congress classify as mandatory the funding for employees necessary to adjudicate veterans' claims. Additionally, Congress should legislate reasonable timeliness standards as an entitlement.

We believe that a crisis situation currently exists in VA's Compensation and Pension Service. In order to address this crisis, there must be a significant increase in the number of employees to adjudicate veterans' benefit claims. The VA has estimated that it will take approximately 1,050 additional employees to reduce the claims backlog to 200,000 claims. These additional employees are but a small price to pay to restore some semblance of timely and quality benefit determinations to America's service-connected disabled veterans and their families.

In addition to the changes needed to ensure a stable funding mechanism for C&P service, it is imperative that VA take a good look at the way it adjudicates benefit claims. It is obvious to all who advocate on behalf of America's veteran population that simply throwing money at the claims backlog will not solve this problem.

In this regard, the IBVSOs wish to acknowledge and commend the Veterans Benefits Administration (VBA) Blue Ribbon Panel on claims processing. Together with representatives from VBA, veterans' service organizations, the Board of Veterans' Appeals (BVA) and General Counsel, VBA has published a report making recommendations to reduce the backlog of claims and improve the timeliness of claims processing.

Initially, the Blue Ribbon Panel identified key aspects of the claims process where delays are occurring. The panel identified three specific areas determined to be causing the most significant problems. These areas are:

* inadequate development of initial and reopened disability compensation claims;

* excessive response time for requested evidence from all sources; and

* the excessive length of time cases remain in the rating boards.

At the heart of the Blue Ribbon Panel's recommendations to improve the claims processing timeliness is the realignment of the "rating activity."

Currently, the VA's rating activity can be likened to an assembly line approach where many people are responsible for assembling the "nuts and bolts" of the end product, but no one is truly accountable for the final product. The panel felt that a team approach would help to streamline the process and to provide accountability for the end product. Other important elements necessary to redesigning the rating activity include:

* centralize development/rating training program;

* wordprocessing capability; and

* reallocation of FTE resources.

Additionally, the Blue Ribbon Panel felt that, while this realignment would help to improve efficiency and timeliness, the VBA could not achieve significant reduction in backlog without full development of ADP initiatives. These initiatives include:

* Claims Processing System

* Rating Board Automation

* On-line Reference Materials

* PC-based letter package

* Automated Medical Information Exchange

* Control of veterans' records

Finally, additional areas targeted by the Blue Ribbon Panel include:

* Expand the current VBA/VHA memorandum of understanding regarding timeliness of examinations to include examination quality measures.

* Establish a joint VBA/VHA education and training effort on compensation and pension examinations.

* Establish a VA/DoD dialogue on separation examinations to ensure they meet VA requirements.

* Educate DoD medical staff on the use of the VA's physician guide.

* Establish a high-level dialogue with the Social Security Administration (SSA) regarding transfer of medical records.

* Establish, if possible, a computer linkage between VA/SSA to obtain medical records.

* Revise and simplify VA forms.

* Review, revise and update VA Regulations.

The IBVSOs encourage the VA to conduct pilot projects at a number of Regional Offices incorporating many of the VSO and Blue Ribbon Panel recommendations. Allowing Regional Office directors who participate in pilot projects to incorporate the recommendations of the VSOs and the panel into their Regional Office operations, we believe, will give the Congress adequate information upon which they can evaluate the best approach to solving the intolerable delays in VA's compensation and pension benefits delivery system.

We are encouraged by VA management's willingness to explore new and innovative ways to process veterans' compensation and pension claims. Their recognition that we cannot continue to "do business as usual" is evident by the scope and variety of VA adjudication pilot projects. An effort must be made to continue to foster even more Regional Office innovation to improve the delivery of compensation and pension to veterans and their families.

For example, in looking at ways to redesign the claims process, the New York City Regional Office is participating in an OMB/White House initiative. This initiative will set up a case management/self-directed work team of highly trained individuals who would share responsibility for all aspects of claims development and adjudication.

The IBVSOs are profoundly impressed by the initiative being conducted in New York and we are very enthusiastic about the positive impact this program will have on the way the VA does business. By the VA's own admission, under the old system of assembly line adjudication, "success is measured by the number of claims you move off your desk." It makes no difference that these claims are shuffled from desk to desk and hand to hand without anything of substance being accomplished. There is no pride in ownership because there is no ownership of that claim or the final product. However, the new initiative is changing this measure of success. Group performance standards will replace individual performance standards for the most part, and there will be accountability established for the final product. This new initiative will also allow the group to review the process from within and to request "waivers" of those procedures which do not benefit the claimant. In their words, "if it doesn't add value to the process—get rid of it." We believe this is a healthy attitude to have.

The team management concept essentially establishes small, manageable regional offices within a large regional office, and it more effectively utilizes the available talent. This new process limits the number of people necessary to handle a claim on an assembly line basis and reduces the number of errors that are made when a vast number of people must handle the claim at various stages of the adjudication process. Under the team management concept, every aspect of the claim is handled within the designated unit. This unit is responsible for every aspect of the case, beginning with the incoming mail, to contact with the veteran, to the case development, and finally to the adjudication of that claim. The advantages of this system include:

* Fewer errors because fewer people are handling the claim.

* Easier access to the claims file because they are stored within the unit.

* The unit is responsible for the claim.

* Veterans can actually speak to the person handling their claim, and can speak to the same person each time they call.

* Overhead costs are reduced.

    * There is individual ownership of the claim and pride of ownership.

* Employees become more client-oriented.

    * Employees know several jobs and have an understanding of the "big picture."

As a result of this new initiative, the VA's New York City Regional Office expects to:

* cut timeliness in half by the end of the first year;

* improve quality from the veteran's perspective;

* provide more personalized service; and

* obtain frequent feedback from the veteran.

This new system is, however, not problem-free. These problems include an enormous investment in planning and training, logistics, and personnel issues. However, the positive aspects of this new system overwhelmingly outweigh any of the negative aspects.

Again, the IBVSOs are enthusiastic about what has taken place over the last six months with respect to this management/self-directed work team concept. We are extremely confident that this new approach will revolutionize the New York City Regional Office and its claims adjudication process. This new initiative is a win-win situation. Not only will the veteran benefit from this initiative, but the VA will certainly reap benefits also. The VA employees involved in this initiative will no doubt develop an esprit de corps and pride in what they have been able to accomplish.

Other innovative approaches to solving Regional Office timeliness problems are taking place at Regional Offices through the country. In

looking at ways to speed up the claims process, Regional Offices are testing ways to combine certain functions of the adjudication and veterans' services divisions.

The VA has a number of other initiatives geared to improve the timeliness of claims processing and reduce the backlog of pending claims; some are associated with Stage I of VBA's ADP Systems Modernization. A number of the major initiatives are noted below in some detail. In addition to these, most Adjudication divisions, under the sponsorship of the four Area Directors and the Compensation and Pension Service, are experimenting with restructuring their workforces to improve the effectiveness of the available personnel by decreasing the number of clerical positions and increasing decision making positions, rating in particular.

o CLAIMS PROCESSING SYSTEM—PHASE I

Recently, work began on Phase I of the Claims Processing System (CPS). This one year project will result in a new system using rule-based technology which will support development processing for all issues related to original compensation and pension claims. This production system is based on expertise gained from a prototype system. The claims development function of CPS will begin at the point the claim is received then flow to the point the claim is ready for referral to the rating board or authorization for final action. Additionally, CPS will include data entry by Veterans Service Division (VSD) to generate the original claim form (VA Form 21-526).

The CPS rule-based system will identify all necessary evidence when the claim is first reviewed, generate requests to the veteran or third parties, and access information through automated interfaces with the BDN. This will eliminate both piece-meal development and overdevelopment. This initiative should reduce the amount of time it takes to acquire essential evidence. Improved timeliness will result because data entered when assisting a claimant with completion of the computer-generated compensation application, will be captured electronically and transferred directly into the claims processing system. This will not only eliminate the need for redundant data entry

but will also result in the generation of evidence requests which can be handed to the claimant as he or she signs the application form. The VA expects to have this ready for testing in the Baltimore and St. Petersburg offices in April 1994.

o EVR REDESIGN

Several changes have been implemented to streamline verification of pension eligibility and ease the reporting burden on VA pension recipients. Eligibility Verification Reports (EVRs) have been redesigned so that monthly Social Security rates are printed on the EVR forms. Beneficiaries are told to make no entry if the preprinted amount is correct. If there is no change in previously allowed continuing medical expenses, a beneficiary need not complete VA form 21-8416, Report of Medical, Legal or Other Expenses. In those cases, the individual must certify that expenses for the received and expected EVR reporting periods are substantially the same as the amounts previously reported. That amount is also now preprinted on the EVR form.

The VA has also redesigned EVRs to include a bar code with the beneficiary's name, claim number, and payee number to facilitate initial EVR processing. Testing of EVR bar coding has been successful in four regional offices. Equipment has recently been sent to five additional offices with other offices to follow as Stage 1 Modernization is fully implemented.

o BIRLS ENHANCEMENT

A project was recently installed which will establish a basic Beneficiary Identification and Records Locator Subsystem (BIRLS) record for each service member at the time of enlistment. This record will be updated as new data is available, including military discharge. In the past, the BIRLS record was not built until the veteran's discharge was received under the Veterans Assistance Discharge System (VADS) program or an application for benefits was received by

VA.

Since October 1992, the Army has been sending service medical records (SMRs) directly to the regional office when a disability claim is filed prior to or at the time of separation. If no claim is filed, the SMRs are sent to the VA Service Medical Records Center (SMRC) in St. Louis. These records are immediately associated with existing claims folders or held at the center until a claim is received. VBA is working with the Navy, Marine Corps, and Air Force representatives on an agreement for transfer of their SMRs to VA. Successful completion of an agreement will have a beneficial impact on claims processing.

o VOICE RECOGNITION

A prototype voice recognition system was developed and tested in the Atlanta and New Orleans regional office rating boards. This technology allows speech to be input directly into a computer for automatic transcription into a word processing document. The final evaluation concluded that the use of the Voice Recognition prototype substantially improved document timeliness and improved document quality without causing any significant increase in the rating specialist's time.

Because voice recognition systems are extremely costly, this technology will not be further developed for use by other regional offices. Utilizing knowledge and expertise gained from the prototype, the New Orleans regional office is developing a similar word processing application which uses a mouse to select and input selected words, phrases, sentences and paragraphs.

o NEW RATING DECISION FORMAT

A new rating decision format became effective on October 1, 1993. The narrative portion of the rating decision now consists of four sections: Issue, Evidence, Decision, and Reasons and Bases. A separate rating decision codesheet is also required for each decision.

Using the revised rating format, the narrative portion of the rating decision may be provided to the claimant as an attachment to a decision letter. This change will assist VA in providing complete, accurate decision notification to claimants.

o RATING BOARD AUTOMATION

The "Rating Board Automation" (RBA) project will develop an automated system for creation of a rating decision using a personal computer. This project evolved from the Voice Recognition Prototype. The VA's goal has moved beyond conventional word processing by taking full advantage of the opportunities that computer intelligence offers them. The design concept will link key elements of individual issues within a rating decision, thereby providing a more systematic and consistent analysis of each rating issue. By doing this, internal consistency will be enhanced for each rating decision with a minimum of keystroke entries by the rating specialists. Rating data essential to award processing will also be generated.

The development of this project has been divided into four phases. The first phase addresses disabilities of the knee which will include the required text and logic for the issues of service connection, evaluation, secondary service connection, individual unemployability, temporary hospital

ratings, special monthly compensation, deferred ratings, new and material evidence, and competency. Completion of this phase with delivery to the C&P Service is scheduled for April 4, 1994. Installation and testing will be conducted in a controlled environment.

Completion of the second phase is scheduled for August 1994. This release will add text using criteria from the rating schedule for the approximately 700 diagnostic codes remaining under 15 separate body systems. Field testing at the regional offices in Baltimore and St. Petersburg will be conducted to measure the impact on quality, timeliness, and production.

The third phase will include memorandum issues, pension ratings, and death ratings. In addition, several special categories of ratings including disabilities associated with Agent Orange, asbestos, radiation, and POWs will be included in this release.

A final phase will address all documents required for the appeal process, including Statements of the Case, Supplemental Statements of the Case, Hearing Officer Decisions, and associated pattern correspondence.

o AMIE

During the late summer of 1993, Automated Medical Information Exchange (AMIE) Version 2.5 was installed by all medical centers. This version included initial enhancements which had been approved by the AMIE Expert Panel (AEP).

VHA management has mandated that the Physician's Guide be included in the AMIE program. A separate work group is working on this project. Version 2.6 will be limited to the Physician's Guide with release currently anticipated in early 1994. Inclusion of the Physician's Guide in the AMIE system should improve the quality of examination reports received for rating purposes. Release of Version 2.7 is anticipated in July 1994.

Conversion to personal computer (PC) workstations in regional offices will eliminate many problems associated with AMIE and provide future capabilities not possible with the WANG based system. Conversion of the system to the PC environment is expected to improve performance, printing capabilities, and overall access.

Many administrative changes to streamline and improve the way VA adjudicates claims have been identified and suggested. These changes alone, however, will not appreciably reduce the ever growing backlog of VA claims. The VA must be provided with sufficient resources to accomplish its mission.

Unlike the C&P service, Education service is not inundated with the enormous backlog of claims or other associated problems. During FY 1993, VA processed more than 1.2 million education benefit claims for 432,777 veterans, service persons, dependents and reservists. The VA projects that it will service about 465,000 individuals in FY 1994 and more than 505,000 individuals in FY 1995.

In FY 1993, 83.39 percent of original, chapter 30 education claims were processed within 30 days; 71.41 percent of the original, nonchapter 30 education claims were processed within 30 days. The percent was even higher for supplemental claims, such as for re-entrance, reductions, extensions, and dependency actions; in both classes of education claims, almost 90 percent were processed within 30 days.

Most of VA's education claims are for benefits under Title 38, USC chapter 30 (56.9 percent) and Title 10, USC chapter 106 (25.5 percent) Montgomery G.I. Bill benefits. Chapter 30 claims are processed at one of four regional offices (Atlanta, Buffalo, Muskogee and St. Louis).

Unlike compensation and pension claims, VA does not have a significant number of pending education claims. Since 1985, pending education claims at the end of each September has represented only about 1 percent of the workload received during that year.

RECOMMENDATION:

- o increase CP&E employment level to 4700

LOAN GUARANTY

The substantial appropriations required to maintain the solvency of veterans' home loan program funds are a continuing source of concern and frustration for the VSOs. While VA has spent billions of dollars to indemnify mortgage lenders against foreclosure losses, inadequate GOE funding for program administration has caused many of these foreclosures and the consequent loss of veterans' homes and credit ratings. Additionally, as of

FY 1992, credit reform requires that VA fund programs' administrative costs through transfers from mandatory program accounts to GOE.

Previous *Independent Budgets* have emphasized the cost-effectiveness of having sufficient employees to cure as many veteran defaults as possible. We have demonstrated time and again that effective loan servicing substantially reduces program costs. In this regard, it bears repeating that the intended primary beneficiaries of veteran home loan programs are veterans and not mortgage lenders.

In FY 1993, approximately 63 percent of Loan Guaranty employees (1,308) serviced delinquent loans, foreclosures and property management. Of this figure, 705 FTEs dealt with loan servicing and counseling.

Once VA learns that a veteran is delinquent on his or her guaranteed loan, it sends a servicing letter to the borrower, encouraging the borrower to contact VA. While the lender has primary responsibility for servicing the default (although their efforts fall well short of the optimum level), VA also attempts to personally contact (usually by telephone) the borrower. These personal contacts are the most effective means of curing defaults.

Successful interventions produce alternatives to foreclosure such as loan reinstatements, refundings, or voluntary conveyances (deed-in-lieu of foreclosure) or compromise claims, for example. VA is charged with (1) helping veterans retain their homes and avoid financial loss and (2) protecting the government's interest by minimizing claim and property acquisition expenditures.

Specifically, in FY 1993, VA intervention on behalf of veterans saved $77 million; this was an average savings of $15,000 per intervention. Additional FTEs would greatly benefit VA loan servicing activities. These additional FTEs would be cost-effective, since successful intervention in only two defaulted loans would more than pay for each employee's salary and expenses, and return money to VA. Rarely do the goals of deficit reduction, program integrity and efficiency, and good service to veterans coincide so exactly, as they do in improving loan servicing.

The VA is in the process of sending letters to approximately 2.3 million veterans with VA home loans with interest rates at 8.5 percent or higher advising them about Interest Rate Reduction Refinancing Loans (IRRRLs). The VA is encouraging veterans to take advantage of the lower rate of interest currently available from lenders. By taking advantage of these lower rates, a veteran can reduce his monthly mortgage payments, thereby decreasing the likelihood of defaulting on the loan. The VA will spend approximately $2 million on this mailing project. It is estimated that the savings generated by veterans who take advantage of IRRRLs will be $130 million over the life of the loan, if at least 10 percent or 230,000 veterans take advantage of the reduced interest rates.

The VA is also in the process of sending a questionnaire to recent recipients of VA-guaranteed loans, about four percent of those who obtained these loans in FY 1993, and to lenders of VA-guaranteed loans. This survey is designed to elicit customer and lender satisfaction with the VA-guaranteed loan program.

The VA will be conducting a pilot program in the Oakland VA Regional Office beginning in January 1994. Under this twelve month pilot program, lenders will be able to close a loan, issue a guarantee certificate, and then send it to the VA. There will be no review conducted by the VA prior to the issuance of the certificate. The review process will be conducted at the end of the completed process.

WORKLOAD

Between FYs 1987 and 1991, the number of new loans guaranteed declined from 479,491 to 181,167. In FY 1992, however, the number of new loans guaranteed rose to 266,021 and, in FY 1993, this figure rose by 44 percent to 383,303.

In the first month of FY 1994, there were 50,000 new loans guaranteed. If this pace was to continue throughout the year, the final figure at year's end would be 600,000 new loans; however, realistically, the figure will probably be closer to 400,000 new loans for FY 1994.

There was also a dramatic increase in the number of refinancing loans closed in FY 1993. These loans were up 144 percent from 66,190 closings in FY 1992 to 161,728 in FY 1993.

The number of defaults and foreclosures continue to decline, as do the number of properties on hand. FY 1993 brought 142,196 defaults reported, down 7.3 percent from FY 1992's 153,389. There were 29,963 liquidations completed in FY 1993, down 12.3 percent from FY 1992. Properties on hand decreased from 13,755 in FY 1992 to 11,283 in FY 1993, representing a reduction of 18 percent. There was also a decline in the number of properties sold; 30,457 properties in FY 1993, down 8 percent from FY 1992. Acquired properties also decreased by 17 percent from 33,824 in FY 1992 to 27,960 in FY 1993.

The VSOs note that, in March 1990, VA established a lender monitoring unit. In FY 1993, this unit had a staff of 25. We cannot overestimate the importance of this oversight/audit activity. In approximately 87 percent of cases, lenders closed loans automatically--that is, without VA approval and in approximately 85 percent of foreclosures, VA acquires the properties. As VA has learned through sad experience, these factors combined discourage sound lender underwriting practices. The VSOs therefore believe that VA should expand and intensify its lender auditing activities.

During FY 1993, the Monitoring Unit conducted a total of 214 audits. This total included 75 companies that serviced VA loans and 139 lenders who originated VA-guaranteed loans. A cumulative total of 525 on-site reviews of lenders and servicers were completed by the Monitoring Unit in FY 1993. Of these total reviews, 422 reviews were origination audits and 103 reviews were servicing audits.

The Loan Guaranty Service has released 198 origination and 44 service final audit reports. As a result of these audits, the VA has:

- recovered losses in the amount of $778,873;

- accepted indemnification agreements in the amount of $2,276,872; and

o denied liability on loans with potential claim and acquisition costs totalling $644,940.

The monitoring unit, working closely with the Office of the Inspector General, investigates bad credit underwriting by lenders. For bad credit underwriting practices, lenders have paid more than $1 million to VA. Additionally, the VA has been absolved of potential liability on $251,366 in loans. While these amounts may seem trivial, one must consider more than the recovery amount--there is also the deterrence factor. Continued VA monitoring should encourage lenders to engage in sound underwriting practices, resulting in a decline in foreclosures.

In this regard, the IBVSOs again observe that the proposal to include resale losses in net value in the no-bid formula (the formula that determines whether VA will acquire foreclosed properties) has not resulted in the cataclysm that some had predicted. We believe it deters lenders from making bad or marginal loans and it has not resulted in a "mass lender exodus" from the program. Moreover, since VA only takes properties for which it will recover money, lenders have put money into properties to avoid having to manage them. Approximately 1,013 or 3.4 percent of liquidations in FY 1993 resulted in "no-bids." To avoid no-bids, lenders bought down 3,159 loans, i.e., put money into these properties. If lenders had not bought down these loans, the no-bid rate would have been about 14.1 percent.

The IBVSOs support the current no-bid formula change. VA and Independent Agencies Appropriations Act of 1993, Public Law 102-389, effectively extended the no-bid formula, which was to expire on December 21, 1992, by applying it to loans closed before October 1, 1993. Under Public Law 103-66, the expiration date for the no-bid formula was extended to September 30, 1998.

We adamantly oppose, however, using VA-generated savings for purposes other than those that serve veterans. With proper management and sufficient employees to administer and regulate the Loan Guaranty Program, it can be "self-sustaining." To allow money, however, made or recouped by aggressive loan servicing and monitoring and loan asset sales to go into non-VA programs is unacceptable. Congress has identified millions of dollars in savings from the change in the no-bid formula, but we

do not believe that this money was put back into VA programs.

In the past, the *Independent Budget* criticized the misguided, short-sighted policies pertaining to loan asset sales. During FY 1993, however, VA conducted three sales that earned more than $1.6 billion. The average of these three sales netted the VA 100 percent of par on the loans.

Finally, we note the legislative changes that took effect in October 1992, and allow for a three-year pilot program during FY 1993, 1994 and 1995 on adjustable rate mortgages on VA guaranteed loans. Also established was a three-year pilot program to permit, at the Secretary's discretion, veteran and lender to negotiate VA-guaranteed loan interest rates. While it is still too early to predict what effect these programs will have on the VA home loan program, it does appear that, thus far, these pilot programs have been successful.

RECOMMENDATIONS:

- o add 50 employees specifically for loan servicing activities.
- o increase loan guaranty employee level to 2,180.

SUPPORT SERVICES

The Support Services program consists of three operating activities. These include Administration, which provides administrative support to VBA programs; Finance, which provides fiscal services to VA benefit programs and other Department activities; and Personnel, which fills vacancies in various areas and advises on policy and program matters that affect VBA personnel activities.

RECOMMENDATION:

- o 3,214 employees are needed for VBA Support Services

GENERAL ADMINISTRATION

General Administration consists of the Office of the Secretary, six Assistant Secretaries and three VA-level staff officers.

RECOMMENDATION:

- o increase employee level to 3,335 for FY 1995

BOARD OF VETERANS' APPEALS

Title 38, United States Code, 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. BVA contains up to 66 members, including a vice chairman. The BVA chairman recommends individuals who are appointed by the Secretary for Board membership. The Secretary appoints them (pending Presidential approval) for nine-year terms.

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 and consistently in compliance 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.

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 CVA remanded to BVA for additional 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 the BVA.

CVA has affected BVA profoundly. Landmark CVA decisions have led to substantial changes in BVA's decisions, content and format. Pivotal CVA decisions include:

* Colvin V. Derwinski, 1 Vet.App. 171 (1991) (BVA must support its decisions with independent medical evidence);

* Douglas v. Derwinski, 2 Vet.App. 103 (1992) (a direct claim for service connection is not invalid as a matter of law, if the evidence of it did not manifest during service or within one year thereafter);

* Gilbert v. Derwinski, 1 Vet.App. 61 (1990) (BVA must review all evidence of record, weigh credibility and probative value of evidence, provide reasons or bases for decisions, and consider benefit of doubt doctrine);

* Harris v. Derwinski, 1 Vet.App. 180 (1991); EF v. Derwinski, 1 Vet.App. 324 (1991) (BVA must address all intertwined issues with the issue on appeal, reasonably raised or inferred from the record);

* Littke v. Derwinski, 1 Vet.App. 90 (1990) (setting forth principal of statutory duty to assist);

* Manio v. Derwinski, 1 Vet.App. 140 (1991) (BVA must perform a two-step finality analysis--that is, determine whether evidence is new

and material and, if so, consider all evidence, both new and old);

* Russell/Collins v. Principi, 3 Vet.App. 310 (1992) (CVA can review decisions of regional offices adjudicated prior to November 18, 1988 for "clear and unmistakable error");

* Schafrath v. Derwinski, 1 Vet.App. 589 (1991) (reductions carried out without observance of law are prejudicial per se unital, and later BVA actions cannot correct them); and

* Thurber v. Brown, 5 Vet.App. 119 (1993) (BVA must provide claimant with notice and opportunity to respond to any evidence obtained subsequent to the issuance of SOC or SSOC).

Change at BVA has occurred at an unprecedented rate. BVA's evolving workload as a result of CVA decisions cannot be adequately managed without an increase in staffing and training resources.

BVA OPERATING STATISTICS

The CVA's profound impact on BVA has had both positive and negative effects on claims adjudication. CVA's positive influence is seen in the rising number of appeals BVA allows. Prior to CVA, the BVA allowance rate averaged about 12 percent. In FY 1993, the allowance rate reached 16.9 percent, up from 15.7 percent in FY 1992. Remanded cases in FY 1993 reached a high of almost 56 percent (greatly impacting regional offices around the country) and finally settled down to 44 percent by the end of the fiscal year, while denied cases have decreased significantly from 62 percent in FY 1990 to 36.9 percent in FY 1993, up slightly from 32.7 percent in FY 1992. (See figure 1.)

CVA has affected the number of decisions each FTE at BVA produces. In FY 1990, each FTE generated approximately 115 decisions; in FY 1991, it was down to 109; in FY 1992, this number decreased to 81.5, and in FY 1993, the number of decisions per FTE was only 60. In FY 1994, it is predicted that this figure will further decline to 54 decisions per FTE. Although the number of appeals BVA receives is declining, the number of

pending cases at year's end is rising. In FY 1991, there were slightly more than 17,000 pending cases. FY 1992 brought almost 22,000 cases and in FY 1993 there were almost 34,000 cases pending. The estimate for FY 1994 is 48,378. The number of decisions BVA issues is also decreasing. It rendered 45,308 decisions in FY 1991, 33,483 decisions in FY 1992 and 26,400 in FY 1993. For FY 1994, this figure will probably dip well below 25,000 decisions. (See figure 2.)

What does all this mean for BVA timeliness? BVA response time--the number of days it takes to render decisions on pending appeals during a year--equalled 139 days in FY 1991 and had increased by more than 100 days to 240 in FY 1992. This figure almost doubled in FY 1993 -- 466 days. The estimate for FY 1994 is 725 days. BVA's average processing time -- the average number of days BVA takes to produce a decision has also increased. In FY 1991, the processing time was 160 days; in FY 1992, 179 days; and, in FY 1993, 314 days. The response time has remained at 314 days in the early months of FY 1994. (See figure 3.)

Another interesting statistic is the cost associated with producing each decision. In FY 1990, the cost per case was $421. In FY 1992, the cost increased to $684, with a significant increase to $1,046 in FY 1993. For FY 1994, it is predicted that the cost will increase to $1,127 per case.

THE FUTURE

There are no "quick fixes" for the problems BVA faces. While the rapid pace with which CVA issues "landmark" decisions may slow in the future, CVA will continue profoundly to effect BVA, including BVA productivity. The long-term solution seems obvious to us. Congress must provide BVA with the resources necessary to hire and train enough employees to adjudicate appeals in a timely manner.

To combat some of these adverse effects, the BVA Chairman plans to conduct 4,000 travel board hearings in FY 1994, up from 1,258 in FY 1992 and 3,533 hearings in FY 1993. In order to accomplish these goals, the Chairman has held one-member hearings, instead of the three-member panel hearings routinely held in the past. He also instituted the trailing

docket concept in FY 1993 to address the "no-show" rate for travel hearing. In addition to the travel board hearings in the field, the BVA also conducted 1,394 hearings in FY 1992 and 1,172 hearings in FY 1993 in Washington, D.C.

BVA staffing levels will remain essentially unchanged in FY 1994. In FY 1992, there were 411 FTEs and this increased to 449 in FY 1993.

To ensure that BVA can retain trained, qualified board members, the VSOs recommend legislation to reclassify BVA board members to allow them pay equity with Administrative Law Judges (ALJs). The work BVA board members perform compares to that of Social Security ALJs. We believe that establishing pay comparability between BVA board members and ALJs is fair and would stop the flow of some of BVA's most qualified board members to the ranks of Social Security ALJs. The cost projections for BVA-ALJ pay comparability has been estimated to be $720,392 in FY 1995 for salary and benefits. The projection increases to $1,267,713 in FY 1996 and then gradually increases each year thereafter to just under $1.5 million in FY 1999. Without ALJ comparability pay, the BVA will be decimated with the loss of so many qualified board members as they leave to accept positions as ALJs.

Congress must provide additional funding for BVA's training programs. This is critical. For too many years the training of BVA staff attorneys has been seriously neglected. 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.

Training activities must be fully funded for FY 1995. The VSOs recommend $200,000 to support senior staff training and travel, as well as on-site training activities for all staff employees. This is a very modest amount compared to amounts invested in training in the private sector.

Also an important factor in producing timely, sound decision is automation and a conducive work place environment. To this end, Congress should ensure that BVA has sufficient funds to continue automation of board sections.

RECOMMENDATIONS

o An appropriation of $200,000 should support BVA's FY 1995 training activities.

o Congress should increase board members' salaries so that they have pay equity with Administrative Law Judges.

GENERAL COUNSEL

The Office of the General Counsel provides legal services and advice to the Secretary of Veterans Affairs and all departmental organizational components. The General Counsel also functions as the Department's chief legal officer in the areas of legal advice, legislation, and litigation.

The most pressing challenge the Office of General Counsel faces is the workload generated by the United States Court of Veterans Appeals (CVA). As with other VA components, CVA has profoundly affected the Office of the General Counsel.

RECOMMENDATION:

o increase employee level to 720 for FY 1995

CONSOLIDATED STAFF OFFICES

This section consolidates the Office of the Secretary, the Board of Contract Appeals, and the Assistant Secretaries for Acquisition and Facilities; Congressional Affairs; Policy and Planning; and Public and Intergovernmental Affairs.

RECOMMENDATION:

- o increase employee level to 310 for FY 1995

OFFICE OF THE INSPECTOR GENERAL

The Office of Inspector General conducts and supervises audits, inspections and investigations; recommends policies to promote efficient administration of and detect and prevent fraud and abuse in department programs and operations; and informs the Secretary and Congress about problems and deficiencies in VA programs and operations needed for corrective actions.

RECOMMENDATION:

- o increase employee level to 530 for FY 1995

OFFICE OF ACQUISITION AND MATERIAL MANAGEMENT: SUPPLY FUND

The Supply Fund is responsible for the acquisition, storage and distribution of supplies and equipment that VA use. The Fund comprises the office of Acquisition and Material Management; Publications Service; and Office of Small and Disadvantaged Business Utilization.

RECOMMENDATION:

- o provide 720 employees in FY 1995

ASSISTANT SECRETARY FOR FINANCE AND INFORMATION RESOURCES MANAGEMENT

The Assistant Secretary for Finance and Information Resources Management is VA's chief financial officer and chief information resource officer. The Assistant Secretary directs diverse programs, namely budget, financial management, information resources management, management controls, performance measurement, and telecommunications.

RECOMMENDATION

- o provide 1,325 employees in FY 1995

ASSISTANT SECRETARY FOR HUMAN RESOURCES AND ADMINISTRATION

The Assistant Secretary for Human Resources and Administration is the principal advisor to the Secretary, the Deputy Secretary and other management officials concerning plans, policies and program operations related to the Department's human resources and administration programs. The Assistant Secretary oversees a variety of programs. These programs include personnel management, labor relations, occupational safety and health, equal opportunity, general administrative support (primarily Central Office services) and office automation (primarily Central Office services).

RECOMMENDATION

- o increase employee level to 500 for FY 1995

CANTEEN SERVICE REVOLVING FUND

Congress established the Veterans Canteen Service in 1946 to furnish, at reasonable prices, merchandise and services necessary for veterans' comfort and well-being in VA hospitals and domiciliaries. It also provides daily food service for employees, outpatients and volunteers. Since this

service is a self-sustaining, non-appropriated revolving fund activity, no Congressional appropriation is necessary.

THE NATIONAL CEMETERY SYSTEM

The National Cemetery System was founded a little more than two hundred years ago by then President Abraham Lincoln to provide a dignified resting place for those who had honorably served this Nation. In 1973, Public Law 93-43 officially established the National Cemetery System (NCS) as part of the Department of Veterans Affairs. Since that time the NCS was grown into a nationwide system of 114 national cemeteries, with 34 soldiers' lots located within municipal and private cemeteries.

The National Cemetery System has a fourfold mission: first, to provide upon request, interment and perpetual maintenance in any open national cemetery with available grave space for the remains of eligible deceased service members, and veterans, their spouses and eligible family members; second, to mark the graves of eligible persons in national, state, and private cemeteries upon proper application; third, to administer the State Cemetery Grants program to aid states in establishing, expanding or improving state veterans' cemeteries; and fourth, to provide upon request Presidential Memorial Certificates to family members and loved ones to honor the memory of those who have served on behalf of a grateful Nation.

The National Cemetery System operates as one of the three major line divisions of the Department of Veterans Affairs. The System is supported by a core staff of ___ located within the Washington Central Office and is organized into three regional areas. The Area Offices are located in Philadelphia which is responsible for cemeteries located in the Northeast and Midwest; Atlanta which has handles the Southern United States; and Denver which has responsibility for all Western cemeteries and those located in Alaska and Hawaii.

There are over 2.1 million veterans and their dependents interred in a cemetery system comprising over 10,000 acres of land, hundreds of miles of roads, and countless structures, many or which are historic. During FY 1993, there were 67,329 interments in the National Cemetery System. Of this, 50,285 were casketed burials and the remaining 17,044 were cremain interments. The acceptance of cremated burial has steadily grown within the National Cemetery System and now stands at 26.3%. The national average

for cremain interments is 20%.

With the aging of the veteran population, the workload of the NCS is expected to increase in all program areas. During FY 1995 interments are estimated at 73,000, an increase of 3,000 over FY 1994 estimates; and maintain over 2.1 million occupied grave sites. There are currently an estimated 273,000 casket, in ground cremain, and columbaria interment sites available within the NCS. It is estimated by cemetery planners that undeveloped acreage could support and additional 1.7 million gravesites.

The Office of Memorial Programs (OMP) processed 330,345 applications for headstones and markers for FY 1993, an increase of 14,500 over the previous year. OPM also issued 269,489 Presidential Memorial Certificates and estimates for FY 1995 stand at 293,000. It is estimated that OMP will experience yearly workload increases of 2% to 3% until the year 2009 at which time the workload should begin to decline.

Two legislative changes which will have a significant impact upon the NCS are the granting of burial benefits to members of the Selected Reserve and changes in the process for notification of the Department of the death of a veteran. In the first case, the expanded eligibility will contribute to an increased workload. In the second case it may be more difficult to obtain a Presidential Memorial Certificate thereby causing an unanticipated drop in workload.

The IBVSOs' have long supported the extension of burial benefits to the Selected Reserve, their spouses, and eligible dependents. However, the unintentional workload decrease caused by the lack of ready access to the first notification of a veteran's death should be remedied. The Presidential Memorial Certificate Program has experienced a 40% drop in workload from a FY 1991 high of 470,570 to 281,633 for FY 1992 and now stands at 269,489 for FY 1993. IBVSOs' support steps to increase awareness of this meaningful government program.

The *Independent Budget* over the years has been complimentary of the management exercised by the National Cemetery System and would like to recognize the continued dedication of the over 1200 NCS employees nationwide; however, it is not a system without significant problems. Unless

the problems of chronic under funding, lack of burial space, the equipment backlog, the aging infrastructure, significant workload growth, and lack of adequate information systems can be effectively remedied the system will continue to deteriorate not only in appearance but also in stature.

With the exception of a Congressionally mandated FY 1991 infusion of $10 million dollars, the National Cemetery System has shown no real dollar growth in programs. The *Independent Budget* requests an appropriation of $81 million, or an increase of $7.5 million over FY 1994 appropriations. To ensure proper maintenance and the preservation of the park like beauty of these national shrines, a total of 1405 FTEE support is requested along with this budget figure. This request presents an increase of 90 FTEE to the base of 1315. Funding at this level will allow the NCS to address the increasing demands of the aging veteran population and also enable the system to maintain the cemetery grounds at a level befitting national shrines.

Of the 114 national cemeteries, 59 or 52 per cent are open to both casketed and cremain burials. The remaining 55 are either closed to all burials or open only to cremations and second family casketed interments. Workload statistics for FY 1993 show a 4.2 per cent increase rate of interments. Of the 67,329 burials in national cemeteries, 26.3% or 17,044 were for cremains. The cremain burial rate in national cemeteries is higher than the rate for private or municipal cemeteries. The higher NCS rate is due to a number of factors most notably is lack of available casketed grave space in many populated areas coupled with a more accepting view of cremain burial. IBVSOs' are dismayed that the policy to have an open National Cemetery within 75 miles of 75 per cent of the veteran population was rejected by the Office of Management and Budget. The NCS has worked tirelessly to find ways to keep established National Cemeteries open but funds for the purchase of adjacent lands have been inadequate. The need for burial space is expected to peak in the year 2009. With 15 years remaining before the peak, monies will be needed to acquire adjacent land to keep existing cemeteries open, open new cemeteries in gravely under served areas, and develop columbaria in existing cemeteries to preserve a burial option for veterans and their families. In a recent Office of Management and Budget (OMB) memorandum, NCS was given the authority to continue with land acquisition efforts for the development of new cemeteries at the following sites: Albany, Chicago, Cleveland, and Dallas (Figure 1). This authorization

does not give the NCS the ability to actually build a cemetery but only to continue planning. Congress must appropriate the money for each site. IBVSOs' support a fast track approach to the planning, acquisition, and development of these sites to address future needs.

The equipment backlog has grown steadily over the years. A 1990 study revealed that over 50% of the heavy equipment was well beyond its scheduled replacement date of 5 years. Although the equipment backlog stands at $6 million this figure does not fully represent the seriousness of the situation or the man hours and productivity lost to equipment breakdowns and graves that cannot be adequately maintained. IBVSOs' supports $2.3 million to begin partial reduction of the equipment backlog.

The aging infrastructure of the NCS is also of concern to the IBVSOs'. Within the National Cemetery System are numerous historic buildings, hundreds of maintenance and other purpose buildings, and over 10,000 acres of land crossed with hundreds of miles of roads. The infrastructure of the System has suffered due to decremental budgeting over the years. In many cases repairs to aged roads and structures are beyond the capability of cemetery personnel. To preserve the shrine like quality expected of National Cemeteries the *Independent Budget* supports a minimum of $2 million be directed for funding of repair projects.

The aging veteran population has placed demands not only on cemetery space but on the perpetual and growing inventory of gravesites and developed lands within the System. Over the years, the need for significant increases in FTEE to address the workload growth have remained unfunded. The NCS is estimated to have a shortfall of 250 FTEE for its current field staffing needs (Figure 2). With pressure to decrease the size of government, it will be important to monitor how and where the cuts will be accomplished. Some thought has been given to the use of replacement equipment monies to fund 25 field positions for FY 1995. It would appear that it is necessary to adequately fund both accounts to maintain the System and that robbing one account to fund another is not an acceptable long-term solution. The IBVSOs' support the funding of $1.4 million and 40 FTEE for incremental workload increases along with a plan to support in FY 1995 a substantial reduction in the systemwide shortfall of 250 FTEE. The *Independent Budget* supports $1.8 million and 50 FTEE to address this

shortfall.

The information needs of the NCS are as critical to this system as those of the Veterans Health Administration (VHA) and the Veterans Benefits Administration (VBA). The computer system for the Office of Memorial Programs is antiquated and often unreliable. The workload increases for OMP are estimated at 2% to 3% per year. For FY 1993 OMP provided 330,345 headstones and markers. The FY 1993 total for Presidential Memorial Certificates (PMC) was 269,489. The procurement of an updated computer support system could provide an FTEE savings to the System. It is estimated that a 3 FTEE savings could be achieved in the PMC program and that a 3.5 FTEE savings could be realized in the Headstone and Marker Program. The new computer system is also necessary for interface with Burial Operations Support System (BOSS). The *Independent Budget* supports $800 thousand for this system in FY 1995.

The feasibility of consolidating all burial related functions and benefits programs merits study in the current environment of making government more entrepreneurial. The IBVSOs' supports a study of the most appropriate organizational placement for programs such as the plot allowance, transportation allowance, burial allowance, and the flag program.

RECOMMENDATIONS

Appropriate $81 million and a FTEE level of 1405 to meet the burial needs of veterans and their families.

Fast track the development of new cemetery sites to address the burial needs of the aging veteran population.

Provide funding to address the growing equipment backlog, and aging infrastructure of the National Cemetery System.

Address workload growth through the support of increased FTEE to the field.

Study the most appropriate organizational placement of burial related functions.

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 with 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 IBVSO's recognize that CVA is not a part of the Department of Veterans Affairs (VA). However, it obtains its funding from the same appropriations subcommittee--VA, HUD, and Independent Agencies--and it so profoundly impacts VA that we include it in this year's *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 of law, are contrary to statutory or constitutional rights, or are without observance of procedure required by law. CVA's authority to hold BVA findings of material facts unlawful is limited in scope, and CVA may only set findings of material facts aside if the findings are "clearly erroneous."

CVA received its first appeal in November 1989, and as of November 1993, has received 6,702 appeals. During calendar year 1991, the number of appeals averaged slightly fewer than 200 per month. In calendar year 1992, this number was down to approximately 110 appeals per month and, in 1993, it averaged about 115 appeals per month.

The biggest problem CVA faces is the large number of pro se appeals filed. These pro se (unrepresented) appeals now represent 82.5 percent of CVA's docket, up substantially from 69 percent 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. This situation remains difficult even though CVA has simplified

procedures to enable pro se litigants to present their own appeals.

Despite the difficulties its large pro se docket presents, CVA has managed to dispose of 433 appeals in 1990, 925 appeals in 1991, 2,289 appeals in 1992 and, as of November 30, 1993, 1,903 cases in 1993. Of the 6,702 appeals CVA has received since November 1989, it has acted upon 5,550 as of November 30, 1993, leaving slightly more than 1,150 appeals pending at the end of November 1993.

During the first eleven months of 1993, CVA concluded 1,903 appeals. Of these, CVA affirmed BVA's decision in 583 appeals, or approximately 31 percent. In the "remanded in whole or part" category, there were 672 appeals, or roughly 35 percent. The second largest number of appeals disposed of were for procedural deficiencies, either for lack of jurisdiction or for defaults. This totaled 588 appeals, or approximately 31 percent of disposed cases. Finally, CVA terminated 3 percent, or 60 appeals because of the denial of extraordinary relief (writs of mandamus or of prohibition); CVA allowed no such appeals. Based on these figures, CVA disposed of almost two-thirds of these 1,903 appeals, while it remanded slightly more than one-third, or 35 percent, to BVA.

THE PRO SE DILEMMA

Early on, the Court recognized that the pro se rate was unacceptable. At the Court's request, Congress passed legislation transferring almost $1 million of Court appropriated funds for the administration of a program to reduce the pro se caseload. Thus the Pro Bono Representation Program was created. Pursuant to the terms of the program, services are offered to those individuals who have already filed meritorious appeals with the Court and are unable to afford or otherwise obtain qualified representation.

Between October 1, 1992 to September 30, 1993, a total of 574 cases, consisting of both the Court's case file and VA claims file, and 214 cases, consisting of only the Court file, were screened for representation. Of the 788 cases screened, it was determined that only 231 cases met the program's financial and merit eligibility criteria and all 231 cases were assigned representation. As of September 30, 1993, 52 of the 231 cases have been completed by the Court; 45 (86.5 percent) resulted in a finding

of error and were remanded to the BVA for correction of that error.

LOOKING TO THE FUTURE

It is too early in CVA's brief history to interpret current statistics or predict future trends. While the number of appeals to CVA in 1993 increased slightly, about 60 more, and the number of terminated cases declined by approximately 54 cases since 1992, the percent of cases remanded by CVA to BVA remained constant at 35 percent. More than one-third of the appeals to CVA are sent back to the BVA for further development, readjudication, or to grant the benefit sought on appeal. Excluding those appeals terminated due to procedural deficiencies or extraordinary relief from the equation, slightly more than 50 percent of those cases considered on the merits are remanded to the BVA for readjudication, further development or to grant the benefit sought or appeal.

One of the most pressing matters facing CVA is the large number of pro se appeals. There has been a 12 percent increase in the number of unrepresented cases before CVA since last year. In 1992, pro se cases represented 69 percent of CVA's docket; in 1993, this figure was 82.5 percent. This increasing pro se docket is cause for alarm and must be studied closely. Certainly Congress should not cut either the Court's funding or its staff.

RECOMMENDATIONS

- o An appropriation of $9.5 million should be sufficient to support the Court's activities in FY 1995.

FY 1995—A Landmark Year

FY 1995 is a landmark year for the *Independent Budget*. It marks the end date for workload targets established for VA health care programs in the FY 1990 *Independent Budget*. Five years ago, the IBVSOs realized the urgent need for VA to enhance its long-term care and ambulatory care programs. The *Independent Budget* co-authors set forth what we believed were reasonable and achievable goals for FY 1995 and established a plan for working toward these goals incrementally in the intervening years between FY 1990 and FY 1995. Over these years, a few of the VA health care programs have grown, but other programs, including those to fulfill veterans' critical long-term care needs, have dwindled. Ambulatory care has not grown to the extent specified in the FY 1990 budget. All workloads in contract care venues are eroding. Enrollment of previously unentitled veterans and possibly even veterans' dependents proposed in the Administration's health care reform plan would make the need for increased workload targets even more essential. With information of the probable challenges to the VA medical system (unimagined in FY 1990), the co-authors of the *Independent Budget* would have established even higher FY 1995 ambulatory care goals. Unfortunately, it is doubtful that even the lower workload targets specified for FY 1995 five years ago will be realized.

FY 1995 marks the year VA will begin to feel the impact of staffing cuts recommended for all Federal civilian agencies in Vice President Gore's *National Performance Review*. VA stands to lose approximately 25,000 employees now devoted to the direct health care needs of veterans over five years. It is difficult to imagine that VA will be able to enhance its geographic accessibility or continue to provide its diverse array of services tailored to veterans' health care needs in this era of fiscal and staffing constraints.

FY 1995 is likely to mark one of the most challenging times in VA's history as its health care system, along with the rest of the nation's, confronts the changes incumbent in most of the currently proposed comprehensive health care reform proposals. The President and the 103d Congress have pinned much to their hopes of enacting comprehensive health care reform. Mid-term elections are likely to be

won or lost on the successful enactment comprehensive health care reform and even the President has made health care reform enactment a focal issue on which to judge the success of his Administration. The President's health care proposal specifies a new role for VA—that of a competitive health care system functioning under a health alliance that will also oversee the operations of private-sector health care plans. Other national health care proposals lack specific roles for VA, but their implications for VA are just as profound. Without a specific role for VA, the system is likely to continue to flounder. Even with a specified role and some additional support to establish a "level playing field", VA is in a difficult transition period with little time to radically alter its organizational culture, its delivery system, and its practice style. With the additional obstacles imposed by limited funding and staffing, VA's place in the reformed health care order is precarious.

FY 1995 will see the continuation of health care reform efforts in the States. The States have echoed the national health care reform debates within their own legislatures, proposing and enacting comprehensive reform measures that will impact the operations of VA medical centers within their boundaries. The IBVSOs have proposed grant aid to VA medical centers within states that are implementing reform that should begin in FY 1994 to place VA in a more competitive position (See Appendix E). Neglect of these states' VA medical centers may mean veterans lost forever to the VA medical system.

As the *Independent Budget* embarks upon its fiscal and management recommendations for the VA medical care system in FY 1995, the *Independent Budget* co-authors are keeping all of these challenges to the system in mind. The FY 1995 *Independent Budget* proposes a series of management initiatives and action items. These proposals lack the specific accompanying funding requirements the *Independent Budget* has offered for medical programs. Rather, these management initiatives offer estimates of the extent to which the hospital director has control over the initiative, the magnitude of additional funding requirements, the staff involvement, and other obstacles to implementation to provide decision-makers with key data on which to base determinations about management priorities and utilization of limited staff and funding. We have also provided case examples of programs that seem to be working

where they have been implemented. This formula is more in keeping with the National Health Policy Reform Project's agenda for system-wide change which will emphasize decentralized management and autonomous decision-making authority. The IBVSOs are in support of these new management principles and believe that VA hospital directors should have the information, but not the directives without accompanying resource support, to make effective decisions regarding their medical care facilities.

As in past *Independent Budget*s the co-authors will address the needs of specific programs in inpatient, outpatient, and long-term care settings. The *Independent Budget* co-authors make funding recommendations for these programs based on FY 1995 targets, even though it now seems unlikely that VA will be able to accommodate the significant differences between the targets and those VA estimates it will be able to treat in FY 1994 within the next fiscal year. Sadly, VA would have been far better able to accommodate implementation of health care reform initiatives had they made more steady progress toward *Independent Budget* (and their own) goals. Accomplishment of *Independent Budget* workload targets would have allowed VA to balance its inpatient workload with more outpatient programs and better meet the unique demands of the veterans' community.

As the co-authors have said in many past *Independent Budget*s, VA is at a cross-roads. Strong leadership at the local level and central strategic management are crucial. VA has a choice, within its limited resources, of being proactive or reactive. Proactive decision-makers have already begun or are beginning to implement the changes their hospitals need to survive health care reform. Health plans or facilities that wait until reform is thrust upon them to initiate meaningful change will be too late. VA health plans and facilities that are not fast, flexible and friendly may be lost forever to the veterans they serve when veterans choose other providers that meet their needs in a more appropriate manner.

So FY 1995 will also give VA an opportunity to prove its worth to veterans and the nation. While the *Independent Budget* co-authors understand well the bureaucracies and fiscal limitations of VA which hamper innovation in the system, there is no longer the choice to "do business as usual". Without meaningful change, many VA hospitals are likely to

close. VA officials can watch it happen or take part in reforms which will cause their health plans to be a choice of veterans.

A REALISTIC "MARKETING" STRATEGY FOR VA

Under a variety of reform plans Congress is now considering, cost-competitive care providers will vie for VA's patients for the first time. VA is having to consider its role as a consumer-driven care provider, rather than a program with a primarily social mission. This quickly shifting role challenges VA managers who have so often had to let budgets and Congress, rather than patients, guide their service mix and delivery style.

VA's proposed role as a competitive provider brings new entrepreneurial challenges to the system. These challenges sometimes daunt VA leaders, trained to meet social demands, rather than those of the market. Many people have a poor understanding of marketing often interchanging the term with advertising. Actually, advertising is a very small part of an effective marketing plan.

Basic marketing concentrates on the "four P's": product, place, promotion, and price. Because VA offers what is termed "free" health care to deserving veterans, VA has thus far only had to meet its consumers' standards for "price". Many veterans would travel long-distances, suffer longer queues, settle for less responsive customer service, and fewer patient amenities, so long as they had no cost-competitive option available to them. For a variety of reasons, VA will have to consider changing their marketing orientation in the near future. Asking questions about the "four P's" may give VA a better indication of changes *they may effect today* to help VA stand a better chance of capturing and retaining market share in a more competitive health care environment. Some VA medical centers are already making notable improvements in their patient care delivery. Below are noted some of the hospitals VA can use as models in their efforts to improve the seemingly intractable problems many leaders perceive in the system today. While our case studies are not meant to be exhaustive of innovation occurring in VA today, they offer useful examples for solving problems that are similar in many VA medical centers.

To develop a successful marketing plan, VA directors must understand the "four Ps" in relation to their medical facilities and the system as a whole. They must also understand the market they now have and the

market they wish to acquire. Why do veterans use the system now? What are the major flaws they identify? Why do some veterans never use the system? What would make them more inclined to use it?

VA periodically conducts surveys that provide some of these answers. The Survey of Medical System Users found that users are most likely to exercise their VA hospital benefits because of their cost (38%).[1] Less than a quarter (23%) of VA medical system users have private insurance that will pay for all or most of their hospital bills. But veterans also use VA because it provides needed services (36%), they have a physician's referral (10%), or they perceive a high level of quality in services received (5%).

The 1987 Survey of Veterans identifies reasons veterans never have used a VA facility. Excluding reasons such as access to other sources of care, lack of need for health care or ineligibility, most veterans have not used VA services because they did not know that they were eligible (17.9%). The Survey further identified awareness levels which verified that most veterans are not aware of eligibility criteria. While most veterans (76%) knew that VA provided hospital care for service-connected disorders, most veterans (59%) were not aware that VA provided hospital care for veterans with low-incomes. This information suggests the need for system-wide outreach efforts.

Other veterans responded that they did not use a VA facility because they: preferred treatment elsewhere (9.5%); live too far from a VA facility (8.5%); felt there was too long a wait/or excessive red tape (4.7%); or, felt that VA delivered a poor quality of care (3.8%).

Using this information, what kinds of things can VA do to make itself a more attractive choice for veterans?

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[1] Department of Veterans Affairs, Assistant Secretary for Finance and Planning, Office of Planning and Management Analysis, Survey of Medical System Users, May 1990

CREATING A QUALITY MEDICAL PRODUCT FOR VETERANS

A product is described as "anything that ...might satisfy a [market's] need or want".[2] To be selected as a provider, VA medical services represent a product that must be *satisfying* to consumers' needs and wants. When people choose a product such as a health care provider, they choose it because of the benefits it offers them: the services, both the type and the quantity, its practice style, its staff, its physical plant and its amenities. To be desirable, a product must offer high-quality, reasonably priced and conveniently located benefits.

Will veterans choose the VA Medical System among other health care systems given a choice? Undoubtedly, some will. Others with options may not. Their choice will be based on their perceptions of the value of the product. Some suggestions (and implications for funding) are listed below in order of their funding priority:

Services: VA facilities must decide what package of services they will deliver. Too many facilities lack direction from a mission that is inconsistent with its population's actual needs. VA must critically evaluate all of its facilities' missions, and with local involvement, decide where it is appropriate to reassign missions. Not all VA facilities have to deliver a full-continuum of benefits to their patients. VAs that survive a competitive environment will seek out networks which allow them to optimize resource sharing. Some facilities may become long-term care providers using a nearby facility as an on-line acute care back-up. Others will agree to "carve out" some of their inpatient care programs that are underutilized to devote more resources to the programs veterans want and need. Leadership will be needed to establish new roles for VA medical centers within networks.

Comprehensive benefits: Restrictive eligibility criteria severely hamper VA facilities ability to provide needed care to veterans. Most comprehensive insurance plans and many reform plans under current consideration include basic benefits packages that are richer than that offered to the

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[2] Kotler, Philip and Gary Armstrong. Principles of Marketing, Fourth Edition. Prentice-Hall: Englewood Cliffs, NJ, 1989.

majority of veterans using VA. The services that most of these packages include that VA too frequently excludes are primary and preventive care services and outpatient care.

VA must have the ability to practice "state-of-the-art" medicine which emphasizes primary and preventive care services, just like most private sector hospitals. Ambulatory care, for example, is currently restricted for most veterans which causes an over-reliance on more expensive inpatient treatment.

Some VA medical centers are doing the best they can to provide a comprehensive array of services to all of their users. For example, Portland VAMC has a Primary Care Nursing program that can offer assistance to any veteran between appointments often preventing the need for an unscheduled appointment.

Sepulveda VAMC has implemented the Pilot Ambulatory Care and Education Program (PACE) which offers a comprehensive array of services to its patients using a delivery style like that of a staff-model health maintenance organization. Sepulveda's care is arguably even more seamless than most of the private-sector's since its service delivery is "seamless". The same team follows patients through outpatient, inpatient, psychosocial, and extended care venues. However, by using ambulatory care as its focal point, rather than tertiary care which is at the heart of the rest of the VA medical system, Sepulveda's practice style is more reflective of the private-sector medical system's. As such Sepulveda VA's successes and shortcomings in implementation serve as valuable lessons for VA medical centers nationwide, who may have to shift their resources to accommodate such a practice style in the very near future. Regardless of the outcome of national health care reform efforts, VA should implement this practice style to provide more cost-effective and coordinated care to its veterans patients. Sadly, medical centers need waivers from restrictive eligibility criteria as well as additional activation funds to effectively implement this type of care throughout VA. Until they have such authority, efforts to coordinate care for its veteran patients will be moot. For many VA facilities, implementing comprehensive services for all VA patients will require a waiver from the eligibility criteria currently existing.

Eligibility Reform: Realization now prevails throughout VA that epochal change is required if the its health care system is to succeed as a direct participant in tomorrow's competitive medical market. Extensive effort is finally underway to identify the full complexity of such change. IBVSOs have long contended, and continue to insist, that top priority must be given to legislative reform of eligibility — changing the criteria for veterans' access to health care services. It remains the critical component of any meaningful strategy for the VA health care system's recovery and the necessary precursor of any valid planning for realignment of VA health care programs and facilities.

Although repeatedly alluded to elsewhere in this publication, so portentous is the issue of eligibility reform that this separate delineation of its relevance is offered. VA concurs in our priority appraisal. VHA's current draft of a standby proposal, *Reform of the Eligibility Rules for VA Health Care*, ends with this statement: "A credible eligibility reform proposal must clearly identify the policy problem at stake and propose a reasonable solution. We believe that our eligibility reform proposal is consistent with promoting a VA continuum of care that emphasizes greater use of non-bed care. From a number of perspectives, it is hard to imagine what other VA policy could be more important".

Last year the final report of the Mission Commission *(Commission of the Future Structure of Veterans Health Care)* advocated that "all veterans, once admitted to the VA health care system, should be accorded the full continuum of services, from preventive to long term care including nursing home care". The *General Accounting Office*, in its December 1992 *Transition Papers*, phrases this recommendation quite succinctly: "....remove differences in veterans' eligibility for inpatient, outpatient, and long term care and provide service-connected and poor veterans with a full range of needed health care services".

Years before the prospect of national health care reform became so timely, IBVSOs started working with VA to design a legislative proposal, acceptable to Congress, for the purpose of correcting the obtuse, fragmented and irrational set of criteria currently governing veterans'

limited access to VA provided health care.[3] These criteria date from 1986 when Congress refined means testing to identify medically indigent nonservice-connected veterans for inclusion in Category A — now called the Core Group of veteran patients. The complexity of these rules dictate many compromises in VA medical care delivery. Services are portioned in terms of service-connected status of both the veteran and their medical condition, the veteran's income, any special status they may have (e.g. POW, agent orange, irradiation, WWI), and the various kinds of VA care they may receive; acute inpatient care, outpatient services, non-institutional long term programs and nursing home care.

[3] A full description of eligibility and entitlement criteria for VA medical care services is provided in Appendix __ of this document.

TABLE MC-1
CURRENT ENTITLEMENT

CATEGORY A	HOSPITAL	OUTPATIENT	NURSING HOME
SC 50-100%-ANY CONDITION			
SC 0-40%-SERVICE-CONNECTED COND.	ENTITLED	ENTITLED	ELIGIBLE
DISCHARGED FOR DISABILITY			
SC 30-40% NSC CONDITION		ENTITLED	
PENSIONER & INCOME < $10,824	ENTITLED	LIMITED TO PRE & POST HOSPITALIZATION & OBVIATE THE NEED	ELIGIBLE
SECTION 1151 (INJURED IN VA)			
PRISONER OF WAR		ELIGIBLE	
WORLD WAR I VET	ENTITLED	UNLIMITED	ELIGIBLE
MEXICAN WAR VET			
SC 0-20% FOR NSC COND.		ELIGIBLE	
NSC INCOME $10,824 TO $18,843	ENTITLED	LIMITED TO PRE & POST HOSPITALIZATION & OBVIATE THE NEED	ELIGIBLE
AOR, RADIATION, MEDICAID ELIGIBLE			

OTHER	HOSPITAL	OUTPATIENT	NURSING HOME
		ELIGIBLE	
NSC INCOME > $18,843	ELIGIBLE WITH CO-PAY	LIMITED TO PRE & POST HOSPITALIZATION	ELIGIBLE

Under these rules the majority of Core Group patients are assured of inpatient hospital care, but denied outpatient access except for pre- and post-hospitalization visits or to "obviate the need" for hospital admission. No veteran has clear entitlement to nursing home care, although its provision is discretionary. Thus economies based on proper venues of care are ignored and VA physicians cannot deliver a continuum of care to veterans in the same efficient way it is provided in the private medical sector. Paradoxically, the Medicaid user has access to a full continuity and venue of health care services, including nursing home care — the very same components missing from current legislated criteria in the VA system.

Last year five veterans service organizations (American Legion, AMVETS, DAV, PVA and VFW) had reached a consensus proposing that, through separate legislation, Congress should reconfirm its historic commitment to veterans' health care and mandate entitlement for the full continuum of care to all veterans fulfilling the criteria of Core Group classification. It should, furthermore, acknowledge responsibility to provide, now and under any future health care reform legislation, funds to assure legally entitled Core Group veterans all necessary and authorized medical services, including preventive, acute, restorative and long term care. To obviate poverty spend-down, all permanently and catastrophically disabled veterans should be Core Group classified. Noncore Group (nonservice-connected high income) veterans should have access to all VA health care through various buy in provisions.

That proposal was voluntarily tabled at the request of the Administration since a considerable increase in VA medical care access was accommodated in the Clinton health care reform proposal. The basic medical benefits package contained in the plan is very generous, with significant limitation, however, in mental health therapy and long term care. VHA is to provide that standard package to <u>all</u> enrolled veterans using <u>all</u> venues of medical care delivery.

While supporting, in concept, the role for VA set forth in the *American Health Security Act of 1993 (AHSA)*, IBVSOs' residual concerns have been made clear. Most prominent among them is this question of

eligibility reform. Under the Administration's plan it amounts to less than what has been requested and it rests on a tenuous base, depending upon the basic medical benefits not being reduced by a cost conscious Congress. Finally, if VHA is to compete for patient enrollment with multiple states already implementing health reform initiatives, the need for unfettered veteran access to VA medical care is now. It is one essential component of a level playing field.

It is for these reasons that IBVSOs feel constrained to monitor closely relevant aspects of the coming health care reform debate in Congress, reserving the right to request separate legislation covering veterans' eligibility reform should that become appropriate. Specifications of such a renewed legislative proposal are premature at this writing.

VA "special" benefits: VA facilities must capitalize on their most significant asset: their special programs. VA is widely lauded for the special services it provides in prosthetics, orthotics, all types of functional and occupational rehabilitation, mental illness, spinal cord medicine, blind care, geriatrics, and long-term care. These programs, specifically geared toward the needs of the service-connected, are likely to be central in VA's future role in health care delivery. Where facilities have these programs, they must continue to preserve their integrity. Special services should be adjacent to or collocated with a tertiary care provider for the full clinical support necessary to ensure that a patient's full continuum of care needs can be met. VA must ensure that these capabilities are preserved by holding hospital directors who have such programs in their facilities accountable for maintaining established quality standards and monitoring compliance with these quality standards centrally. Input from patient boards and VSOs can also help to ensure that VA facilities are delivering the types of services in a responsive manner. Patients and their VSO representatives can identify problems, but they may also be able to identify workable solutions.

Improving Patient Management: VA can wage war upon consumers' perceptions of service inaccessibility on several fronts.

Triaging/ Information: VA should provide patients with information regarding their medical care whenever possible. Do patients know where

to find answers to questions regarding their conditions or scheduling? If appointments are running late, are patients told why? Are patients' conditions and treatment regimens explained to them understandably? Do patients have the opportunity to ask questions?

Some VA medical centers, like Portland VAMC, have established successful triage programs. Originally began as a telephone care program and primary evaluation clinic in 1989, the program now includes a phone-in pharmacist, a primary care nursing component and an eligibility hotline system. With this four-pronged approach to triage, the Portland VAMC has been able to reduce its emergency care unit workload by 20% and its outpatient visits by 10-15%. Getting non-emergency conditions out of the emergency/screening room is particularly critical to smoother operations—physicians determined that three-fourths of the triaged veterans had non-urgent conditions.[4] In the Portland VAMC, nurses can counsel veterans whose concerns do not merit immediate medical attention. Over the phone nurses are trained to make initial assessments and refer patients to appropriate specialty care or schedule diagnostic work. Primary care nurses provide patient education, case management, and continuity of care in between outpatient visits which also reduces the need for outpatient care. These initiatives have also led to increased patient satisfaction and reduced waiting times. A directive is currently being issued to instruct all VA medical centers to emulate Portland's initiatives.

Waiting Times: Waiting times seem to be a special nightmare for many VA facilities. The problems are so severe that they seem intractable. Directors are frustrated into inaction. What is important to realize is that private-sector patients, with whom the VA may soon be competing, take for granted that they will be seen within a reasonable amount of time. Unless they significantly exceed private-sector standards, correcting the problems in waiting times will not win patients for the VA system. Reasonable waiting times are something patients expect in the private sector.

VA faces two different problems in correcting its waiting times. First, it

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[4] GAO/HRD-94-4 VA Health Care.

has scheduled appointments which will be dealt with below. Second, it has unscheduled walk-in appointments to its emergency/screening room. As a system entry point at most VA medical centers for all venues of care, emergency rooms in VA are overburdened. According to GAO, most of the problems (75%) seen in VA emergency rooms are not urgent or emergent care. With better triage protocols (which allow veterans to phone a nurse or pharmacist to understand the urgency of their problem and subsequently schedule an appointment at the appropriate clinic, for example), VA could generally schedule appointments for these types of conditions and better control its workload to relieve the excessive burden on emergency room staff.

According to GAO, fifty-seven-percent of emergency clinics do not even bother to try to schedule appointments. Often, emergency clinics in VA are misnamed and misused. Many of veterans using the emergency clinics could and should make appointments at a general medical clinic. Too often these clinics are not available or do not offer the veteran an opportunity to schedule appointments directly with them. Instead of being systematically routed through the emergency room, patients could be directly referred and scheduled for treatment in a general medical clinic. At that time, they could be referred to special clinics that can most appropriately respond to their initial diagnoses. This lack of schedule allows for ensuing 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 VAMC has made significant improvements in reducing patient waiting times by improving patient flow. Dallas administrative officials identified "bottlenecks" in its previous 6 or 7 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 also optimizes its utilization of automated patient records. These innovations have reduced waiting times for unscheduled appointments from about two hours to an average of 27 minutes! Dallas used *no additional resources* in implementing their "one-stop check-in" service for unscheduled appointments.

Specialty Clinic Schedules: According to the VA's Inspector General, not enough clinics are meeting acceptable waiting times for scheduled appointments. Veterans using private-sector providers seem to believe that a thirty minute delay in a scheduled appointment time was generally an acceptable threshold.[5] Since VA policy prescribes a maximum of a thirty-minute wait, this should be the goal for which all facilities strive. Too many VA facilities still practice block scheduling (telling too many veterans to come at the same time) and overbooking (not giving physicians enough time for appointments) for clinic appointments. These practices are inefficient and ineffective. By using them, VA gives over any control of its workload and frustrates its patients and staff unnecessarily. At many facilities, even when patients do have appointments, it is not uncommon for them to come in the early morning with a packed lunch. Patients who must wait from 9 AM until 3 PM will leave the system if they have a choice. VA facilities must implement effective scheduling procedures to compete.

VA is typical of other medical systems in having significant queuing problems for its specialty clinics. According to the GAO, at the 721 clinics they surveyed, veterans wait an average of 62 days for appointments at specialty clinics. Often patients have a 3-6 month wait for a clinic appointment. For some appointments, check-ups or screenings, for example, that are not likely to result in an exacerbated problem, some waiting time is acceptable. However, for problems that are likely to worsen, this wait is unacceptable. More-complicated problems are more difficult to treat and require greater labor and resource investments for the facility as well as unnecessary discomfort for the patient. A prime example of such a problem are pressure ulcers which plague immobilized patients. If a pressure ulcer is treated in its initial stage, a ten-minute office visit with a dermatologist might substitute for months of inpatient care. The same philosophy applies to countless other problems encountered in high-risk patient populations. Some of these problems can be solved through a better triage system—VA medical centers must do a better job identifying these types of disorders in which preventive or primary care can be most effective, particularly for high-risk populations.

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[5] Paralyzed Veterans of America. Focus Groups. Summer 1993.

Effective triaging is probably the best thing facilities can do to reduce their scheduled appointment waiting times. One facility implemented a case management program which used primary care physician to screen all patients. This practice allowed the specialty clinics to drop their waiting times for clinics to 30 days. When care is administered in the appropriate clinic, it reduces the pressure on a specialty clinic. GAO suggests that periodically, medical personnel should review their clinic's patient records and redirect some patients to general medicine clinics.

Patient follow-up offers a better alternative to overbooking clinics and controlling workload more appropriately. Patients should be reminded of appointments by phone call or postcard well in advance of their scheduled appointment. If rescheduling is necessary, it should also be confirmed by phone call or postcard.

Again, Dallas VAMC offers a successful model of what can be done to improve waiting times within existing resources. Patients know that they will be seen within 30 minutes and are not allowed to check-in more than 30 minutes before their scheduled appointment. At Dallas, laboratory and x-ray work are scheduled as separate appointments up to two-hours before the physician appointments so that physicians may make informed decisions in treating patients. This practice exceeds many private plans' protocols. Health summaries easily accessed through the Decentralized Hospital Computer Program have expedited the process. Implementing a program like Dallas' is not easy. Resources and personnel must be shifted to optimize their utilization. Patients must be educated about the 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. The result is a much improved consumer complaint rate from the ambulatory care center. Dallas is promoting its quicker and less complicated scheduling process because NOW they have a better product to sell.

Optimizing shared and contracted services: Sometimes, even the best patient protocols will not compensate for insufficient resources. In these cases VA facility directors must optimize their utilization of shared or contracted services for care that they are not able to provide in-house in a timely manner. Often contracting for services may offer a less expensive

alternative to providing the same service in-house. For example, women's services are not widely available or accessible in VA. More medical centers should consider coordinating care for its women veterans with an academic affiliate or military facility. Once women are aware that an accessible option is available to them, demand may grow. At this time, VA can reconsider its decision to provide services in-house or continue on a contract or shared basis.

Additional Clinic Hours: Many VA Medical Centers are also recognizing the need for longer clinic hours on weekdays and weekend hours to make the clinic more accessible to veterans. If these opportunities are taken, staffing patterns should enable veterans to be seen within a reasonable amount of time whenever they enter the clinic. If waiting times cannot be shortened during regular clinic hours, VA should not attempt to run additional clinic hours which will spread scarce staff even thinner and exacerbate problems during normal clinic hours.

Practice Style: Practice style has to do with the manner in which care is delivered to the patient and often corresponds with the way care is financed. The majority of VA medical centers are still overly reliant on episodic inpatient care rather than the more coordinated ambulatory-based care growing more prominent in the private-sector. For VA this creates fragmented care delivery and leaves many patients with a sense of alienation from their care providers. Too often VA patients never see the same provider twice. There is no continuity in their care delivery and even medical records lack vital information from one visit to the next. This often leaves the veteran patient feeling abandoned in a system in which they have too little control. Too compound the problem, veterans feel they have little recourse to problems they encounter because they feel no one in the system cares. Too often, no one is familiar with their faces, their names or their case histories. Some VA medical centers have been successful in preventing or ameliorating these problems.

Veterans want to have a choice in their care providers. When asked what veterans value most about their private-sector health plans, the most common response seems to be their choice of physician (PVA Focus Groups, Summer 1993). Because of its academic affiliations' rotation

schedules for medical residents, VA may not always have this option. There are ways, however, VA can enhance a patient's sense of control over his choice in provider. First, VA medical centers should assign patients to one provider or a "team" of providers. Some VA medical centers could consider allowing patients to choose their physician or "team" rather than randomly assigning patients. If allowing this "upfront" selection is not a workable solution, then centers should certainly give patients the ability to select another provider or team if they consider it in their best interest to do so. Granting patients this level of control enhances their confidence in therapy and increases patient satisfaction by increasing their trust in their provider and giving them alternatives routes to care should they desire them.

In many ways VA is well-suited to further adopting the principles of managed care. There is just cause for doing so in a competitive system. The wide-spread popularity of HMOs in private-sector medicine has been well documented over the last decade. The Health Insurance Association of America estimates that between 1982 and 1990, group coverage through a managed care arrangement (either a health maintenance organization or a preferred provider organization) increased from .3% of those covered to 25.3%!

VA is most suited to the role of a "staff-model" health maintenance organization (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 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 inter-disciplinary 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 is aware of the need to adapt a managed care paradigm. Task forces in the central office and elsewhere are busily identifying how best to implement managed care throughout the system. It is generally agreed that the following components are integral to the success of managed care

adaptation:

- a case management system for every enrollee
- a tracking system to ensure that an enrollee is exposed to the counseling or diagnostic work appropriate to their conditions, ages, and genders.
- a primary care workforce: this includes both additional physician generalists and "mid-level" care providers—nurse practitioners and physicians assistants who are capable of triaging patients; it may also require hiring dieticians, nutritionists, health educators, and others who can counsel veterans on health promotion activities such as diet and exercise, smoke cessation, alcohol and drug abuse, etc.

- equipment to effectively screen and diagnose for age/gender specific conditions (mammographic equipment, endoscopic equipment, and any other appropriate equipment not presently available)

Some facilities in VA are already working toward a more integrated delivery style. They are discussed below.

Case Management: As discussed above, a single point of contact greatly enhances a patient's perception of accessibility to the system and his 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 best thing the VA can do to compete effectively against better funded medical facilities. The Pilot Ambulatory Care and Education Program operating in Sepulveda VAMC is proving an excellent model for other VA medical centers to emulate. PACE developed Academic Global Care Teams who are fully responsible for randomly assigned patients' care. Though these teams are ultimately accountable for assuring their patients access to and treatment in appropriate settings, even more rigorous case management is available for the most needy patients.

Primary Care Orientation: It is often said that, "An ounce of prevention is worth a pound of cure". Untreated problems will either worsen or

eventually take care of themselves after causing patients unnecessary pain or discomfort. Too often, current eligibility criteria make it, at best, cumbersome and, at worst, impossible to get the "managed care" to which private-sector health care plans are moving. The private-sector is shifting its care emphasis to prevention and primary care. Entitlement to VA care is a barrier to providing this same type of appropriate care to patients. Many veterans have only restricted access to ambulatory care and preventive care has been limited for all veterans. Even with the Preventive Medicine program now authorized most veterans continue to receive inadequate access to diagnostic/screening services warranted by their age and/or gender. Most hospitals have no tracking system in place to assure care providers that their patients have been exposed to these services including:

- hypertension screening
- cholesterol screening
- breast cancer screening
- cervical cancer screening
- colorectal cancer screening
- substance abuse inquiry/ counseling
- nutrition counseling
- physical fitness counseling
- seat belt usage inquiry
- smoking inquiry/ counseling, and
- immunization for influenza.

Antiquated eligibility criteria have "frozen" VA into a delivery style that is overly reliant on inpatient care, the only modality of care to which all Category A (ie, "core group") veterans are currently entitled.

Recruiting a primary care workforce (or retraining staff already onboard) and converting and building additional clinic space are major challenges VA faces in becoming a "full service" health plan. Implementing an effective case management program which individualizes treatment plans and efficiently channels patients is another challenge which may lie ahead. Such changes may alter the nature and structure of VA's teaching affiliations—case managers (usually, generalists or mid-level health professionals) may provide most of the stability in the patient/staff

relationships and greater accountability for treatment exposure while rotating students are given a new role as part of a care team.

Funding considerations have prohibited many VA health care facilities from converting inpatient hospital bed wards to additional ambulatory care capacity. Most VA hospitals operate below capacity. Staffing shortfalls have forced other hospitals to close wards and leave VA equipment, space and beds idle. Because individual facilities have no ability to control their construction dollars and because the total dollars for the system overall are so restricted, hospital directors have no ability to shift their resources to the modalities of care most appropriate for their patients.

VA may find it advantageous to use a variety of approaches in developing additional primary and preventive care capacity—contracting, sharing services and developing a VA service are all appropriate options for different locations. Where possible, however, it would be preferable to develop an in-house capability to provide services. Building the service in-house allows VA some control in structuring its workload. Adequately defining workloads in different modalities of care allows VA to match its resources to its caseload in an optimal way. It gives VA access to all services veterans may need—contracting for services has been a limited option for VA, always the first cut in times of budget shortfalls while VA prioritized funding for in-house services. Congress would have to ensure an adequate funding stream, under a capped budget, to guarantee access to contracted services—perhaps by capitating their primary/preventive services budget for all enrollees if contracting is the chosen delivery method.

Sharing services has also been beneficial to VA in many instances, and should be further exploited in further implementing primary care. For example, military treatment facilities can provide women veterans' with access to gender-specific services where there is no critical mass to justify VA developing their own. A sharing agreement in this instance provides the "best of both worlds". VA can retain control of its workload and provide less fettered access to quality services while also optimizing the use of its resources. Purchasing services allows VA to preserve its resources and provide better care to more veterans. It may also provide

82-758 O - 94 - 9

better care to beneficiaries by exposing them to a more knowledgeable and experienced care provider. Staff cannot maintain skills when practice volumes are too low.

In the near future, each VA medical center may have to decide to "make" or "buy" their primary and preventive care services for all their patients. The decision will vary by facility, location, and cost. In the meantime, VA facilities should develop, for veterans who are eligible, a primary care program that meets their needs.

Orienting Staff to a Consumer-Driven Delivery Style: VA employees are, for the most part, dedicated to the patients they serve. VA professes that it is committed to its courtesy and caring campaign—"VA--Putting Veterans First" implemented in July of 1993. However, many veteran patients still believe they are treated like numbers or, as one VA official said, "cattle" as they are channeled through the system. Staff are frustrated by the system's inability to provide appropriate care for the patient, bureaucracy, and micromanagement from a variety of sources. Many of these problems are not within the control of local directors, however, innovative directors can train and empower employees to make them more responsive to the needs of their customers.

Customer-service training: Some organizations should consider sending employees to training sessions or providing in-house training to employees to better equip them for dealing with veteran patients as consumers rather than captive users. Some of the skills VA should try to foster are empathetic listening, defusing and taking appropriate action in dealing with patient complaints, and courteousness. VA medical centers may be able to use existing personnel who receive or have received appropriate training (social workers or human resources managers) to train the VA workforce. VA can look to the private-sector to help learn customer service training.

Employee empowerment: Management must also empower VA employees to be effective patient care advocates. VA employees must receive clear direction in what the expectations of their jobs are. Further, they must be encouraged to go beyond the parameters of their jobs when appropriate. For example, Central Office has, on some occasions,

discouraged employees from helping veterans complete necessary paperwork to acquire care claiming that the practice was a distraction from the fulfillment of their own job performance. While this is not within the job description of VA employees, it is sometimes necessary to allow veterans access to necessary care. Such practices should be rewarded, not discouraged. Hospital directors should redefine job descriptions to be more flexible 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, Edward Deming, found much more acceptance for his ideas of "quality circles" in Japan in the 1950s. The basic premise of quality circles is that employees know processes best and are often able to identify solutions or suggest improvements in procedures. VA has been implementing its "Blueprint for Quality" at various levels throughout the system. Individual facilities might also utilize these techniques to find answers to their own problems and to cultivate employee commitment by empowering them to problem solve. Employees who participate in developing new protocols and procedures are more likely to accept them and be committed to performing them well.

Employee recognition: Central Office and Congress must also give local directors more ability to hire, fire, adjust pay scales, reward and punish job performance without the bureaucracy that impedes the effective practice of such measures. When employees excel, VA managers should more routinely reward their performance—various hospitals already have some recognition programs, like employee of the month. Veterans Service Organizations also offer cash awards to some outstanding employees. VA medical centers should take advantage of revolving funds to offer bonuses for exemplary performance. VA should also have the ability to punish poor performance. VA employees should also know that even if customer service is not an expressed part of their job performance, rudeness or unresponsiveness to a patient's needs will be punished. A VA employee who ignores a thirsty patient's request for water, for example, should be punished, even if it involves only a reprimand from a supervisor.

The organizational culture must be recognizable to employees through the consistent application of rewards or punishments. Non-monetary rewards may be just as meaningful to employees in different situations as monetary rewards. Directors might make a habit of calling employees who receive commendation from patients, who find innovative ways of saving the facility money or who show initiative in solving problems. They may find opportunities to 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 their managers with initiative will find out what their outstanding employees value and find meaningful ways to reward them consistent with the values of the organization.

Patient representatives: Patient representatives can make systems less impersonal and confusing. Often patients with complaints just want someone to acknowledge their situation or answer their questions. Successful patient representation programs will offer not just a sympathetic ear, but a real explanation or solution to a patient's problem. Strong programs must have the overt support of the leadership. It must also have the respect of the medical staff who must provide many of the answers to patient's questions.

Augusta VAMC implemented its patient representative program in October, 1990. The hospital director gave strong support to the program to ensure that staff could readily recognize the organization's commitment to the program and would cooperate with patient representatives. The program was promoted on signs throughout the hospitals. Patient representatives make efforts to see every new admission to the hospital 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 they have identified as "big visiting days" so they can better assist families. Most complaints are handled and patients return to the facility for future care needs.

Volunteers: Most VA medical centers have a dedicated corps of

volunteers. In FY 1993, volunteers donated 14.2 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 supervision from staff to make significant contributions.

Volunteers can be mobilized to provide many types of services that simply make a patient's hospital stay friendlier and more comfortable. Volunteers can be used to collect and distribute paperback books, to talk to veterans in waiting areas or hospital beds, to retrieve items for immobilized veterans or to offer comfort to veterans in distress.

Most hospitals should consider having a volunteer coordinator to recruit and coordinate the efforts of a strong and active volunteer force. Creative uses for volunteers are innumerable.

Quality Assurance: Patients judge quality medicine by two equally important standards: how good their medical care is and how well they are treated. Providers who want to assure 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 quality in the care they receive.

VA medical reputation is not as solid as it should be because of sensational media in recent years. Instead of containing the damage at the facility level where it occurred, these events have served to indict the VA system as an inferior care provider to many Americans. This reputation is unfair and undeserved in most facilities, but unfortunately, VA has not responded well on its own behalf to correct this image.

VA does much to assure quality medical services for its patients. VA is a voluntary participant in the Joint Commission of Accreditation of Health Care Organizations. All VA medical centers meet JCAHO standards and over the three year accreditation cycles, several of the VA medical centers typically receive "Accreditation with Commendation". Unfortunately, this information is not widely disseminated. There is a common misunderstanding in the veterans community and elsewhere that VA does not meet external quality standards.

In VA's "Blueprint for Quality", a strategic plan for quality assurance created by the Office of Quality Assurance, programs such as external peer review, risk management, outcomes measures, and ongoing exploration into practice guidelines will be key ongoing activities in the years ahead. VA is, like many other providers interested in assuring quality medical outcomes, pushing the technological envelope of standards currently available. Outcomes measures are highly dependent on information systems that have not been widely implemented in the American health care system. Many national health care reform proposals rely on this information being available so consumers can make educated health care purchases. VA, like others, will have to have systems in place to make this information available.

VA, both as a system and as individual facilities should ensure that veterans are "satisfied" with the health care they receive. VA is currently revamping their customer service surveys for inpatient and ambulatory care venues. VA is reputedly restricted by regulatory barriers from running surveys on its patients as often as they would like. VA should be relieved of these restrictions and run surveys on veteran satisfaction on a regular basis feeding back information to health care decision-makers to allow them to deal with perceived problems in a 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 adhering to a reasonable quality benchmark and even harder on correcting patients' perceptions of their care. Positive word-of-mouth is essential to the future success of the system.

Physical plant: Many VA facilities suffer from having a less modern and attractive physical plant than their private-sector competitors. Some of these problems are intractable without significant financial investment. In other areas, however, VA can improve without significant resource investment.

Major construction/modernization: Major construction dollars are increasingly scarce and their use is not under the control of a hospital director. While some types of facilities and services are needed in VA to

better meet shifting demands of the patient population, inpatient hospital services are becoming less necessary. With few exceptions, VA does not need new hospitals! Replacement hospitals may be required, but VA must be able to clearly project its patient utilization before these decisions are made. Leasing may present an attractive alternative for providing additional outpatient clinic and nursing home space. VA should carefully consider available resources in the area and reconsider missions of various facilities within the area before it engages new construction projects.

Cleanliness/attractiveness: Painting, carpeting, window treatments, plants, furnishings and other attributes contribute significantly to the patient environment. These features are often less costly and more directly within the control of the hospital director than construction. A bright and attractive internal environment is also a large determinant of staff and patient morale. Many VAs are on attractive campuses which should also have appropriate upkeep.

While some of these features require significant investments, some VA medical centers have found ways to cut costs of making some changes. Dedicated staff at Sepulveda VAMC, for example, volunteered their own time to paint and carpet before PACE was implemented. Volunteers might be mobilized to do the same at other VA medical centers. Veterans Service Organizations and others, who already contribute significant volunteer hours to the system, might be approached to participate in local "VA Appreciation Days" which could include painting, groundskeeping, fixing furniture, or merely provide funding for plants and pictures.

A culture must also be prevalent in VA medical centers to make veterans and staff take pride in their facility. Patients respond more positively to clean and attractive surroundings and demonstrate more positive regard for them. Similarly, staff will intensify efforts to upkeep the appearance of a facility if it is attractive from the onset. An immense start-up effort (as discussed above) might be effective for some hospitals in instilling employees and patients with a greater sense of pride in their facility. Follow-up activities should be immediate and ongoing so that the facility does not atrophy into disrepair.

Amenities: VA will have the hardest time competing with others on the basis of patient amenities, and yet these are probably the least important to the patient's perception of quality care. Most patients value good information and responsiveness from their care providers far more than "hotel courtesies".

VA does not have a great many private rooms available. In-room telephones are becoming more common, but it is still more common for veterans to share one phone in a ward. Like many other hospital patients, some VA patients do not think highly of the food they are served. Televisions are not accessible to all patients. These are attributes which may be examined further down the road as other, more important, problems are handled.

"COMPETING" ON PRICE

VA has no choice in the prices it can establish for its clientele. It is both the blessing and the bane of VA that Congress funds its medical care facilities. On the one hand, the VA medical system is a service promised to veterans for which the Federal Government must take responsibility. On the other, VA hospital leadership have had to rely on inconsistent and unreliable appropriation levels since the first VA hospital was built without, like other medical care providers, being able to shift costs onto wealthier consumers. The only payer VA deals with is the Federal government. Third-party payments and reimbursements are sent directly to the U.S. Treasury. Under a sharing agreement with the Department of Defense, a local facility may retain funding.

Minimum prices should be based on cost. A VA facility could better make its case for a favorable allocation by identifying its costs. Costs should dictate the minimum amount any organization can receive and still maintain its current operations. What VA calls a "current services level" is not based on costs, but rather on what Congress appropriated in the past fiscal year.

VA will soon implement a system to improve its cost-accounting and quality reporting in ten facilities. The Decentralized Medical Management System (DMMS) will allow VA to define what it costs for a facility, a group

of facilities or the system to deliver a given service. VA facilities can then compare themselves to like facilities inside and outside the system. It will be able to provide facilities with better information on which to base decisions to cut or augment services. By identifying the cost of its services, VA can more exactly show Congress and the Administration the trade-offs in lost workload, unpurchased equipment, or other manifestations associated with inadequate allocations and appropriations. This concrete identification of "shortfalls" will serve as a rallying point for veterans' lobbying efforts and possibly a greater appropriation. It may also serve as justification for risk-adjustment (a higher capitated premium) under a "managed competition" scenario if VA showed that its care for a more complex (older, sicker, and more intensive) case mix resulted in a higher expenditure.

The VA's Inspector General submitted a report that showed that some VA facilities handled similar diagnostic related groups less expensively than their academic affiliates with similar outcomes. Given a capitated funding base under a national health care system, confirmation of this information by each facility may give that facility an opportunity to expand benefits for veterans. In other words, VA facilities would be able to provide more benefits at less cost.

Finally, VA's costs could be a "benefit" that would be desirable to purchasers, especially under a competitive system. Comparing VA's costs of delivering care to other providers' costs should give consumers with an option who can afford to pay for care a reason for choosing VA.

EXPANDING GEOGRAPHIC ACCESSIBILITY

Benefits must be conveniently located to be desirable to most veterans. Many VA facilities have looked at ways of expanding geographic accessibility for their patients. Placement of VA facilities must be a system-wide effort. Networks must be established and resources allocated appropriately within them. Not all VA facilities will be able to deliver all benefits to the patients in its catchment area. Some services are more appropriately shared or contracted for.

Networking: VA is the nation's largest health care provider. Networking

within the system has only tapped the surface of potential opportunities available. VA Central Office is currently reviewing a national model for networking the system: the Veterans Service Area Report (now renamed Veterans Health Plans) in part inspired by the work of the Commission on the Future Structure of Veterans Health Care.

Chicago has an interesting plan for networking the four facilities in its area. The Chicago Area Network Facility Development Plan capitalizes on the strengths of each facility within the catchment area. The goal of the plan was to assign patient workloads to appropriate care settings within the network, expand access for veterans and allow facilities to consolidate resources to bring about cost savings.

Chicago planned its network to allow its patients maximum access to primary care providers who could coordinate veterans' health care services. All hospital directors remain the managers of their facilities and participate, jointly, on a management council to oversee and make 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 newly created position would oversee ambulatory care operations for the entire network. The plan identifies new sights for potential "off-campus" ambulatory care clinics. This model will certainly not work for every facility—Chicago facilities have the advantage of being proximate to one another. However, Chicago facilities should be commended for their efforts to pull together to serve veteran patients in the separate facilities better through a unified system.

Expanding Sharing Arrangements: VA already has an expansive sharing program. Most VA medical centers (114/171) have formal sharing arrangements with academic affiliates, the Department of Defense, the Indian Health Service, or community providers. VA medical centers should only offer services to the community or any sharing partner where there is excess capacity and the benefit of running the service (allows access to an underserved population or provides a unique or superior service to that offered outside VA) outweighs the benefit of contracting with an outside agent to provide services to eligible veterans.

The most common services offered are diagnostic radiological services, medical services, and clinical lab services. VA medical centers must often purchase radiological therapy, MRI services and diagnostic radiological services. Sharing is most often mutually beneficial to the provider and the purchaser as it optimizes resource utilization and increases service availability.

Some novel and far-reaching approaches to sharing are already operating in some VA medical centers. Albuquerque and El Paso VA facilities are actually running facilities jointly with Department of Defense providers. At least one study has shown the cost-savings in Albuquerque to accrue to both VA and their Air Force partner. Portsmouth VA is a partner in the "TRICARE" prototype in the Tidewater region of Virginia. Tucson VA is also entering a consortium comprised of military providers and the Indian Health Services providers in the Southwest Region of the United States. There is not yet enough information on these programs to assess such issues as quality assurance, cost-effectiveness and patient satisfaction which are associated with such ventures. Nevertheless, sharing offers a promising way to consolidate services without displacing veteran users from a system they can call their "own".

Leasing: The *Independent Budget* has supported facility leasing as an excellent way of expanding availability to veteran patients while allowing VA to maintain management authority by using its own staff and resources. In the last two years, the *Independent Budget* suggested that VA use leasing to expand its nursing home capacity. Leasing can also be considered to expand primary and preventive care services. Although entitlement currently restricts VA from offering these services to some veterans, there may soon come a time when VA will be asked to either deliver or contract for them for system users. Choosing to deliver services may require VA to deliver care in communities where veterans live. Many patients are willing to travel to access specialty care, but they are less willing to travel for primary care. Beneficiary travel funds are not available and few veterans are able to expend the time and effort in going too far for an uncomplicated service. Leasing will allow VA to put accessible clinics in areas densely populated by veterans without the more permanent investment construction requires.

Some "storefront" operations are already authorized for homeless

populations (not necessarily using leased facilities). These programs will serve as screening, diagnostic, and referral centers for 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 a number of facilities in the community it may consider in developing its medical presence in the community such as vet centers and community residential centers. There are also many non-VA community medical facilities which have excess capacity that could be leased by VA.
Contracting: There are some instances in which VA may be better served contracting with private-sector providers for services to be delivered to VA system users. State veterans homes are one avenue to providing services whose costs can be split by the state to veterans. Other potential contractees that hospital directors can consider include local health maintenance organizations, physician networks, or satellite clinics.

PROMOTING VA SERVICES

Advertising: Advertising is any paid promotion for activities associated with a certain agent.
There is no current authority for VA to advertise for patients although there are "outreach" activities that might be construed as advertising under a different guise. Under the national health care reform plan proposed by the Clinton Administration, VA will be given this authority. They may use Congressional funding to recruit employees. A campaign is currently underway to do so.

Advertising is important to VA, but perhaps not to the extent that some VA leadership believes. VA medical centers who would promote quality services and customer service as they are available in many of VA's facilities today will be seen as charlatans. Many VA medical centers must "clean house" *before* investing funding in advertising campaigns.

Once VA begins to advertise, they must not promote a VA that alienates those it is now charged to serve. Showing only the healthy, younger veterans from higher-income groups that VA hopes to recruit will not only estrange VA users from the system they now rely on, it will show a false

picture of VA to the external community. Advertising for only the healthy could have another dangerous backlash, raising the question of why Congress should fund a system which serves such veterans. The nation does not need another Kaiser Permanente for its veterans, but rather the maintenance of a strong system dedicated to their special treatment needs and able to execute the missions of research, medical education and a contingency provider to DoD in the event of emergency. Any advertising campaign should concentrate on these unique contributions to national objectives.

Public Relations: Public relations is building a relationship with any of an organization's publics. VA's publics clearly include veterans, but they also include Congress, veterans service organizations, its employees, other health care providers and the community in which they serve. A good public relations program creates a positive "image" for the organization.

Public relations activities for VA today are limited by the number of staff allocated to the function. VA hospitals are lucky to have one person assigned to public relations who is the also the spokesperson and media and community liaison. Central Office staff are not close enough to the individual hospitals to develop "rapport" with the community's media, health providers, and leaders. Too often VA public relations officers' energies are invested in fending off unfavorable stories about VA, rather than proactively promoting the good works VA does. This lack of balance creates a negative image for VA.

Many veterans who have never used the VA have terrible images of VA—far worse than those who are using the system (PVA Focus Groups, 1993). It is likely that these veterans derive their views from the larger community, rather than those that actually use the VA medical system. Individual VA medical centers must be far more aggressive in the proactive dissemination of positive information to counteract negative publicity about the system. Individual VA medical centers have another problem that inequitably affects the VA system as opposed to a private system; that is, a specific problem at one VA hospital indicts the system as a whole. When a private hospital that is part of a system has a problem it remains that hospital's problem. VA medical centers could do far more to counteract that image by boosting their own achievements in

the local community. Where VA medical centers are perceived as strong, most local community members will be able to differentiate the problems of the system from the problems of the individual local facility. This was evident in PVA focus groups who found that communities with strong VA medical centers attributed the problems in the system to "other hospitals". Communities with weaker medical centers were more likely to attribute another hospital's problems to the system as a whole. The lesson to draw is that where VA programs are perceived as weak, the identification with another center's problem is greater and creates an even worse image for the local VA.

Press Relations

Public Relations, in the short-run, may be VA's best strategy for dealing with VA's image problems. Cultivating a solid working relationship with the press is the best "free advertising" local VA medical centers could want. Hospitals must devote the time to establishing a friendly press relationship by spending time with local reporters, showing them around the hospital grounds and discussing new programs and improvements they are making. Even if the information is not immediately used, it will set the tone for a less antagonistic relationship should a problem arise. It is better for VA officials to seek out and set the tone for these relationships than to only be sought out when a problem arises.

Community Relations

Creating an alliance with the community through interactions with the local medical and business communities is one avenue many VA hospital officials take to familiarize local leaders with the VA. Affiliations offer many opportunities for these interactions. Individual VA's can also offer solutions to local problems; often sharing arrangements can provide services to a local group that would otherwise have no access to them. These efforts should be publicized so that VA becomes a recognizable part of the community it serves.

Participation in special events, particularly, but not limited to veterans'

activities and community public service activities (ie, sponsoring blood drives) can bolster a hospital's image. Speeches to local groups are also opportunities for an enhanced mutual understanding. So long as VAs are viewed separately from the community in which they serve there will be problems in creating a new image for VA. In most instances, familiarity will breed mutual understanding, not contempt.

VSO Relations

VSOs are a great ally to any VA hospital. VSOs contribute volunteer labor, vans, and employee awards for meritorious performance. They also can serve as ombudsmen for the local veterans community and have many creative and workable solutions to local VA problems. Hospital officials need to be receptive to meeting with VSOs and active in seeking out their ideas and suggestions. National VSOs should be involved in strategic planning efforts for the system as a collaborative partner committed to a quality veterans health care system, never as an adversary trying to catch VA in a slip.

Outreach: Personal selling is critical to changing VA's image for veterans and others. VA employees and leadership must be committed salesmen for their services. They must be convinced and convincing that VA services are top of the line.

When VA has made improvements, it must make every effort to show it. VA can hold "open houses" or offer a community group meeting space to bring people into the doors. VA hospitals should make every effort to contact veterans in their service area to apprise them of their benefits. This can be done without advertising. Minneapolis VA created a Women Veterans program starting with a database of about 300 women veterans, which over its implementation, grew to over 10,000! No advertising funds were used. A creative women veterans coordinator and a dedicated clinical staff served as the catalyst for motivating a strong "word of mouth" campaign. Brochures and pamphlets were also used to describe the services available.

Mostly, veterans want to hear from other veterans they trust—friends,

family members, members of their local VSO chapter—that VA is improving. Genuine improvement in services or meeting veterans' needs will largely fulfill this need.

TABLE MC-2
Recommended Initiatives for VA Medical Center Managers

	Local Control (Can be done within the hospital director's current authority)	Financial Investment (Start-up Costs)	Staff Investment (Activation)	Other Obstacles	Long-Term Gains
Case Management	High	Moderate	High	Eligibility criteria restrict some VA patients from receiving full-continuum of care. Academic affiliations must be willing partners.	Higher patient satisfaction; more appropriate utilization of resources; improved patient flow
Triaging/ Information	High	Low	Moderate	None	Higher patient satisfaction; more appropriate utilization of resources; improved patient flow
Scheduling Improvements (Waiting Times)	High	Low	High	Redirection of staff and resources necessary	Higher patient satisfaction; improved patient flow
Queuing Improvements (Service Delays)	High	Low	Low	Redirection of staff and resources necessary	Higher patient satisfaction; more appropriate utilization of resources; improved patient flow
Additional Clinic Hours	Moderate	Moderate	Moderate	May require additional staff	Improved patient accessibility
Restructuring Benefits	Low	High	High	Current eligibility criteria, retrenchment and possibly enhancement of resources necessary	Improved patient flow, increased quality of care, increased customer satisfaction
Customer-Service Training	High	Low	Low	None	Increased customer satisfaction, improved organizational image
Employee Empowerment	High	Low	Low	None	Increased employee satisfaction-improved retention
Employee Recognition	High	Low	Low	None	Increased employee satisfaction-improved retention
Patient Representation	High	Moderate	Moderate	Must create "authority" for patient reps among staff through leadership's commitment; have staff "buy-into" patient advocacy	Improved patient flow; increased consumer satisfaction
Mission Conversions	Low	High	High	Legislative authority; funds for construction	Creation of "economies of scale" resulting in cost-effectiveness; improved patient flow and likely improvements in quality of care

Networking with Other VAs	Moderate	Low	High	Collaboration and willingness of other VA hospital directors	Creation of "economies of scale" resulting in cost-effectiveness; improved patient flow and likely improvements in quality of care
Sharing	Moderate	Low	Low	Resistance of external parties	Cost-effective delivery of care; optimization of resources
Major construction/ modernization	None	High	Low	Central Office prioritization, appropriated funding	More attractive facility may serve as recruitment for employees and patients
Cleanliness/ Attractiveness	Moderate	Low-Moderate	High	Staff willingness	More attractive facility may serve as recruitment for employees and patients
Amenities	Moderate	Moderate	Low	None	More hotel benefits may serve as recruitment for patients
Cost Identification	Moderate (with implementation of DMMS/DSS)	None	Moderate	Implementation schedule, need for education and training in use of package, possible staff additions necessary	Improved resource allocation; justification for improved appropriated resources
Advertising	Low	High	Low	Legislative authority	When used with other measures, recruitment of patients who will add to patient base and enhance case-mix, employee recruitment tool
Media Relations	High	Low	Low	Cooperation of local press	Better corporate image
Community Relations	High	Low	Low	Image of local VA	Better corporate image
VSO Relations	High	Low	Low	None	Additional volunteers, resources, more favorable image
Outreach	High	Moderate	Moderate	Dedicated staff person necessary	Recruitment of patients who will add to patient base and enhance case-mix.

A. 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 conducted in VA health care facilities.

The Meaning of the Independent Budget

This FY 1995 *Independent Budget* presents a documented assessment of Veterans Health Administration (VHA) funding requirements, based on veterans' needs. Past *Independent Budgets* have served as effective counterpoints to Administration budgets that did not allow enough money 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 an emerging national health care system.

A.1. Funding for Veterans Health Programs—FYs 1980-1993

A.1.a. Funding Trends

For the past thirteen years, VA spending in constant dollars has declined while national health care expenditures have increased exponentially. In FY 1980, VA funding amounted to 4 percent of the federal budget; by FY 1990, it was only 2 percent. In FY 1985, VA received 7.7 percent of the federal health care dollar, in FY 1995,

VA expects to receive only 4.5 percent. Because health care inflation has outstripped general inflation, and because the Office of Management and Budget (OMB) under past administrations has consistently understated inflation, level funding for VA has in fact steadily eroded VA's buying power. Chart MC-1 presents a clear picture of an institution that is losing the struggle to meet increasing demands with static resources.

A.1.c. Conclusions From the Data

VA's funding crisis is the result of perennially inadequate adjustments to an inadequate base, which, 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 FY 1988, VA responded to budget shortfalls by delaying equipment replacement, postponing maintenance, and cutting strategic planning, information resources modernization, and other activities not directly related to patient care. By FY 1988, the accumulated shortfall could not be accommodated by this "cannibalization" and VA was forced 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 other state and federal providers. Chart MC-2 shows the *Independent Budget* estimated Medical Care shortfall from FY 1988 to FY 1994 that is responsible for workload curtailment and funding redirection.

The most destructive effect of budget constraints, however, has been VA's inability to adequately 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 sufficiently increase its capacity for the outpatient care, community-based long-term care and nursing home care that veterans, particularly World War II veterans require.

TELEPHONE SURVEY

The VSO co-authors of the *Independent Budget* have long been concerned that many legislative changes, at both federal and state levels, governing the management and operation of VA's health care system will be required to enable it to compete with the private medical system in the pending environment of national health care reform.

A notable example has been the long standing request for reform of the criteria currently restraining veterans access to a full continuity of VA delivered medical care. That eligibility reform should have already been accomplished is now confirmed by the precipitous impact of direct market competition on multiple VA medical centers in states where implementation of proactive health care reform programs is already underway. For those VA facilities the future is now.
The VA cannot engage in competitive health care program enrollment with the current limitations on access to the system.

Reform initiative may well spread to other states before there is a Congressionally legislated national program. Nearly half the states have under consideration legislation for health system reforms that center around the managed competition scenario.

In early December of 1993 the *Independent Budget* staff conducted a telephone survey with the directors of VA hospitals in six states where comprehensive health care reform is imminent — Florida, Minnesota, Oregon, Washington, Tennessee and Vermont. Assurance was given that the survey report would be generalized and without attribution.

Survey input included estimates of the nature and degree of state reform program impact on local VAMCs, local understanding of requirements for adjusting to those impacts, incidents of any VA participation in state planning, prospects for more meaningful VA sharing with emerging community health care networks, and the nature and timing of Central Office guidance received for local management adjustments and initiatives.

Without exception all directors contacted were well informed regarding their own state health care reform legislation. Five states had not involved the VA in their plans or through testimony, with the exception of

Vermont. However VA's input there appears to have been minuscule. In Florida, a senior VA physician was involved with an early state planning commission, but in the final analysis the state program does not significantly implicate the VA. Several states have specifically excluded from access to enrollment in their state health care program, all residents who are currently "eligible" for any federally provided health care. This, in spite of the fact there is universal misunderstanding of differences between eligibility for and entitlement to VA delivered medical care. Many of these "dually eligible" veterans in these states may not be able to receive much of the ambulatory care from VA that they would be able to receive from their state's plan.

Such exclusion of veterans is currently the case in Tennessee where enrollment begins January 1, 1994. The "TennCare" situation is further confused by lack of adequate financing for the intended initial extent of enrollment and from the strong opposition of both the state hospital association and state medical society. Not only does the Tenncare plan not provide for long term care, the state is also reducing its psychiatric hospital beds from 1400 to 500 where veterans have been comprising 20 percent of the census. All of which, ironically, will place greater demand on VA hospitals within the state.

When most facility directors were asked what initiatives they could undertake immediately, with current resources, to improve outpatient workload, they professed inability for any increased commitment to ambulatory services or the promotion of primary care due to the lack of required personnel. Commonly reported were prolonged clinic waiting times and appointment delays from three to nine months. Only two of the centers have accomplished some enhancement in ambulatory care capability.

There was consistently dismay over recently announced plans for personnel cuts which reportedly will amount to 2,700 FTE in FY 1995. In FY 1994, VA had to relieve 1000 FTE hired within budgeted dollars to conform to its staff ceiling. Contrary to what is commonly claimed, the inevitable price of sizeable staff reductions is a loss of clinical workload. All of these barriers to patient access can only defeat any VA effort to recruit veteran patients in competition with a better staffed and more

readily accessible private medical sector.

Every facility contacted reported the need for incremental funds for delayed replacement of obsolete equipment, facility renovation and restructuring. The latter needs include expanding of outpatient clinic spaces, remodeling for more attractive environments, and hospital bed conversions to nursing home use. Several directors, mindful of likely multiple sources of future funding, also addressed the essential requirement for adequate annual budgets, equitable resource distribution, and unequivocal Congressional commitment to the historical obligation of supporting certain veteran programs exclusively through appropriation funding.

Whereas guidance across the system from VA Central Office had at the time of this telephone survey been minimal, much encouragement manifested from the announcement of the appointment of the National Health Policy Project which, among other analyses, will examine state reform issues and appoint a VA director for each state's reform efforts. A unanimous opinion was elicited that tomorrow's VA health care system must have optimal decentralization and that extensive authority must be transferred from Central Office to the managers of local VA facilities commensurate with their market place responsibility.

There was a general belief on the part of all directors that their own facilities could succeed as a participant in a competitive medical market *providing the necessary VA enabling legislation is accomplished at the federal and state levels.* Two directors were particularly explicit in fully itemizing interim legislation required today — regardless of what Congress may do tomorrow.

A.5. *Independent Budget* Methodology
A.5.a. Principles

The concept for an *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 serves as a

counterpoint to the President's budget, which fiscal and political considerations, such as the overall federal budget and the deficit, temper. While the *Independent Budget* co-authors 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 even kept pace with medical care inflation or the federal health budget's inflation rate. The *Independent Budget* recommended appropriation for Medical Care is shown in Table MC-3.

A.5.b. "Current Services"

VA funding levels became severely deficient in the Eighties. During that time, the *Independent Budget* co-authors decided to track spending using a "current services level" approach. The current services level represents the dollar amount needed to support an FY 1988 workload, with adjustments to compensate VA for its progress toward *Independent Budget* goals since that time. The *Independent Budget* used FY 1988 as a "baseline" year. After FY 1988, workload, predominantly in community settings, dropped precipitously as VA began to experience severe medical care funding shortfalls as shown in Table MC-4.

Each year since FY 1988, the *Independent Budget* has adjusted the current services level for increases in 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* has added funds to accommodate workload increments VA has achieved toward *Independent Budget* targets in past fiscal years. This funding is reflected as "Adjustments to the FY 1995 Program Base" in the *Independent Budget* recommended appropriation in Table MC-3. Incorporating these inflationary costs to maintain the FY 1988 service level and accommodating the progress VA has made toward meeting *Independent Budget* objectives results in a new current services level for each fiscal year.

The *Independent Budget* current services line compares to the VA appropriation for Medical Care, because it does not assume legislative changes and does not include dollars for the *Independent Budget's* proposed "funding initiatives". Rather, the *Independent Budget* current services level recommends funding necessary to allow VA patients the same access to quality health care services in FY 1995 that they enjoyed in FY 1988, including the improvements VA and Congress have implemented since then. In FY 1994, VA falls approximately **$800** million dollars short of the FY 1994 *Independent Budget* current services recommendation.

A.5.b.i. Payroll Costs

Medical care is a labor-intensive industry. Payroll costs for FY 1994 comprise more than **60** percent of VA's Medical Care budget. Lately, VA, like other medical care providers, has had to address 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 benefits and pay.

Although its pay raise rate is "capped" at the level Congress enacted for federal employees, Congress has recognized the need for VA to make concessions to the labor markets in which its facilities operate. Congress' recent initiatives to enhance VA recruitment and retention have included locality pay, new wage structures, and special pay. All of these initiatives have become part of VA's payroll costs and increase the *actual* inflation rate VA realizes, beyond the Congressionally enacted federal pay raise rate, for its labor.

Congress has insufficiently funded VA for special pay initiatives. Special pay plans, such as the *Nurse Pay Act of 1990*, have experienced difficult implementation, partly due to underfunding. VA nurses also blame survey methods used to evaluate various labor markets. When VA must absorb its special pay initiatives and some existing payroll requirements, funding available for other purposes, such as equipment and physical plant upkeep, is diminished. Insufficient appropriations for the payroll ultimately translate to a diminished standard of VA patient care.

Labor costs in the overinflated medical care sector are drastically different from those in other markets, and VA must have more adequate means of accommodating medical care labor market inflation. 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.

A.5.b.ii. Inflation

VA applies the Office of Management and Budget (OMB) 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 a medical inflation rate include pharmaceuticals, x-ray equipment, contract services, land and structures, and thermometers. Examples of non-medical items include paper, printing, and transportation costs.

Table MC-5 shows the difference between the actual medical care inflation rate and the OMB-projected rates. The difference between these two rates averaged **1.5** percent between FY 1988 and FY 1993. Applying an inadequate OMB-imposed inflation rate to past year's purchases consistently underestimates actual inflation costs for medical items. For example, if a case of thermometers cost $300 in FY 1994, and the OMB-imposed medical care inflation rate was 6 percent for FY 1995, then VA would project that a case of similar thermometers would cost $318 in FY 1995.

If VA had to buy a case of thermometers at a "real" inflation rate of 8 percent ($324), VA would fall $6 short of the actual purchase price. With VA's massive purchasing requirements, such differences easily translate into hundreds of thousands of dollars. Currently, VA must accommodate the shortfall for items that have higher-than-projected costs from monies appropriated for other purposes.

The *Independent Budget* will begin to track the dollars lost to

underestimated inflation rates. A line titled "Compensation for Inadequate Inflation Factors" shown in Table MC-3 will reference this dollar amount. The IBVSOs believe that Congress should give VA a supplemental appropriation to accommodate the dollars lost to an inadequate medical inflation rate in any fiscal year. This may encourage OMB to project a more realistic medical care inflation factor in future fiscal years.

The *Independent Budget* will also project its own inflation rate using historical differentials between OMB-projected rates for medical care and actual rates VA experienced. The IBVSOs will apply this inflation factor to VA's costs to determine a dollar amount for inflation for each fiscal year. Chart MC-1 displays the Medical Care Appropriation in current and constant dollars. Despite the fact that VA appropriations have grown annually, VA's purchasing power has stagnated while growing demand and mandated expansion have increased VA's resource needs. The shortfall results in redirected funding ("cannibalization") and delay and denial of care.

A.5.b.iv. Facility Activations

VA requires certain funds to staff and equip new facilities that come on-line as it completes construction and renovation projects. VA funds new or additional equipment and employees through the Facility Activations account.

OMB, anticipating delays in construction, applies a "slippage" factor to avoid providing funds to activate facilities that are not ready by their scheduled completion date. The slippage factor applied in past years has been too high. OMB should re-estimate this rate, based on recent VA experience. Lack of activation funds leaves newly constructed or renovated facilities unstaffed and unequipped when the time comes to open the doors. Veterans get 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 FY 1995 will require approximately **$200** million. This includes the costs of capital investments in equipment for these activations.

A.5.c. Initiatives

Below the "current services" line, the *Independent Budget* funds critical initiatives for VA to enhance its ability to respond to veterans appropriately and cost-effectively. Recognizing the need not only to maintain the FY 1988 service level, but also to expand care—institutional and community long-term care, outpatient care, and various psycho-social programs—in areas with immediate need, the *Independent Budget* incrementally funds workload "targets" established for FY 1995. The targets are displayed in Table MC-7. *Independent Budget* workload targets are based on the 1980 decennial census veteran population estimates. The cost of meeting these targets is shown in the inpatient, outpatient, and extended care program workload increases in the budget. Inpatient and outpatient care increases include funding for care received in VA medical facilities or in contract settings. The extended care program increase includes funding for: VA, state and community nursing homes; adult day health care; respite; and hospice programs. Funding for additional geriatric research, education, and clinical centers (GRECCs) is also included. These initiatives are addressed below.

The *Independent Budget's* workload targets call for optimal use of the most efficient health care delivery modalities which provide high-quality care for veterans. *Independent Budget* recommendations assume that, while the Veterans Health Administration must continue to rely heavily on hospitalizing veterans, VA facilities will succeed in expanding non-institutional programs and shifting some workload from inpatient care.

The *Independent Budget* uses computerized models to project future VA inpatient, outpatient, and nursing home workload. The inpatient model identifies certain procedures, such as cataract surgery and carpal tunnel release, that the private sector typically performs as outpatient services. The *Independent Budget* models remove these and other short-stay hospital services from the inpatient workload targets and add them to the outpatient targets. Since VA could care for most patients with disproportionately long hospital stays less expensively in long-term care settings, the *Independent Budget* model reassigns the excess workload that long-stay hospital patients incur to the nursing home current services baseline. The *Independent Budget* model also assumes that VA will

provide the workload projected in the FY 1995 President's budget. This is not always the case, as Table MC-8 demonstrates. The Administration's projections sometimes err by as much as 18 percent from actual VA workloads.

The *Independent Budget's* models project future workload for inpatient, outpatient, and nursing home programs, based on an FY 1988 service level, in settings that are efficient, appropriate, and practical under current entitlement rules.

4. VA Programs
a. Hospital Inpatient Care

Inpatient care provided by VA medical centers is a vital component of the veterans' medical care system. VA hospitals act as the cornerstone of the system, serving as the center of research, graduate medical education, and care delivery activities for the entire medical care system. Without these important institutions, VA would be unable to effectively support its vital outpatient, community, and long-term care programs.

The 171 VA medical centers provided inpatient care to 920,311 individuals, with an average daily census of 42,419 in FY 1993. This was a decrease of 14,186 patients treated over the previous fiscal year and a decline of 15 percent since FY 1988 (See Chart MC-5). The decline can be partly explained by the increased reliance on other modes of care, such as outpatient clinics and community-based care.

Even with these declines, VA must continue to support its own inpatient care capacity because the same demands for hospital inpatient care exist today as in FY 1988. It is important to hold the *Independent Budget* target for inpatient hospital treatments constant for two primary reasons: First, the VA user population demonstrates some unique characteristics which increase its inpatient utilization rates; Second, the restricted access to certain types of care created by current eligibility criteria puts pressure on inpatient care capacity.

An analysis of the veteran population shows that veterans who use VA medical services tend to be at higher-risk for certain conditions than veterans who do not use VA services. These veterans are older, and older patients usually have more episodes of care and more intensive care needs than other patients. This aging trend and subsequent intensification of inpatient care use counteracts any attrition in the size of the overall veteran population that would lead to less utilization of medical care services. Chart MC-6 shows the hospital inpatient treatment rates by age group, demonstrating that the cohort comprised of veterans older than seventy-five consumed almost twice as much care as the group younger than sixty-five. Also, VA system users tend to have less income than other veterans or the general population. In fact, half of VA's

inpatient users report a family income below $10,000, which places them below the federal poverty line.[1] Additionally, veterans using VA health care services tend to be less well insured and less educated, and are less likely to have intact family support structures than other veterans or the population at large. These characteristics make VA users more prone to illness and injury, and offer them fewer opportunities for home and community-based health care alternatives than their peers. These circumstances combine to create an artificially high demand for VA's inpatient services.

Current entitlement criteria (outlined in Table MC-1 and Appendix B) also contribute to VA's immediate need to maintain its FY 1988 level of hospital inpatient treatment. Some VA patients are only eligible for inpatient care, unless outpatient care "obviates the need" for inpatient care or is used on a pre- or post-hospital basis. Because of this obscured eligibility criteria, inpatient care settings become a "safety net" for patients who might be more effectively treated on an outpatient basis - patients who, like other veterans with more comprehensive entitlement, rely on VA as their only source of care.

The *Independent Budget* uses the FY 1988 current services level as its target for inpatient care. At that time, 1,086,500 inpatients were treated in VA medical centers and 1,025 ADC in state and community hospital systems was supported. In FY 1993 920,311 inpatients were treated in VAMCs and 21,818 inpatients were treated in state and community hospital systems and State Veterans Homes Hospitals. This inpatient workload has consistently declined since FY 1988, as can be seen in Chart MC-5. VA needs to expand its inpatient services to meet the FY 1988 targets.

Recommendation: Provide hospital inpatient care resources to accommodate 1,086,500 patient treatments in FY 1995 and resources to accommodate an average daily census of 1,025 patients in state and community hospital systems.

Cost: $11,678,000 in FY 1995 for additional community-based hospital

[1]Testimony of D. Joanne Lynn, M.D., The American Geriatrics Society; SCVA, May 19, 1993.

care, particularly for women and others whose needs VA cannot appropriately meet.

i. Intermediate Care

The intermediate care beds in VA hospitals serve a unique and important function. Veterans requiring a level of care between acute and long-term or extended care are treated in these intermediate bed sections. Often these patients have nowhere else to turn because of their conditions' intensity or complexity, 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. However, VA often utilizes intermediate care beds 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 for lack of access to a more appropriate setting. 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, allowing veterans access to the full array of care, would remedy misplacement of many veterans. Without eligibility reform, however, restructuring resources to utilize more appropriate care settings will not be possible. The IBVSOs remain committed to the idea that eligibility reform is necessary for VHA to adequately allocate its resources and treat its patients.

b. Domiciliary

The Domiciliary Care Program is the oldest of the VA's health care programs, first initiated in the 1860's to provide homes for disabled volunteer soldiers of the Civil War. For many years these homes were considered "old soldiers' homes," but the domiciliaries of today go beyond

this original mission. VA's modern Domiciliary Care Programs have been proactive in adapting 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 prepare capable veterans to return to community living. Domiciliary's 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 very cost-effective. Veterans who would otherwise be destitute or institutionalized are placed in this environment appropriate for their needs. The average cost for care in a domiciliary are approximately $86 to $92 per patient day.[2] This compares favorably with the average daily cost of **$196** for nursing home or hospital care, to say nothing of the social costs to those left without care.

VA Domiciliary Care Programs supported an ADC of 6,061 in FY 1988. By FY 1993, this level had grown to only 6,197 ADC. VA estimates that the Domiciliary Program will grow to an ADC of only 6,718 in 39 programs by FY 1994. These levels are not adequate to serve the needs of veterans who require the type of specialized care that only Domiciliary can provide. VA has not compensated for this drop-off by increasing the level of VA patients served through the State Homes' Domiciliary Care programs. In FY 1988, these State Home programs accommodated an ADC of 3,326; the FY 1993 ADC was only 3,326. VA needs to develop its Domiciliary care capacity to meet the *Independent Budget*'s recommendation of 7,600 ADC for FY 1995.

Recommendation: VA must continue to expand its domiciliary care capacity and accommodate an average daily census of 7,600 in its own programs and 4,000 ADC in VA-sponsored domiciliary care programs in FY 1995.

Cost: $33 million

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[2]Executive Summary, Testimony before Senate Veterans' Affairs Committee, May 19, 1993, Paul Smits, M.S.W., Martinsburg, VAMC.

c. Outpatient Care

Outpatient delivery of service in VA has gained increasing importance as a cost-effective and 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 fully capitalize on the virtues of outpatient care due to eligibility criteria which control patients' access to certain modes of care. Regulations often prohibit VA physicians from providing necessary care in the most proper setting; instead they are forced to admit patients to sites of more intensive care delivery in order to provide any care at all. These eligibility criteria essentially bar some veterans, whose only option for medical care is VA, from receiving care in outpatient settings. Changing the current governing eligibility law - a top priority for the IBVSOs for FY 1995 - 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 would otherwise be unable to receive care through VA or any source. This Program targets its outreach efforts at populations with high concentrations of service-connected and poor veterans and 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 being treated by the Mobile Clinics are those that would otherwise never have visited a VA medical center or clinic.[3] These types of innovative programs need to be continued, strengthened, and expanded to meet both the challenges that face VA in the future 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

[3]VA Senior Management Directory, Fall 1993.

primary care to veterans in their local communities and could operate with only one full-time nurse practitioner or physician assistant and one-half FTE clerical assistant. The need and demand for these types of community-centered and administered modes of care for veterans is clearly demonstrated by the success of the Mobile Clinic Pilot Program. Establishing clinics in the Vet Centers would provide veterans with access to basic medical services and would enable VA to take advantage of the important community resources provided by the Vet Centers. Vet Centers already boast VA's lowest cost average for both cost per visit and cost per veteran served, for treating Post Traumatic Stress Disorder[4]. This efficient model could be applied to primary care provision and medical referrals.

Also, in planning for outpatient care delivery, VA needs to pay special attention to its women veterans. The goals of the VA Advisory Committee on Women Veterans merit increased vigilance to the needs of women veterans. In the event that VA cannot provide appropriate services to these veterans, access to private-sector providers must be assured. VA health care services for women veterans will be addressed more fully below, on page **XXX**.

In FY 1988 VA provided 21,473,402 staff outpatient visits and 1,759,492 fee-based outpatient visits for veterans; these levels were 23,144,396 staff visits and 1,091,699 fee visits in FY 1993. Outpatient utilization rates are projected to continue to increase in the future. Chart MC-6 shows that, like hospital inpatient utilization rates, outpatient treatment increases with age. In FY 1988 outpatient treatment rates for users older than 75 years were almost three times as high as those for users younger than 65. While in FY 1993, the age discrepancy decreased, older veterans still demonstrate significantly higher outpatient user rates than younger groups. The *Independent Budget* recommends that treatment these levels be increased to 24,000,000 staff outpatient visits and 1,880,000 fee visits in FY 1995 to accommodate the growing demands of an aging veteran population.

Recommendation:

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[4]Senior Management Directory, 1993.

• Increase outpatient workload to achieve the *Independent Budget* target through 855,604 additional staff and 120508 additional fee visits.

• Fund 50 "storefront" clinics in Vet Centers and provide resources for 50 Nurse Practitioners and 50 one-half FTEE clerical staff with additional funding for beneficiary travel to VA medical centers.

Cost: $66.3 million

i. Prevention

The emphasis on outpatient care in VA is paralleled by an increased need for preventive services. These services, such as inoculations, cancer screenings, and regular physical exams, have been 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 pain and suffering of the patient. However, VA has not provided consistent and regular preventive care to its patients. The IBVSOs hope that VA will recognize savings and improve patients' quality of life by offering routine diagnostic work for early detection of disease 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 VA's ability to offer services comparable to those offered by other providers.

The VA needs to be particularly sensitive to the needs of women veterans and expand its gender-specific preventive services such as mammography screenings. (The needs of women veterans will be discussed more fully below.) To accomplish these goals, VA should be appropriately funded and increase staffing levels for preventive services. VA also needs to increase funds to purchase screening equipment. VA medical centers will be unable to provide adequate preventive care without the appropriate medical equipment designed for these services.

Congress must attach sufficient funds to these preventive health initiatives to ensure that VA can implement preventive health programs without

redirecting funds from other worthy and important programs. These projects need to be independently funded to ensure that they do not act as a drain on other important service delivery programs.

Recommendations:

- Add one women veterans coordinator at the 50 centers with the highest women's utilization rates for women's ambulatory care preventive services.

- Add funding for approximately 10,000 fee visits for women's ambulatory care preventive services.

- Add funding for direct care staff and equipment to implement preventive medicine program interventions.

Cost: Funding for the women veterans coordinator included in Women Veterans Programs initiatives.

ii. Outreach and Education

The Outreach and Education activities are another form of preventive care VA must continue to promote. Bringing veterans into the system early in their lives will allow VA to introduce young veterans to preventive care and other practices that will promote good habits. This will 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 made aware of their benefits by activating and appropriately funding the Transitional Assistance Program (TAP) and the Disabled Transitional Assistance Program (DTAP) of the Veterans Benefits Administration. The resulting increase in utilization of VA services will benefit VA medical centers through 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 acute care younger patients is important to maintaining strong academic affiliations, as well.

The Patient Health Education (PHE) program in 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.

The IBVSOs encourage VA to continue these outreach and education efforts aimed at preventing illness and disability among the veteran population.

Recommendation:

- 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 intense treatment when necessary.
- Continue to support the effective and importance activities of the Patient Health Education program.

Cost: Included in outpatient initiative.

iii. Case Management of Outpatient Services

In an attempt to limit health care costs and to increase quality, many health care providers have adopted managed care techniques, including the use of case managers. These individuals are responsible for monitoring patients' care and ensuring that patients are given the most appropriate, timely, and efficient health care services possible. The case manager guides patients through the system, exposes the patient to preventive interventions, and fosters patient education.

VA uses this case management model for its elderly patients in the Geriatric Evaluation Management (GEM) program (discussed below). VA should expand such managed care techniques to other programs, especially those treating veterans with specialized care needs, such as spinal cord injury and psycho-social impairments. In implementing this technique, a provider with a generalized medicine background, such as an internist or a general practitioner can be prepared to act as a case manager. With proper education, alternative care providers such as physician's assistants or nurse practitioners can also fill this role.

In addition to utilizing case management, VA needs the ability to manage its own patients. Congress should eliminate restrictive eligibility criteria so VA can treat its patients in the most appropriate setting for the patients' medical needs. VA should expand the gatekeeper function throughout the system with concurrent eligibility enhancements for veterans health care.

d. Long-Term Care

Long-term care services of VA are gaining importance as the demand for these services increases. Dramatic growth in the population of elderly veterans has placed pressure on 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 population were veterans and one in every four veterans was over 65 years old. By the year 2000, it is estimated, over 60 percent of the entire U.S. male population over 65 will be veterans. In 1980, 3.0 million veterans were older than 65 years old; by 1990, that number had

skyrocketed to 7.2 million, a 136.5 percent increase.[5] Currently, 50 percent of the veteran population (13.5 million veterans) are over age 56. This growth in the elderly population is expected to continue, despite projections that the total veteran population will decline 26 percent during the period 1990 to 2010, from 27.2 million to 20.0 million veterans.

This high concentration of older individuals in the veteran population forces VA to confront a crisis of increased demand for long-term care and geriatric services. Other private providers will not face this predicament in the general population for another decade. VA is an extraordinarily valuable national resource and its experimentation with cost-effective long-term care offers important lessons for national health care reform. As an integrated system, VA endeavors to care for patients within its own programs and VA should be encouraged to build on its successes in developing and evaluating innovative care delivery, especially comprehensive and coordinated long term care.

VA has a unique opportunity to set the pace for efficient, effective long-term care delivery in the next decade. The veteran population has reached an average age when rapid expansion of long-term care services is absolutely essential. Service-connected veterans offer VA the challenge of delivering specialized long-term care to those with disabilities. If national health care reform creates a regional commitment to coordinating service capacity and to establishing integrated responsibility for long term care, each VA medical center must become a participant in its local system of care and in the planning for development of that system. As the population shifts and needs change, it must become possible to develop alternative uses for under-utilized service capacity, including VA hospitals. VA's mission to care for populations that are aging or have service-connected conditions makes it an ideal setting for demonstrations in meeting the nation's future long-term care needs.

As a long-term care model, VA offers some services not generally covered by other private or public health care plans, including custodial care, social services, and long-term rehabilitative therapy. Utilization of these types of non-institutional long-term care will become increasingly

[5]"Our National Veterans' Changing Population," National Center for Veteran Analysis and Statistics.

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, construct new facilities, and enter into enhanced lease arrangements. When considering such expansions, VA should plan for the need for hospital beds beyond the near future. The IBVSOs also maintain that sustained low occupancy rates in some VA hospitals indicate the opportunity to integrate inpatient and long-term care facilities, and to establish the multi-layered, long-term care programs described below.

VA has not sufficiently expanded its long-term care programs in recent years because of insufficient funding and inadequate capacity. The Administration should 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.

i. Nursing Homes

During the period FY 1985 to FY 1990, the average daily census of veterans in VA nursing homes or VA-sponsored nursing home beds remained almost constant. However, the capacity of these programs should have been expanded in response to the increase in the number of older veterans and potential nursing home residents. As has been previously discussed, the veteran population is growing older and will require more long-term care services in the future. To meet this demand, VA needs to adjust its nursing home capacity accordingly.

However, deficiencies in the VA budget have placed constraints on veterans' access to nursing home care. Hospital directors, experiencing budget shortfalls, are pressured to either cut programs or reduce service availability. Often, because nursing home care is not guaranteed to veterans, this service is one of the first to be cut. Given eligibility constraints and limited capacity, VA either denies many veterans nursing

home care, limits length of stay, or moves veterans into more costly intermediate care hospital beds.

Both VHA and the IBVSOs base their models for long-term care demand on the 1985 National Nursing Home Survey. This survey's results indicate that approximately 20 percent of all veterans in nursing homes 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 level. In FY 1988, VA realized a 19-percent market share, and since then that number has decreased. After FY 1988, VA began to curtail nursing home workload even as the growth in the elderly veteran population dictated that it expand services.

VA provides nursing home care in three settings: VA-operated homes, state-owned nursing homes, and by contract with private-sector providers in community homes. Beginning in 1988, the average daily census of VA or VA-sponsored nursing home care has changed at an unpredictable rate. (See Chart MC-7) The number of patients treated in community-based nursing homes has dropped by more than 30 percent, while state home nursing home care has grown at approximately 20 percent. VA's own nursing home capacity has only made limited progress toward its goals for expansion and is not nearly that needed to compensate for the drastic cuts in community nursing home care venues.

The FY 1995 *Independent Budget* goals for average daily census levels in VA nursing home programs are 40 percent in VA facilities; 30 percent in state homes; and 30 percent in community-based nursing homes. The Office of Management and Budget (OMB) developed a planning model for VHA that assigned 30 percent of nursing home ADC in VA facilities; 30 percent in state homes; and 40 percent in community-based nursing homes. These figures appear to be impractical when compared with the actual distribution of workload today. (See Table MC-6) In FY 1993, the true distribution was 41 percent in VA facilities; 32 percent in state homes; and 26 percent in community-based nursing homes. VHA's projected workload for FY 1994 is similarly distributed.

In FY 1993, VA supported an ADC of 13,476 in its own nursing homes and treated 31,668 patients. VA projects 96,980 veterans will need

nursing home care by 2010, a number that far exceeds its current capacity. State Home Nursing Homes contributed to VA's overall nursing home capacity with an ADC of 10,601 in 66 programs; and community-based nursing homes provided 8,418 ADC to VA's nursing home capacity in FY 1993. The *Independent Budget* targets for FY 1995 are 19,200 ADC in VA nursing homes, 13,600 ADC in Community nursing homes, and 14,000 ADC in State Home Nursing Homes.

TABLE MC-6: Comparison of Nursing Home ADC in VA Operated and Sponsored Settings

TYPE OF FACILITY	1995 *Independent Budget* Goals (ADC)	Office of Management & Budget Goals (ADC)	Actual Distribution FY 1993 (ADC)	Proposed Distribution FY 1994 (ADC)
VA-Nursing Homes	40%	30%	41%	41%
State Home Nursing Homes	30%	30%	32%	35%
Community-Based Nursing Homes	30%	40%	26%	25%

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 FY 1988. The IBVSOs are discouraged by this trend and feel 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 bed capabilities. This expansion can be accomplished through the conversion of hospital bed wards, expanded leasing of nursing homes and enhanced use leasing, or building new nursing homes.

However, the IBVSOs do acknowledge that growth in nursing home capacity is more likely in VA or state home programs. VA often eliminates community-based care first, rather than diminishing care provided within the system. The *Independent Budget* recognizes this reality, though still encouraging the use of community-based care with its often lower per diem costs.

a. VA Nursing Homes

VA's Nursing Home program provides care to individuals who are not in need of hospital care, but who require nursing care and related medical or psychological services in an institutional setting. This important program provides continuing health care, 24-hour nursing care, and rehabilitation to achieve the highest degree of independence and well-being for veterans. VA currently operates 129 nursing home care units with 14,790 beds.

These facilities supported an ADC of 13,476 and current services level of 31,668 patients treated in FY 1993. The *Independent Budget* bases its nursing home workload targets on the anticipated expansion of VA nursing home programs and the greatest expansion feasible in state and community nursing home programs. The *Independent Budget* recommends increasing the average daily census of these systems to 19,200 in FY 1995. VA will have to accommodate much of this growth in the community since it will not have the short-term capacity to deal with it "in-house." This can be accomplished through hospital bed conversions, appropriate exploitation of enhanced use arrangements, and facility leasing programs. However, VA must still fulfill its commitment to plan for the long-term needs of veterans through the obligation of funds for nursing home construction projects.

1. Hospital Bed Conversions

VA has not been meeting its promised level of hospital bed conversions. In FY 1993, VA converted 253 hospital beds, far less than the expansion that the IBVSOs had hoped for. VHA plans to convert an additional 1,358 hospital beds to nursing home care beds between now and FY 1998. However, VA has not been meeting previous targets and current

conversion levels do not satisfy the critical need for nursing home beds.

The *Independent Budget* recommends that VA convert 2,992 hospital beds to nursing home beds in FY 1995. VA has historically been slow to implement these conversions due primarily to budget constraints and hospital directors' resistance to mission changes. VA facility directors have been unable to convert substantial numbers of hospital beds to nursing home beds because of the shortage of funds, even though long-term savings would result. VA nursing home days of care are considerably less expensive than the hospital inpatient or intermediate care days which are often inappropriately substituted. The 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 a replacement of physician staff with less trained and, thus less costly, care providers. In many under-served areas, physicians derive most of their incomes from VA and would be unable to practice without this financial supplement. VA, in effect, "subsidizes" care in areas without great veteran demand. Without the acute care resources at some VA medical centers many communities would be medically underserved.

Lack of large, contiguous blocks of space also prohibit conversions. VA must change missions for entire wards and add space for recreational and social areas to satisfy space requirements for nursing homes. Construction funds to convert space to meet this need have been severely restricted.

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 FY 1998. This year, VHA sets its targets at 1,358 conversions between FYs 1994 and 1998. These goals demonstrate that, in policy, VHA is willing to develop

nursing home capacity within the VA system through hospital bed conversions, but must temper their efforts to do so because of fiscal constraints. The IBVSOs hope that VA will further efforts to meet these goals in the future.

2. Nursing Home Construction

The *Independent Budget*'s standing recommendation for nursing home construction has been that VA build four 120-bed nursing homes to add 480 new beds to the system. For the long term, the IBVSOs propose that Congress fund four new 120-bed nursing homes 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 meet the needs of a growing elderly population. VA has not demonstrated an ability to build and activate nursing homes in fewer than six years. The "Construction Programs" section discusses ways to expedite construction timeliness. Until VA addresses problems in its construction protocol, it must find alternative means to meet veterans' immediate need for long-term care.

The Construction Section on page **XXX** of the *Independent Budget* details the requirements necessary for these changes.

3. Nursing Home Leases

Another option for expanding VA's nursing home capacity is through increased leasing arrangements. The resulting capacity can alleviate some of the need while additional nursing homes are constructed. The IBVSOs recommend that VA lease twelve 120-bed nursing homes which VA would manage and equip. The Medical Care budget initiatives include activation funds for these leased facilities.

4. Enhanced Use Leases

In addition to leasing nursing homes, VA must exploit enhanced use arrangements to add 480 average daily census to the nursing home

census. Under enhanced use leasing unoccupied or under-occupied VA facilities agree to lease space to an external party for an activity that will benefit 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, the best interest of all parties is served by allowing outside parties to lease space and provide additional services to veterans. VA can attract potential participants by making sufficiently large spaces available and by "fronting" reasonable funds to attract private-sector interest in enhanced-use leases.

VA needs to further expand its enhanced leasing programs through aggressive solicitation and outreach. Even within VA, there is not a clear understanding of the objectives of the initiatives or the extent to which VA is already involved in these programs. To entice additional partners to engage in these endeavors, VA may need to explore the cost-effectiveness of advancing funds to these potential partners for renovations and improvements to the physical plant.

Enhanced lease arrangements can assist VA in compensating for its lack of nursing home capacity. In total, the *Independent Budget* asks that VA add 480 to its average daily census through these arrangement. However, these types of programs cannot and will not adequately meet VA's need for expanded nursing home capacity. 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 can be projected into the future, short-term leasing does not release Congress and the Department from their obligation to construct or convert facilities for future veterans. The demand for nursing home care by veterans will only increase. As different service era cohorts begin to age and utilize more nursing home care, VA will be required to dramatically expand its capacity. (See Chart MC-8) The aging veterans of the World War II service era will be quickly followed by those of the Korean Conflict. The age distribution of this generation and of the Vietnam generation will provide only a temporary reduction in the need for nursing home beds around the year 2010. VA

must look beyond the temporary trends and instead develop the capacity to provide 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 through conversions of hospital beds. This will provide VA with additional capacity until more nursing homes can be constructed.

Recommendations:

- Increase the VA nursing home average daily census to 16,724 in FY 1995 by converting 25 120-bed hospital wards, leasing 12 120-bed nursing homes, and entering enhanced use leases for another four 120 bed wards.

- Add major construction funds for four new 120-bed nursing homes in FY 1995.

Cost:

- Cost of constructing new nursing homes included in the Construction Budget.

- $328 million for VA nursing home workload increase

- $35 million for activation funds for leased nursing homes

b. State Home Nursing Homes

An additional way in which VA attempts to meet the long-term care needs of veterans is through approved State Home Nursing Homes. These State Homes include facilities for nursing home care, and some, unlike VA's nursing homes, admit veterans' dependents. The construction and operation of these facilities are subsidized by VA, with VA 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 most potential to develop VA-sponsored nursing home capacity. Currently, 72 programs in 41 states provide nursing home beds for veterans. In FY 1993, VA-sponsored beds

in State Homes supported 10,601 ADC in 66 homes. Plans call for an additional 675 ADC and nine new units in FY 1994. VA also expects to add an additional 1,375 State nursing home beds through construction projects during that period. The FY 1995 *Independent Budget* recommends an ADC of 14,000, taking into account state programs' workload growth which exceeds that in other venues for nursing home care VA operates or funds.

Expanding the use of State Homes to provide nursing home care to veterans is a sound fiscal policy. States bear the bulk of the financial responsibility for these programs, so VA spending is maximized. 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 average per diem cost for State Homes is $31 compared with $193 for VA nursing home care. VA should increase its contribution to state nursing homes to equal one-third (1/3) of State Home operating costs (or approximately $45) based on its 1986 agreement with them. The *Independent Budget*'s cost projections are based upon this agreement. Given VA's commitment to expanding its average daily census of nursing home patients, State Homes provide an attractive way to reach its goals. The savings realized by placing veterans in the less expensive State Homes quickly compensates 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*'s recommendations for grants to fund construction of additional state home beds are given on page **XXX**.

Recommendations:

- Increase state nursing home average daily census to 14,000 for FY 1995. This assumes considerable growth in bed availability.

- Fulfill the obligation to compensate State Homes for one-third (1/3) of the average per diem cost of care for veterans in those Homes.

Cost: $26 million

c. Community Nursing Homes

The Community Nursing Home (CNH) Program places veteran patients requiring nursing home care in community nursing facilities at VA 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 can remain in these nursing homes for a period of up to six months as a transition from hospitalization in VAMCs. Veterans hospitalized primarily for service-connected disability are exempt from the six month limitation.

Because VA has remained dedicated to increasing its own nursing home capacity, emphasis upon community-based nursing homes has remained limited. The IBVSOs and VA appear to advocate expanding capacity within the system, rather than utilizing this mode of care. The IBVSOs support using VA as a model for long-term care in its elderly patient base.

Under current law, veterans are not entitled to this 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. Every year since FY 1988, the average daily census level has declined, decreasing by 32 percent between FY 1988 and FY 1993.

In FY 1993, VA offered community-based nursing home care to an average daily census of 8,418. The IBVSOs remain committed to their belief that VA should furnish long-term institutional care in the community when at all possible. Community nursing homes are a cost-effective means of delivering care, and VA's nursing home program currently functions as a failing safety net. VA must use community capacity to provide needy veterans with care until it can meet construction goals and expand its own capacity.

Recommendation: Increase community-based nursing home census to

13,600 in FY 1995.

Cost: $67 million

ii. 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 both at enabling independence and reducing system costs, and needs to further these efforts. Programs such as hospital-based home care, community residential care, and hospice and respite care have produced cost-savings for VA and increased patient satisfaction.

Some of these modes of care, specifically home-based care, respite care, and hospice programs, operate interdependently and merit the coordination of case managers. 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 more effectively use its resources; physicians and nurses are freed from some of the administrative details that are more effectively dealt with by case managers. 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.

a. 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 FY 1973, funding was secured for six demonstration hospitals. Since that time, the HBHC program has grown to a total of 75 programs systemwide.

HBHC provides services to patients in their homes through hospital-based interdisciplinary teams. This program is specifically aimed at serving homebound veterans whose caregivers are willing and able to assist in their care. Studies regarding the effectiveness of HBHC and the satisfaction of its patients have shown that these programs greatly assist in the early detection of treatable secondary conditions, such as infections, and provide timely, cost-effective care. Also, HBHC reduces inappropriate use of hospital, emergency room, and outpatient clinics, and helps prevent premature nursing home placement. Studies conducted for the VA have clearly shown that nursing homes become a last resort on the part of discharge personnel when hospital-based home care is an option.[6]

The 75 HBHC programs currently in operation supported a 5,003 ADC in FY 1993. VA has accomplished most of the expansion in this program 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 the tight budget constraints of VA.

Recommendation: Activate HBHC programs at the 96 remaining hospitals then currently lack them in FY 1995.

Cost: $55 million

b. Respite Care Programs

A VA program of respite care was authorized under Public Law 99-576 and program guidance for the establishment of a Respite Care Program was first furnished to medical centers in November 1987. Respite Care programs at VA medical centers are designed as an inpatient period of care for the homebound veteran and a time of rest for the caregiver. This program uses unoccupied VA hospital or nursing home beds. Generally,

[6]Gerontological Society of America, Testimony. May 19, 1993.

veterans are admitted for a period of 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 the family or other members of the household, they are able to live at home. At the same time, there is recognition that such arrangements for the care of a patient at home may place severe physical and emotional burdens on the caregiver and household, necessitating some form of respite care program. Providing respite services can prolong the time a caregiver is able to provide care in the home and delay the patient's entry to an institutional setting.

Recommendation: Activate respite programs at the 35 hospitals that currently lack them in FY 1995.

Cost: Included in Hospital-Based Home Care funding initiative.

c. Hospice Care

Hospice care is a coordinated program of palliative and supportive services provided in both home and inpatient settings for patients in the last phases of incurable diseases. Hospice care requires the acknowledgement of the patient, the family and the physician that the illness is terminal, and a mutual agreement that aggressive treatment will no longer be pursued. VA has established a program of specialized Hospice Consultation Teams consisting of a physician, nurse, social worker and a chaplain to administer some Hospice Care programs. These Teams function to provide a planned and organized approach to care of terminally ill patients and their families, including program planning, education of staff, consultation and treatment responsibilities, and coordination of services.

Hospice care is provided by VA in a number of ways, some or all of which may be used by a medical center. These program options include: (1) referral of eligible veterans to community-based hospice 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 a number of options for terminally ill veterans seeking hospice care.

VA could expand access to this important program further by creating its own community-based program with existing HBHC teams. As of FY 1993, 96 VAMCs had established a Hospice Consultation Team, and 28 inpatient hospice units had been established. All VA medical centers currently operate some type of hospice program. However, not all centers have Hospice Consultation Teams. An extension of these teams could also serve to project VA's hospice care programs through the community-based programs.

Recommendation: Expand the VA hospice program by creating community-based programs with existing HBHC teams.

Cost: Included in hospital-based home care initiative.

d. Adult Day Health Care

The VA's Adult Day Health Care (ADC) Programs were authorized by Congress in November, 1983 (PL 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 those elderly, functionally disabled veterans who might otherwise require institutional placement. This therapeutically-oriented outpatient program is specifically aimed at vulnerable populations, such as frail elderly, those with functional or cognitive impairments, and veterans with multiple interactive medical problems, significant social issues, and psychological needs. VA both provides this service directly and contracts with other providers. The Contract ADHC programs serve patients who live in the program's primary service area with a reliable transportation system. During the past ten years, VA's own ADHC programs have grown in number from five to 15. The *Independent Budget* goal for FY 1995 is 40 programs. In FY 1993, these programs supported an ADC of 738 in these centers. VA supported 28 contract ADHC programs in FY 1993; the IBVSOs recommend that this be increased to 60 in FY 1995.

Recommendation: Increase the number of hospitals with VA or VA-sponsored adult day health care programs from 43 to 100.

Cost: $16 million

e. Community Residential Care

The Community Residential Care (CRC) program provides room, board, and limited personal supervision (at the veterans' expense) along with home visits by VA nurses and social workers and outpatient care for the veteran. CRC facilities are most appropriate for patients who require care for medical and/or 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 the elderly with mild impairments. Because the VA is responsible only for the cost of administering the program, CRC is operated at minimal expense in a highly cost-effective manner. These programs are especially cost-effective considering their potential for reaching members of the marginal population who have some means but cannot manage their lives without this formal support.

In FY 1993, Community Residential Care programs provided 10,388 ADC in 135 programs. The *Independent Budget* urges VA to expand this program to all VA medical centers by the end of FY 1995.

Recommendation: Establish community residential care program at 36 VA medical centers.

Cost: $5 million

iii. Accommodating the Long-Term Care Needs of Veterans

a. Multi-Level Long-Term Care Facilities

With its unique patient base, VA is in an excellent position to develop model multi-level geriatric and long-term care centers. Each VA medical region should select one secondary care hospital near a tertiary referral

VA medical center and, by converting its beds and mission, 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 result in the development of approximately four new multi-level geriatric care facilities. The *Independent Budget* has supported development of these facilities since FY 1990. Still, VA has not made these enhancements in their geriatric care program. Last year, the VA Commission on the Future Structure of Veterans Health Care concurred with the *Independent Budget* recommendations for enhancing geriatric care programs. The influence of this expert panel will, hopefully, encourage VA to begin to develop multi-level geriatric care programs in FY 1994.

Specifically, the *Independent Budget* agrees with the Commission that VA should:

- Expedite the integration of acute care and long-term care programs geared toward the elderly, thereby encouraging continuity of care for these veterans.

- Implement additional geriatric evaluation and management units and geriatric treatment units, to coordinate treatment of older veterans as they move through the VA system.

- Expand geriatric research education and clinical centers (GRECCs) to enhance academic affiliations and to attract and retain high-quality clinicians to care for this population's specialized care needs.

Implementing these concepts which the IBVSOs have encouraged for years, has become even more urgent as the veteran population ages.

With the budget restricting the delivery of care to veterans whose needs continue to grow, VA must provide care in more cost-effective, efficient ways. The concepts outlined above can enhance VA's ability to deliver more cost-effective and high quality care to elderly veterans.

Recommendation: Establish four multi-level, long-term care facilities.

Cost: No incremental funding required.

b. Geriatric Evaluation and Management Programs

Geriatric Evaluation and Management (GEM) Units were pioneered in the VA. These unique centers provide a specialized program of 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 assessment of the patient is followed by an interdisciplinary plan of care, including treatment, rehabilitation, health promotion and social service interventions. Studies of the efficacy of GEMs demonstrated improvement in the survival rates of patients, reduction in nursing home admissions, reduction in hospital admissions, and improvement in functional status.[7] These inpatient units have been shown to coordinate and plan care so well that patients live longer with less disability and fewer episodes of re-hospitalization 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 FY 1995. In FY 1993, 113 GEMS were in operation throughout the VA medical care system. The IBVSOs urge that 58 GEMS be added to increase access to this mode of care to veterans in all areas.

Recommendation: Increase the number of geriatric evaluation and management units from 113 to 171.

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[7] "Annals of Internal Medicine," article - "New Technologies of Geriatric Evaluation Units." quoted in the Gerontological Society of America's testimony to the SCVA, May 19, 1993.

Cost: No incremental funding.

c. Geriatric Research, Education, and Clinical Centers (GRECCs)

In 1976, the VA established the GRECC program to focus attention on the aging veteran population, to increase the 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, coordinated efforts are made in regard to a focused area of health care 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, those seeking to evaluate treatment, and projects 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 the VA. The IBVSOs urge that the GRECC program be expanded so that these innovations and effective discoveries are developed more rapidly.

One area which 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 both veterans and the general public.

The number of GRECCs needs to be expanded to fulfill its original goals, and meet these new missions. In 1986, Public Law 99-166 authorized an increase in the number of GRECCs from 15 to 25. However, since that enactment only one additional GRECC has been added and VA does not propose an increase in FY 1994. The Independent Budget recommends that VA institute 25 GRECCs by FY 1995.

Recommendation:

- Establish nine geriatric research, education and clinical centers (GRECCs), including one GRECC dedicated to spinal cord injury treatment and research in FY 1995.
- 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 million.

iv. Psycho-Social Programs

Veterans are, as a group, especially susceptible to certain psychosocial disorders, including PTSD, severe psychoses, substance abuse, and homelessness. These conditions tend to contribute to each another, and it is imperative that providers coordinate care to dispense an integrated response. The Robert Wood Johnson Foundation recently conducted a study which demonstrated 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 pulling services together and providing housing and case management services can their future be improved.[8] VA, as an integrated delivery system, makes an ideal test-site for this approach to care delivery.

Traditionally oriented toward institutionalization, VA needs to 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. Schizophrenia and manic-depressive disorders account for 71 percent of all veterans who are currently receiving 100 percent disability benefits for psychiatric disorders. VA needs to increase its commitment to services research on persons with severe mental illnesses such as these to identify the most economical and efficacious treatment programs in the hospitals and in the communities.

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[8]Shore MF and Cohen MD: The Robert Wood Johnson Foundation Program on Chronic Mental Illness: An Overview. Hospital and Community Psychiatry 41: 1212-1216, 1990.

The psycho-social programs of VA are directed at addressing the unique characteristics of the veteran patient population. 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 which has been extremely effective at this is the Community Support Group, operated within the Mental Health Clinic at Bay Pines VA Medical Center. The Community Support Group provides specialized services to veterans in settings appropriate to their needs and abilities. Patients are divided into those needing intensive therapy at the center, those able to meet on a weekly basis in community-based settings, and a those whose needs are best met in a small, intensive treatment group. An auxiliary of family members, friends, and supporters of the veterans has become very active in promoting this program.

Furthermore, VA psychiatric programs serve patients that 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 coverage and particularly need access to VA's psycho-social programs.

a. Homeless Veterans Programs

The U.S. Conference of Mayors' *10th Annual Survey of Homelessness*, released in December 1993, found that veterans comprise an average of 21 percent of the homeless population; this estimates that 250,000 veterans are homeless in the United States. These numbers are as high as 40 percent of the homeless population in San Diego and 35 percent in Salt Lake City.[9] A majority of these homeless veterans are believed to be Vietnam-era veterans. This high prevalence of homelessness among the veteran population requires VA to remain vigilant on this issue.

Programs for veterans at risk of homelessness need to recognize the fact that health problems and homelessness often go hand in hand.

[9]Newslink, 12/22.

Tuberculosis, HIV infection, pulmonary diseases, hypertension, alcohol and drug abuse, and serious mental illness affect homeless persons at higher rates than the general population. Veterans may also suffer from combat-related health problems such as PTSD and exposure to Agent Orange. It is estimated that over thirty-five percent of the veterans who participate in the Homeless Chronically Mentally Ill (HCMI) program reported physical health problems at the time of intake.[10] 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 various programs to ameliorate veteran homelessness, including those listed in Table MC-9. These programs provide treatment and assistance to approximately 10,000 veterans every year. The HCMI program aids veterans who need psychiatric and medical care through community-centered rehabilitative services. The Domiciliary Care for Homeless Veterans (DCHV) program treats, in a residential setting, problems that have contributed to each individual's homelessness. Also, each VAMC has a Social Work Homeless Services Coordinator who collaborates with appropriate organizations to determine areas of unmet needs and develop appropriate strategies for intervention. A recently implemented pilot program features drop-in centers which serve a portion of the veteran population that is often very difficult to reach and treat. These centers offer the veteran a supportive but unobtrusive means of receiving assistance. Tables MC-9 and MC-10 list other services for veterans with psychiatric and substance abuse problems, both contributing factors to homelessness.

The IBVSOs applaud these efforts by VA to address veteran homelessness, including the Summit on Homeless Veterans scheduled for February 1994. The programs currently in existence for homeless veterans provide valuable services to a large number of needy individuals.

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[10]"Reaching Out: The Second Progress Report on the Homeless Chronically Mentally Ill Veterans Program" (West Haven, CT: Veterans Administration, December 21, 1989).

For example, the Homeless Chronically Mentally Ill (HCMI) program provided 123,835 visits to its 57 units in FY 1993. The Domiciliary Care for Homeless Veterans (DCHV) program saw 3,186 admissions in FY 1993, and was able to provide care to only a fraction of all veterans in need of such services.

Recommendation:

- Expand homeless veterans programs which focus on enhancing veterans' independent living skills. VA currently runs many innovative programs through its homeless chronically mentally ill programs, and should continue to utilize this venue.
- VA should expand care at new and existing sites through the types of programs shown in Table MC-9.
- VA should also continue to develop drop-in centers in communities with unmet needs and metropolitan areas, and establish two new HCMI programs.

Cost: $20 million.

textbox

TABLE MC-9
Programs Run for Homeless Veterans:
Homeless Chronically Mentally Ill (HCMI) Programs
Number: 57 sites provided 123,835 visits in FY 1993

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: VA runs 31 programs and supported 3,186 admissions in FY 1993

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. Structured programs and activities that enhance daily living skills
3. Provision of meals and shower and laundry facilities
4. Entry to more serious treatment or rehabilitation

Veterans' Industries (Compensated Work Therapy/Therapeutic Residence programs)
Number: **14 programs (2 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: **19** VA medical centers are being activated to disburse **750** vouchers dedicated to homeless veterans

Purpose:
1. Provide permanent "Section 8" housing (federally subsidized housing for which the disabled, including mentally impaired, among other categorically defined groups, are eligible) through HUD
2. Link housing to ongoing case management and VA clinical services

6. Joint Social Security Administration/VA Pilot Project
   Number: Programs run through **three** of VA's homeless veterans treatment programs

   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

7. Joint VBA/VHA Project
   Number: **1** project

   Purpose: Monitor and evaluate services provided to homeless veterans

8. Comprehensive Homeless Centers
   Number: **1** project
   4 more projects planned for FY 1995

   Purpose: Serves as an umbrella for such programs as:
   1. HCMI
   2. DCHV

3. Veterans' Industries
4. VASH
5. SSA/VA pilot project

9. Homeless Outreach

10. Health Care for Homeless Veterans

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b. Long-Term Psychiatric Care

VA's psychiatric care programs rely heavily on custodial care to treat the chronically mentally ill veteran population. In FY 1993, 188,816 veterans were treated 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.

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 MC-10. 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.

Cost: Included in community residential care recommendation and veterans' industries recommendation.

textbox - TABLE MC-10

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

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end text box

c. Substance Abuse Treatment Programs

Substance abuse has continued to overwhelm both private and VA capabilities. Despite persistent attempts to eradicate, or even stem, the spread of alcohol and drug abuse the number of those effected continues to rise and the severity of the impact intensifies. Veterans have been particularly troubled by this epidemic and VA's programs to treat substance abuse have been stretched to the limit. Recent datashow that between 25 percent and 50 percent of veterans presenting themselves for treatment at VA medical centers have a substance-abuse disorder in addition to their other medical and psychiatric conditions.[11]

VA's commitment to addressing the problems of substance abuse among veterans can be traced back to 1946 and the publication of a policy statement affirming the VA would provide treatment for veterans with alcohol-use disorders. The first drug-dependence treatment program administered by VA was established at the Washington, D.C. VAMC in October 1970. In 1980, VA began contracting with non-VA community halfway houses for rehabilitation services for veterans with substance-abuse problems.

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 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 MC-11 for veterans suffering from alcohol and drug abuse.

VA needs to use its limited resources effectively by implementing treatment protocols that have proven to be the most successful. 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

[11]VAnguard, April 1992.

community to do so. It is important that VA continues to address the problems specific to veterans' substance abuse. This type of disorder is often the manifestation of other problems and conditions, many of which may have a basis in the veterans' military service.

Recommendation: Enhance substance abuse programs for veterans, where possible in their communities.

Cost: $10 million, included in funding recommendation for community psycho-social programs.

textbox - TABLE MC-11

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

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end text box

d. Veterans' Industries

VA has developed an innovative program to provide care, training, and rehabilitation services for veterans with substance abuse problems, psychiatric, neurological or physical disabilities. These Veterans' Industries programs have also been successful in treating the special needs of homeless veterans.

Veterans' Industries emphasize a work-oriented approach as a means to facilitating psycho-social rehabilitation. Varying abilities and skills of individual veterans involved in the programs are handled by different structures and activities appropriate to their needs. The common denominator for all veterans' rehabilitation is some form of work or enterprise. The level of intensity varies from those receiving training in comprehensive living skills to those seeking enhancement of their work skills.

Substance abusers comprise a large proportion of the populations that Veterans' Industries programs serve. These veterans enter therapeutic residencies which provide substance abuse aftercare, transitional housing, compensated work therapy, vocational counseling and job placement. The North Chicago VAMC is operating 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 VAMCs. The program, lasting up to nine months, allows the veteran to make the transition back into the community as a productive member.

These types of programs have had high success rates and should be further supported. With low staffing requirements and through contractual arrangements with private enterprise, Veterans' Industries offer veterans valuable therapy at minimal cost. Congress should be congratulated for its efforts to enhance veterans' access Veterans' Industries programs by authorizing VA to provide this therapy as a non-profit venture with private-sector providers and employers.

The IBVSOs strongly support these effective and resourceful programs to assist veterans with considerable hurdles to face. VA needs to continue its efforts to coordinate its programs with private, non-profit organizations, and with 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

e. 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 individuals' psychological response to war and other violent events. Post-Traumatic Stress Disorder is a condition effecting a large number of veterans in which a brutal event in the past, such as military combat or involvement in other highly stressful event, interferes with normal living in the present.

The number of war veterans suffering from PTSD is difficult to gauge. PTSD or a milder variant, post traumatic stress syndrome, is estimated by some to have affected as many as 850,000 veterans. VA is the primary provider for veterans suffering from PTSD. In FY 1992, prolonged PTSD was the fifth most frequent primary diagnosis in VA hospitals nationwide. VA has long 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's medical centers and mental health clinics, as well as from a network of 201 veterans' outreach centers, which provide counseling to veterans and their families on a variety of readjustment problems. Research conducted by the National Center for PTSD has helped guide evaluation and treatment efforts as well. VA's National Center was established in 1989, and the multi-site center is a collaborative effort based at four VA hospitals.

The VA's three major PTSD programs are its 23 Specialized Inpatient

PTSD Units (SIPUs), 202 Vet Centers, and 61 PTSD Clinical Teams (PCTs). A number of 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, especially where no other PTSD programs exists, also treat veterans suffering from PTSD.

In FY 1993, the VA's PTSD clinical treatment teams had 183,000 visits to their 61 programs and estimate that, with the addition of a proposed 13 teams the number of visits will increase to 229,000 in FY 1994. An additional 2,484 patients were treated at the 23 Specialized Inpatient PTSD units, and 2,290 patients were seen in Evaluation and Brief Treatment Centers in FY 1993.

However, despite these admirable efforts, more remains to be done. A hearing of the House Veterans' Affairs Subcommittee on Oversight and Investigations (September 15, 1993) revealed that the VA has treated only ten percent of those veterans suffering from PTSD. This clearly highlights the need for an expansion of VA's PTSD programs, especially the PCTs which are responsible for initial assessment and evaluation of veterans.

The IBVSOs commend Congress for recognizing this serious problem and hope to be able to acknowledge the continued support and expansion of these programs in the future.

Recommendation:

- Continue to target eligible veterans and address their specific PTSD treatment needs with the types of programs shown in Table MC-12.

- Establish PCT's in 30 additional VA medical centers.

- Enhance treatment resources at existing facilities.

Cost: $2 million

Textbox TABLE MC-12

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 1993

Specialized inpatient PTSD units
Specialized inpatient PTSD unit enhancement
Evaluation and brief treatment inpatient units
PTSD residential rehabilitation programs
PTSD clinical teams
Pacific center
Veteran centers

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end text box

v. Programs for Veterans' Specialized Care Needs
a. Women Veterans' Health Initiatives

Current estimates state there are 1.2 million women veterans comprising four percent of the veteran population, and two percent of hospitalized veterans nationwide. It is projected that by the year 2040, 10.9 percent of all veterans will be women. The growing number of women veterans who will seek care at VA facilities presents VA with the challenge of meeting women patients' needs in a health care system historically oriented toward men. Women veterans, and their providers, need to be especially vigilant about their health because women veterans suffer from the same increased incidence of disease as male veterans. The 1985 Survey of Women Veterans found that women veterans have a nine percent life-time 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. Unless contrary to medical indications, each woman receiving VA care is also entitled to a yearly Pap smear. When VA 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 the VA's purchase of the services locally.[12]

However, the Inspector General (IG) of the VA recently conducted an investigation of women's health care centers at VA facilities and found these services to be deficient in some areas. For example, of the 166 facilities surveyed 75 offered no on-site women's health care clinics. Out of the eight such facilities the IG visited, two opened their women's health clinics every other week for merely four hours, five facilities offered gynecological care on a contract basis and only two facilities had rape kits

[12]"VA Health-Care Programs for Women Veterans", VA Fact Sheet, July 1993.

and obstetrical kits available.[13] This lack of resources specifically designed for women patient's special needs creates a real barrier to quality health care for these veterans.

The U.S. General Accounting Office (GAO) has found that physical examinations, including cancer screening for women veterans, continue to be sporadic. This lack of continuity in women's services leads to insufficient preventive and primary care. As has been previously discussed, these types of services increase health care quality while decreasing cost. VA needs to make every effort to ensure that all veterans, but especially this often neglected group, receives timely and comprehensive health care services.

The GAO report identified some other weaknesses in VA's services for women veterans. For example, they found that VA medical centers are not adequately monitoring their in-house mammography programs to ensure compliance with quality standards; and VA medical centers have inadequate procedures to ensure that patient privacy limitations affecting women patients are identified and corrected during facility renovations.

To address some of these deficiencies, in June 1993 VHA launched a series of health-care initiatives for women veterans including the designation of four Women Veterans Comprehensive Health Care Centers and four PTSD treatment teams, as well as hiring counselors in 69 locations to treat the after-effects of sexual harassment and assault. Each Women Veterans Comprehensive Health Care Center will serve as a resource, providing a full range of services for women veterans in a specific geographic area, and each of these centers will support a specified group of VA facilities with these services. Each center will also represent a "pilot" program for duplication throughout VA. Also, the Little Rock, Arkansas, VAMC 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 1993 for these and other

[13]Testimony of Pat Schroeder before the House Veterans Subcommittee on Oversight and Investigations, June 23, 1993.

expanded services for a growing population of women veterans.[14] VA has also established a new division within the National Center for Post-Traumatic Stress Disorder devoted to the study of the impact of military trauma on women veterans. The Women's Health Science Division is the first of its kind in the country. The Division will exclusively examine the effects of PTSD on women veterans' mental health and physical well-being including problems caused by sexual harassment and sexual assault. These innovative programs aimed at providing appropriate, high-quality, gender-specific care for women veterans need to be recognized and duplicated. These initiatives will help address the problems related to access to health care for women veterans. In addition, the Women Veteran Coordinators Program is being expanded. There are now 18 full-time coordinators, and plans to increase the number to 22.

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 *FY 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 will now be reviewed simultaneously at the field facility and regional director level. An additional review of sexual harassment complaints filed will occur in VA headquarters.

These efforts will gain increasing importance as the number of women 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.

Recommendation:

- Continue implementation of the VA Advisory Committee on Women Veterans.

- Provide counseling to women veterans who have experienced sexual abuse while on active duty.

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[14]Vanguard, March/April 1993.

- Authorize funding for 50 new, dedicated FTEE for the Women Veterans Coordinators programs.

Cost: Funding for 50 new dedicated full-time women veterans coordinators at VA medical centers included in outpatient workload increase initiative.

b. Programs for Gulf War Veterans

Large numbers of Persian Gulf War veterans have been suffering from baffling symptoms and ailments. Speculation on the cause of these disorders has centered on exposure to smoke from oil fires, desert parasites, vehicle paints, and the uranium used to reinforce tank and artillery shells. The volume, severity, and intensity of these complaints have led VA to act.

A Persian Gulf Registry was authorized by Congress to track to track the health of Gulf War veterans and has currently enrolled and examined approximately 13,000 veterans. VA also established three referral centers in Washington, DC, Houston, TX, and West Los Angeles, CA, to handle cases of these unusual symptoms in Persian Gulf War veterans. Secretary Brown established the 16-member Persian Gulf Veterans Coordinating Board 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 is also collaborating with the Department of Defense to enter into a joint agreement with the National Academy of Sciences for a review of the scientific, medical, and other consequences of Persian Gulf service, as well as the conduct of epidemiological studies. VA has also been tracking compensation claims of veterans who attribute problems to environmental exposures, such as oil well fires. Thirty-two Persian Gulf War Family Support Centers have been established in 26 states, providing marriage and family counseling services for veterans, their spouses and children. In addition, VA is now authorized to provide readjustment counseling services, including counseling for post-traumatic stress disorder, to Persian Gulf War veterans through VA's 201 Vietnam Veteran Outreach Centers. As of early 1993, over 25,000 Persian Gulf War veterans have been seen in Vet Centers for readjustment counseling.

On December 20, 1993 President Clinton signed legislation authorizing VA to treat Persian Gulf War veterans for any diseases that may have resulted from their exposure to toxic substances or environmental hazards in the Gulf. VA requested this legislation to elevate the existing policy to a statutory basis. The law allows VA to reimburse these veterans for any copayments they may have made to VA for care that might have been necessary as a result of their exposure. While this is certainly an important step, the 1993 bill authorizes priority treatment for Persian Gulf syndrome for one year only.

The *Independent Budget* urges Congress to pass a more comprehensive measure that would provide a long-term authorization for Persian Gulf-related illnesses. The IBVSOs also encourage continued outreach to Persian Gulf veterans. The VA is to be commended for the surveillance and treatment efforts already undertaken, and the IBVSOs hope to see these programs extended.

Recommendation:

- Extend authorization for VA coverage of Persian Gulf syndrome 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.

c. Disabled Veterans' Programs

One of VA's strengths is its ability to provide specialized services for those veterans who have suffered disabling injuries. These programs, such as prosthetics, spinal cord injury, and blind rehabilitation, 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 the Department of Defense, academic affiliates, and other providers. Such agreements provide VA the opportunity to demonstrate its expertise while granting high-quality care to disabled

individuals who would otherwise not be provided 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 will completely meet the disabled population's specialized needs and VA needs to maintain veterans' access to this care.

1. Prosthetics Users' Programs

Programs that provide care for prosthetics users are an example of the specialized, high-quality services VA provides for disabled veterans. Recently, prosthetics and sensory aids services have been significantly improved through implementation of VA's Prosthetics Improvement Implementation Plan. "Fencing" the prosthetics budget has also enabled Prosthetics Services to provide devices without long delays that were common in recent years. Funding for the purchase of prosthetic appliances has been centralized and is now reviewed on a quarterly basis.

New Prosthetic and Sensory Aids Service programs have been established at 47 sites in an effort to extend the availability of these services. Program site visits have been conducted at 146 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. These 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, is focused on reducing these delays and has already reduced the processing time for orders by 57 percent. This program should be supported in its effort to offer timely service to veterans.

VA needs to continue to improve its ordering process aimed at reducing

waiting times. Increasing the number of orthotic labs will help Prosthetic Services to 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 were pleased to note that the Prosthetics Service has implemented a Prosthetic Patient Satisfaction Program to judge VA's performance in prosthetics and sensory aids. The type of patient feedback gained through these surveys allows VA to manage its own achievements and weaknesses.

Recommendation: Fully implement the Prosthetics Improvement Implementation Plan, particularly those elements intended to expedite purchasing.

Fund additional FTEE to staff continuing and additional programs.

Continue to "fence" the prosthetics budget and operate it as a centralized account.

Establish new orthodic labs to provide extended access to these services for veterans.

Cost: $7.7 million

2. Programs for Veterans with Spinal Cord Dysfunction

Spinal cord injury (SCI) is an example of a catastrophic illness that requires not only multi-specialty medical care, but social and economic resources as well. For more than four decades, VA, which created SCI treatment centers following World War II, has been at the vanguard of providing life-saving and life-sustaining treatment to people with spinal cord injuries.

VA's reputation for high quality SCI services is now in jeopardy. The past ten 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 degenerating spiral of annual budget shortfalls that erodes the entire VA health care system. Their rejuvenation depends on increased funding. Only adequate incentive pay will attract and hold SCI-qualified physicians and nurses.

VA has been developing 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. Parent centers should train and supervise satellite clinics' professional staff and monitor SCI patient care. In-service SCI training for clinic personnel is necessary for successful satellite SCI program development.

In FY 1993, 7,498 veterans were treated in the 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, these hospitals' personnel must have special training to care for paralyzed patients safely. VHA should continuously rotate trainees through its SCI centers to expand its cadre of SCI-qualified physicians, nurses, and therapists. VHA should provide special pay incentives for nurses and therapists who successfully complete these training programs. The 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 who are familiar with the special needs of spinal-cord injured veterans.[15] The IBVSOs applaud these types of programs to 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 conditions comparable to those of 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

[15]PN, January 1994.

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 what they would have been had these individuals not become paralyzed. As a result, there is a need for studies in geriatric SCI care. VHA should designate a geriatric research, education, and clinical center (GRECC) to focus specifically on the needs of older paralyzed people.

The IBVSOs would also like the see the Independent Living Fund funded more fully. This program provides money for veterans with spinal cord dysfunction to see movies and participate in field trips as a group, as well as other activities. Activities like these facilitate newly injured veterans' rehabilitation and reacclimation to the community. It is important that these individuals have the opportunity to socialize with other disabled veterans and interact outside of the hospital.

Recommendation:

- VHA should expand SCI training programs and provide special incentives for SCI-qualified nurses and therapists.
- VHA should designate an SCI GRECC.
- VA should establish a new SCI clinic.
- The Independent Living fund should be fully funded.

Cost: Additional $500,000.

3. Blinded Veterans' Programs

VA has also 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 consider blindness and its potential effect on veterans' lives as the veteran population continues to age. A conservative estimate of the current blind veteran population is approximately 93,000. During the next twenty years, that number will reach 135,000. Among chronic disabilities of the aged, blindness is the third leading cause of dependency. VA needs to 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 funding mechanisms Congress constructed in Prosthetic Services have helped VA restore the integrity of VA's programs for blind rehabilitation services. This Congressional effort created a program that more equitably distributes "high-tech" equipment and other fundamental program resources.

Still, the aging veteran population has created a backlog of applicants for admission to rehabilitation programs. VA's eight blind rehabilitation programs, five blind rehabilitation centers, and three blind rehabilitation clinics treated 1,048 veterans in FY 1993. The average system-wide waiting time for these programs is ten months to one year. VA has set a goal to reduce these waits to 120 days and plans to activate one additional program in Tucson, Arizona in FY 1994 in an attempt to reach this objective. However, the need for services will be far greater than the additional capacity created by this facility. VA should add operating beds to its blind rehabilitation programs through the creation of 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. 98 of VA medical centers currently have these teams but only 62 have a full-time

coordinator. A fully capable 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, include acute hospital admission or nursing home placement.

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, their rehabilitation would be more effective if conducted in an out-patient 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. This type of outpatient care implements effective managed care techniques and provides a full continuum of care services to blinded veterans.

Blind rehabilitation is a special program in which VA has excelled beyond anything offered in the private medical sector. And a blind rehabilitation program similar to that provided by VA 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.

Recommendation:

- Add funding for outpatient Specialists to treat blinded veterans at VA medical centers without dedicated rehabilitation facilities.
- Establish one new blind rehabilitation program.

Cost: $500,000 for FTEE in support of outpatient services and new program. Activation funds as necessary for additional blind rehabilitation program.

Education and Training

Education of health professionals is one of the Department of Veterans Affairs' four Congressionally mandated missions. The magnitude of that educational activity makes VA the nation's single largest medical professional producer. At any given time the VA system is training 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. Most of these graduates enter the private medical sector.

The *Independent Budget* authors place great importance on the continued integrity of these affiliations. Students in various health care disciplines rotate each year through more than 30,000 unfunded positions and approximately 8,500 VA-funded resident positions are available for graduate medical education. Rotating through these latter billets are an average of forty percent of the nation's residents in training during any given year. Conversely, VA medical centers, particularly the large tertiary care facilities, depend heavily on resident physicians for patient care. Not only do these affiliations positively influence the quality of patient care, but through the years they have 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. The pending national health care reform, and the associated medical market dynamics already in operation, present challenges to medical schools and their academic hospital centers of no less magnitude than those affecting the VA health care system. In fact, proactive reform in the health care industry is happening faster than can any legislation. Regardless of the exact nature of an ultimate national reform bill, all roads lead to a medical insurance enrollment system of managed competition built around primary care. It is estimated that no less than 85 percent of health care in the United States will be delivered through such capitated plans. Academic medical centers along with affiliated VA medical facilities will both be enmeshed in that competitive market.

Medical schools and their teaching hospitals are complex structures of tertiary care so fragmented into high cost academic departmental enclaves that multidisciplinary, cost-competitive, programs for the contract arena will 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, however, restructuring to acquire primary care services and form integrated delivery systems. Even if successfully networked the true test is whether they can compete on price.

In today's environment, VA's sharing with their academic affiliates, the provision of both faculty income and GME stipends becomes the more meaningful. There has been a protracted erosion of traditional sources of academic revenue with continued reduction in Medicare appropriations, payment rates, graduate medical education funding and depletion of research budgets — while 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 to a degree not currently provided in any legislative reform proposals.

Resident Training Programs

In 1991, the Accreditation Council on Graduate Medical Education (ACGME) significantly upgraded quality standards governing residents' education and their care of patients. Altered criteria for Graduate Medical Education (GME) program accreditation calls for better supervision and shorter duty hours for residents. Consequently, implementing the ACGME standards required more supervisors, greater ancillary support, and augmented emergency room staffing. VA, as a result, must provide more resources to meet these criteria. The IBVSOs commend VA for adhering to these criteria voluntarily. In the last three fiscal years the *Independent Budget* has reflected the VA's budget in adding 3,000 FTEE to fulfill these requirements. The Administration's proposed reduction of 25,000 VA direct care personnel over the next five

years seems all the more ironic with examples like the system's needs for physician staff complements to comply with residency standards.

Increasing stress on resident house staffs clearly justify an increase in VA resources. Multiple factors explain the need to maintain this increased level of staffing: Increased complexity of remaining inpatient care following the shift of less complicated cases to ambulatory care; pressure to reduce length of patient stay; burgeoning paperwork; markedly expanding base of medical knowledge and increasing technology of care; shortage of adequate support staff and equipment due to budget shortfalls.

Beyond 1995 even more radical changes are expected in graduate medical education as national health care reforms are implemented. In response to a growing demand for improved access and lower costs, redress of medical specialty imbalance is being planned, coupled with a lack of confidence that training institutions will make the changes needed to achieve a mix of 50 percent generalist physicians and 50 percent of specialist physicians (in contrast to the 30 percent ratio of primary care physicians that exists today). Academicians insist that, even if medical schools started graduating 50 percent generalists tomorrow, it could take 25 years to redress the imbalance.

Not to be dissuaded, however, the Council on Graduate Medical Education and the influential Physician Payment Review Commission are recommending Congress should assert its authority by requiring first-year residency positions be limited to the number of medical school graduates plus 10 percent. This would amount to a 25 percent reduction in current billets. The Administration would establish a National Council on GME to set the number of positions by specialty establishing a national workforce goal of 55 percent generalists and 45 percent specialists.

Unless and until VA hospitals and affiliated academic centers greatly increase their involvement in primary care, such legislative control of residency allocations would markedly reduce the size of resident house staffs in those facilities, and in any case, create severe volume limitation in the specialty care needed by hospitalized veterans.

Recommendation: Maintain the additional FTE level allocated to direct care in FY 1992-4
Cost: Included in IB current services level

Residencies and Fellowships in High-Demand Specialties

As noted above, VA continues to need certain physician specialists and, particularly with the coming emphasis on primary care, associated professional personnel. Retraining will also be required by certain medical specialists for optional or concurrent service as primary care providers. Both VHA and the *Independent Budget* have repeatedly requested increased funding for this critical purpose to no avail. The *Independent Budget* does so again this year, for physician graduate training in ambulatory care, substance abuse, geriatrics and post-traumatic stress disorder, and for additional associate health fellowships for nurses, psychologists, physician assistants, physiotherapists, laboratory technologists, social workers, and audiology and speech therapists.

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, independent of medical school affiliations, initiated post-graduate fellowship training in geriatrics in the late 1970s. Through such organized efforts, VA has since expanded both gerontology knowledge 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 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 — now one of the main sources of primary care talent.

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. 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 for incorporating quality ambulatory care education into medial residency training. Expansion of VA's ability to provide education in areas such as ambulatory and primary care will allow VA to respond to the growing need for generalist physicians and associated health specialists.

Recommendation: Provide funds to support 160 FTEEs for residencies in high-demand specialties.

Cost: $10 million

The Tuition Reimbursement Program

VA has successfully retained many of the registered nurses who attended school under this program, and the program's existence is a positive recruitment tool. We urge continued funding for at least 750 new appointees. This will require $1.5 million in funding.

Recommendation: Provide funding for nursing tuition reimbursement.

Cost: $1.5 million

Satellite TV Programming

VHA increasingly uses their 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 cost effective and timely presentation of clinical training and management messages.

Recommendation: Provide funding for expanded satellite television programming, requiring 15 FTEEs.

Cost: $2 million

Career Field and Service Chief Development

We referred to this important program earlier in the "Employee Welfare

and Morale" section. Although VA needs continued funding to ensure the professional growth of senior administrative and clinical chiefs, Congress denied the FY 1992 request for specific funding.

We repeat, as 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 that work with AIDS-infected veterans. This training gives caregivers the knowledge they need to properly manage this special class of patients and avoid the risk of contracting this fatal disease.

Recommendation: Provide funding for AIDS related training

Cost: $3 million

Human Resources Development

In anticipation of national health care reform, VA will have to undergo a radical transformation from an inpatient-focused medical system to an outpatient-focused health care system. Current dynamics in the health care industry dictate such change in VA orientation must occur sooner than later. The change 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 the burden of short-term transitions which will, hopefully make VA a faster, friendlier and more flexible institution in responding to its patients' needs.

The change will not be easy. VA has a highly specialized focus in its health care professionals now. Academic affiliations have provided medical students, interns and residents who have maintained the focus on medical specialties. Cost-competitive providers outside the VA, however,

have been implementing managed care which uses preventive and primary care to pre-empt the need for more intensive specialized medical care. VA does not do this because they do not have the broad mission for primary care. Reform — of entitlement or health care generally will be necessary to clarify the mission. These anticipated reforms necessitate that VA enhance its preventive and primary care services and balance its highly developed specialized tertiary care services with them.

To achieve this goal, VA must make an effort to recruit more generalized physicians and mid-level professionals to supplement those already on staff.

Nurses

Nurses are a critical component of the VA clinical staff, accounting for almost 45 percent of its direct care workforce. Their services are invaluable to the system and, like their private-sector peers, they have been in short supply, a situation which is improving in some VA facilities due to pay scale adjustments and other enhancements in 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 many of the health care reform proposals being debated by the 103d Congress. Nurse practitioners are capable, under supervision, of administering much primary and preventive care, thereby supplementing the number of physician services that can be delivered. In the short-term, because of sudden demand, general practitioners will be scarce in the medical labor market. It therefore makes economic sense for VA to recruit nurse practitioners to complement its general practitioner services.

Recommendation:

- Continue to monitor the implementation of amendments to the Nurse Pay Act and problems in the areas of salary compression and pay retention.
- Recruit nurse practitioners to supplement primary and preventive VA providers.

Cost: None (need 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 to be 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 been successful providing the academic affiliates education and research opportunities and providing VA with physicians-in-training who provide inexpensive, quality services to supplement VA's physician workforce.

Third, VA 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 successfully recruit such specialty personnel as neurosurgeons, orthopaedic surgeons, radiologists, anesthesiologists, and psychiatrists. Congress needs to extend to "contract" physicians, practicing in VA facilities, the same legal protection that VA physicians receive would enhance VA's ability to recruit contract providers. Such protection will not leave veterans without a legal forum for tort claims. Benefit accrues 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 contract physicians. With more successful contract arrangements, veterans can have more ready access to services they need.

VA will have to closely monitor its interactions with the academic affiliations 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. More generalists will certainly be needed as VA becomes increasingly involved in primary and preventive care. VA undoubtedly will need to offer re-training to certain physician specialists, whose positions are in excess of 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 physicians contracted by VA when treating VA patients.
- Reprogram staff requirements to emphasize primary and preventive care needs.
- Offer generalist "re-training" to specialists as a recruitment tool.

Cost: $5 million for primary care re-training for 200 physician specialists

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 provide improved care and enhanced opportunities for VA dental research.

Recommendation:

- 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 nations' largest employer of Physician Assistants (PAs), employing some 1,000 of the 21,000 in the U.S. PAs are trained to provide much care physicians traditionally performed, including triage and diagnostic work. They may write certain prescriptions under physician supervision. They also provide administrative support. VA utilizes PAs to comply with Accreditation Council for Graduate Medical Education (ACGME) standards. Generally, like nurses, VA and other providers increasingly view PAs as appropriate and cost-effective alternative care staffing to complement physician staff.

VA has, unfortunately, been neglectful of its physician assistant workforce. Congress enacted pay grades and certification criteria for VA's physician assistants in 1978 and they have not been amended 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 rate over the last two to three years, and the vacancy rate has climbed from between 2 and 3 percent to between 8 and 9 percent over the same period.

Recommendation:

- Take corrective steps to ameliorate retention problems and to improve recruitment of physician assistants by implementing more acceptable pay grades.

Cost: Requires new legislation to amend PA pay grades.

Decentralized Hospital Computer Program

Automated information systems provide support which is essential for delivering quality care to veterans. The Decentralized Hospital Computer Program (DHCP) has been a great success as the information base for the VA medical centers. The user-designed, modular approach has enabled innovative staff throughout VA to install cost-effective, highly customizable information systems. The basic system has proven its flexibility and durability over several years, and over 60 DHCP modules

are now available to the VAMCs. Automation of hospital processes has enhanced the quality of patient care, improved communication between hospital wards and clinical services, and increased staff productivity.

VA should continue its commitment to the DHCP as its primary hospital information system. Recent innovations allowing the replacement of mainframe computers with banks of networked desktop computers will result in significant hardware savings, improve system performance, and allow the DHCP to enter a new period of expansion.

Steady growth of the DHCP calls for more IRM staff at the facility level. As more clinical modules are added, uninterrupted IRM support becomes critical to round-the-clock patient care. Productivity at VA's Information Service Centers (ISCs) has driven the steady expansion of the DHCP system while the facility IRM departments have remained understaffed. The continuous development of new clinical modules and the extension of DHCP via the Hybrid Open Systems Technology (HOST) to include off-the-shelf software demands more staff to load and maintain the new programs, train hospital staff, and coordinate data transmissions.

Recommendation: VA should increase staff at the VA medical centers to provide 24-hour IRM coverage at all VA medical centers, and to support clinicians in using automated tools. This will require in an increase of 1,700 FTEE nationwide.

Cost: $65 million

Automated Patient Record

Congress should support the performance of the VHA mission by ensuring that all VA facilities have adequate resources to access information on VA patients. From a medical standpoint, all information about the patient must be known and accessible as soon as possible across the system which provides health care and medications data. This is critical to the VA hospital network, since a VA patient may be seen at any of the 500+ VA health care facilities. To assure continuity of care, VA patient records must be as complete and accurate as possible, and

electronic access to patient information provided to autnorized health care providers. VA should automate the patient record to improve patient care and to collect reimbursement for the cost of medical care services.

The development of an automated patient record is critical to VA's ability to measure outcomes and evaluate treatments. Outcomes measurement and reporting provides the information that clinicians and administrators must have to balance the requirement for cost-effectiveness with the commitment to quality care. Outcomes measurement has become central to health care systems management and will certainly be a primary requisite to participation in competitive health care markets.

Recommendation: VA should implement prototypes of the automated patient record in three VA medical centers to determine the best use of automation in improving the patient care delivery process, to maximize the medical care cost recovery process, and to improve the data exchange capability between VA medical centers and private care providers and billing institutions.

Cost: $20 million

Needs for Information Resources Management under Health Care Reform

Health Care Reform will necessitate sweeping changes in VA patient care, particularly increased emphasis on managed care in ambulatory settings. VA must produce a competitive health care product. New types of information support will be required to support preventive care and care in alternative settings. VA will also need data-driven decision support processes, both in the clinical and management areas. Front-line health care professionals must be provided with clinical decision support that is patient specific, and includes information on preventive services, health care reminders, therapeutic options, and costs.

VA must establish an information network which will position VA medical centers for success in the post health care reform arena. This network must serve the patient care, educational, research, and DoD support missions of VHA by supporting appropriate sharing of patient record and

multi-media information among the VA medical centers, private care providers, and billing institutions. This network must have a growth path for the future, as well as serve the current needs. VA managers will not be able to make informed treatment, quality, and business practice decisions without an adequate information network.

Investing in a strong automated support component and an information network is essential to VA's ability to develop a competitive health care system.

Congress should support the VA in modernizing its basic 15-year old technology, upgrading its networking capability, and providing a adequate support infrastructure at the VA medical centers. VA should invest in the infrastructure at the VA medical centers to provide adequate IRM support to enable VA to compete in the health care market. VA should upgrade networking capability at VA medical centers, so that patient data can be exchanged among VA medical centers, and with private care providers. VA should upgrade the basic technology at VA medical centers to include workstations which will support decision support tools.

The investment will be substantial, on the order of 500 million dollars, but it will be absolutely essential to the creation of a viable, 21st Century VA system.

Pharmacy Initiatives

In FY 1990, VA spent more than $650 million on drug procurement and dispensing. VA's 229 pharmacies filled more than 58 million prescriptions on an outpatient basis for veterans. VA mailed about 34 million of these prescriptions, and the remainder were dispensed to the medical center pharmacies.

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 them by using available equipment. The Office of VA's Chief of Pharmacy is in the process of consolidating its mail-order pharmacies to assure these savings accrue to VA well before most of the private

sector has such systems in place. The *Independent Budget* supports VHA's plan to consolidate its pharmacies.

Pharmaceutical unit dose dispenses individually packaged drugs to patients by single dosage, rather than by multiple dosages. This type of packaging avoids waste, enhances VA's ability to account for its drug inventory, and enhances patient treatment. After FY 1994, ten VA medical centers must still convert to unit dose dispensation.

Recommendation:
- Fund the remaining ten centers to implement the unit dose program.
- Complete consolidation of VA mail service pharmacies.

Cost: $10 million

Equipment

Funding to eliminate the equipment backlog is one VA's most critical needs. VA currently estimates the backlog at about $840 million. VA has pledged to fund retirement of this backlog, through a 10 percent annual reduction of the backlog it estimates for replacement equipment at the year's end. Congress's inconsistent and inadequate "add-ons" to reduce the backlog, however, have not begun to 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. Prioritization of purchased equipment should reflect the new orientation of the external health care environment on primary and preventive health care services, more collaborative service delivery and less proliferation of high-tech, high-cost equipment. VA must balance these incentives for creating a system less centered on tertiary care with its need to be "state-of-the-art" in order to compete. We suggest that VA re-evaluate its prioritization with these principles in mind and create a list that reflects the backlog and its cost available for public scrutiny. We continue to suggest an annual increment

to retire the $840 million-dollar backlog within five years.

Recommendation:	Retire a newly prioritized equipment backlog within the next four fiscal years.
Cost:	Add $168 million in each fiscal year, for FY 1995 through FY 1999.

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 upkeep its physical plant. This inability to make repairs and perform maintenance activities has ramifications for patient safety and quality of care. It also promotes a negative image of VA. Incidents such as patients being trapped in broken elevators and failure to meet JCAHO safety standards are legend at VA medical centers, counteracting all of the system's positive outcomes. The physical plant will eventually need repairs, modernization, beautification and amenities, including paint, wallpaper, and window treatments to be competitive with private-sector facilities. VA must maintain its plant or risk patients' safety, staff morale, and the system's image. This is particularly critical as VA begins to transform into a competitive health care system.

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-dollar backlog within four years. This amounts to $161 million in each fiscal year, for FYs 1995 through FY 1998.

Recommendation:	Retire the non-recurring maintenance backlog within the next four fiscal years.
Cost:	$161 million in each fiscal year, for FYs 1995 through FY 1999.

Medical and Prosthetic Research

The VA research program slowed to a virtual standstill during the past five years. The Office of Management and Budget routinely rejected even moderate increases proposed by the Department in annual budget negotiations. The VA research budget crisis gained the attention and concern of the Congress. Congress increased the FY 1994 research appropriation by $20 million to $252 million which was a positive step to help overcome previous year's shortfalls. However, moderate yearly upward adjustments in appropriations have failed to counter the effects of inflation, yet alone provide for program growth enjoyed by most other federal research and development programs during the same time period. Even with the FY 1994 increase, medical research program will actually drop this year from 1769 programs in FY 1993 to 1668 programs in FY 1994. We anticipate that the FY 1995 budget request from the Administration, will call for major reductions in already limited research funding.

The gross deterioration of VA research funding has shaken the confidence of the research community in looking at VA as a stable resource to combine clinical practice and quality investigation. This demoralization has seriously undermined the two primary objectives of the research program, award winning clinical research and the ability of research opportunities to attract and retain health care professionals of the highest calibre to care for the veteran patient.

Research is a major part of the foundation of the VA health care system. Opportunities to conduct research with direct clinical application in the VA, the nation's largest health care provider, have attracted hundreds of the most qualified physicians to the VA system each year. Successful VA research grant applicants must commit themselves to serving 5/8ths to full time in VA medical facilities utilizing their expertise and professional experience to the direct benefit of the veteran patient.

VA Research and Health Care Reform

Research as a recruitment and retention tool becomes even more important as VA gears itself to compete in a reformed national health care

environment. The competitive process envisioned under most major pending health care reform proposals will require VA, as one of many health plans, to vie with other plans over cost, quality and patient participation. VA does not have the luxury now, and will not have the resources in the future, to compete with the private sector over the acquisition of high quality health professionals on the basis of salary alone. An adequate VA research appropriation will allow the federal government to shore-up an already threatened clinical research base in the United States. Unique VA research opportunities will help the system level the playing field with the private health sector in the competition over attracting clinicians of the highest quality and experience.

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CHART -MC-9
--VA Medical and Prosthetic Research Appropriation in Actual and Constant Dollars FYs 1985-1994
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Accomplishments of VA Research

Historically, VA research constitutes one of the Department's most distinguished chapters. The contributions VA researchers have made to medical knowledge and improvements in the health and welfare of the American people has returned many times over the original investment in research. Contrary to common misconception, VA research does not duplicate research conducted by the National Institutes of Health (NIH). VA research is clinically based and derived directly from the health problems of veterans. While only 25 percent of NIH-funded researchers are clinicians, more than 80 percent of VA researchers see VA patients on a daily basis. The additional 20 percent in the VA research workforce are mainly PhD's who assist in support of direct patient care as well. Highlights of VA research achievements include:

Development of the cardiac pacemaker and the nuclear-powered cardiac pacemaker.

First liver transplant

Development of radio-immune assay techniques (Nobel Prize)

Clinical trails pioneering the use of pharmaceutical for treating tuberculosis and hypertension; the oral treatment of diabetes; psychotropic drugs for the treatment of schizophrenia; and lithium carbonate for the treatment of mania.

The self-supporting suction socket for artificial legs

The "smart" wheelchair

The first robotic limbs

The laser cane for the blind

The Seattle foot prothesis

The discovery of peptides manufactured in the hypophysis that control body functions (Nobel Prize)

The discovery of carcinogenic viruses

The size and uniform structure of the VA system presents major opportunities for researchers 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 seeking ways to curb runaway health care costs and improve quality of care. In fiscal year 1993, for example, the system provided treatment to 14,080 individuals with AIDS offering a clear opportunity to examine the cost experience and efficacy of services and experimental drug treatment and development.

One cost analysis study released in January 1994 conducted at the Durham, N.C. VA Medical Center compared the differences in costs of care among patients with AIDS-related Pneumocystis carinii pneumonia (PCP) treated at VA, other public and private hospitals. Compared with other public and private hospitals, the study found, the average monthly inpatient and outpatient cost of care was significantly lower at VA hospitals. Mean monthly inpatient and outpatient costs for PCP patients who were hospitalized at public hospitals were $5,468 and $506 respectively; $6,438 and $616 at private hospitals; and $3,128 and $366 AT VA hospitals. The study suggests that VA as the largest single provider of health care in the nation can be a prime testing ground for the nation demonstrating how a large medical system works to reduce hospitalizations and overall health care costs.

In FY 1970, the VA research budget equaled 3 percent of the Medical Care appropriation. In FY 1987, that proportion fell to 2.2 percent. In FY 1992, the research budget represented just 1.5 percent of the Medical Care budget and the program entered a critical juncture. In FY 1993, budget constraints forced a 25 percent reduction in the number of research programs. Funding for all new programs was canceled. The VA research career development program, designed to provide long term research funding to attract physician researchers to come to the VA and stay with the VA, was placed on hold due to funding shortages. By comparison, the private sector uses the goal of 5 percent of its medical care costs allocated to research as being necessary to maintain a competitive standard.

The Myth of Extramural Funding

Critics of adequate funding for VA research complain that increases in research appropriations put a strain on already finite health program expenditures. They theorize that VA research does not actually suffer when the VA research line item stagnates or falls, pointing to the considerable amount of extramural funding VA researchers are able to attract 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. However, those research dollars would not have come to the VA if researchers had not already been eligible for and receiving VA research dollars. As VA research opportunities dry up, researchers still might be able to acquire research support from other sources, but they will leave the VA and take those extramural grants with them. The VA research account is the "seed money" that attracts and leverages the extramural funding to benefit VA.

There is considerable evidence that the shortfall in VA research funding is already taking its toll on extramural funding. In FY 1986, 64 percent of VA funded researchers who had additional funding from NIH conducted their NIH research in VA medical centers. Funding for NIH research doubled over the past ten years. And yet, by FY 1990, as VA funding became increasingly more difficult to obtain, only 40 percent of VA investigators with NIH grants did their NIH research in VA settings. Demonstrating another disturbing trend, total expenditures of non-VA research funding brought into the VA from NIH or other sources dropped more than $10 million in FY 1993 for the first time in recent history, from $250 million in FY 1992 to $239 million last fiscal year. Funding from the Department of Defense (DoD) for the DoD/VA cooperative research program for FY 1994 was also cutback by the Congress from $30 million to $20 million.

In 1990, the Reagan Administration appointed a blue-ribbon Advisory Committee on Health Research Policy consisting of nationally prominent medical research authorities. The commission was tasked to analyze the status of VA research structure, activities and potential and to recommend appropriate funding levels. The Commission recognized that VA research had been sorely under-funded and recommended a sizeable increase in research funding to a base of $280 million for FY 1992. Their recommendation was $53 million higher than the actual appropriation for that year. Despite adjustments by the Congress each year, the annual appropriation has never been close to the $280 million recommended by the Blue Ribbon Commission. When the Commission's recommendation was increased to offset the effect s of research inflations for FY 1993 and again in FY 1994, the gap widened. These budget levels became the

Independent Budget's research funding current services recommendations for each of those years. The actual appropriation fell $71 million below the recommended level for FY 1993 and $65 million short in FY 1994.

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Table MC-13A
COMPARISON OF VA RESEARCH APPROPRIATIONS And *Independent Budget* RECOMMENDATIONS
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Recommendations

In late 1993 the executive directors of the four *Independent Budget* veterans service organizations (IBVSO's) wrote to Secretary Brown asking for his direct intervention in the FY 1995 budget negotiations with OMB to secure an adequate VA research budget. The executive directors called on the Secretary to raise the VA research budget to the level recommended by the *Independent Budget* which mirrors the original recommendation of the Reagan Administration's Blue Ribbon Commission increased by the cumulative effects of medical inflation. The intent of the *Independent Budget* organizations was to "lift the VA research program out of its long downward spiral once and for all."

IBVSO's research budget recommendations are shown in

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Table MC-13
Medical and Prosthetic Research and *Independent Budget* Recommended Appropriation
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The *Independent Budget* recommends an overall research appropriation of $348.6 million in FY 1995 for medical, rehabilitation and health services research. The amount includes $328.6 million to meet current services requirements and $20 million for special initiatives in priority ares of aging, women's health studies, AIDS, and spinal cord injury programs. Each of these priority research fields fall within unique areas of medical expertise within the VA health care system or encompass significant health needs of the veteran patient population.

Medical Research

Opportunities to pursue answers to medical programs have never been greater, especially in molecular biomedicine. The techniques of this subspeciality apply to many areas of medicine, but particularly to brain and spinal cord trauma and disease, the aging phenomenon and malignancies. The *Independent Budget* recommends a budget of $269 million for biomedical, clinical and prosthetics research.

Rehabilitation Research

Rehabilitation research applies advances in engineering computer science and material technologies to create new devices and techniques that help severely injured veterans maintain their independence and mobility. The *Independent Budget* recommends a budget of $35 million for rehabilitation research.

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. A well-funded health services research program is essential to VA in the critical year ahead. It is the health services component of VA's research program that will provide the analysis to support the restructuring and reconfiguration of the veterans' health care system to accommodate anticipated changes in the nation's health care delivery and financing system. National health care reform and reform of veterans' entitlement to health care services will result in dramatic shifts in

VA's workload and case-mix. VA health Services Research and Development Program and its Management Decision Resource Center must have the resources to anticipate and guide VHA's response to these shifts.

The *Independent Budget* recommends a budget of $45 million for health services research.

MAMOE -*INDEPENDENT BUDGET*

The Medical Administration and Miscellaneous Operating Expenses (MAMOE) appropriation supports a current Central Office FTEE level of 860. This appropriation supports the organizational structure of both clinical and administrative services within VA Central Office. 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 314. Represented within MAMOE are all Hospital Based Services, Ambulatory Care Services, Environmental Medicine and Public Health Services, Rehabilitation and Prosthetic Services, the 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.

The wide range of functions within MAMOE covers the management spectrum from policy development to operational issues and oversight in the form of quality assurance and credentialing activities. This diverse spectrum of activities and responsibilities has resulted in both praise and criticism for those whose salaries are paid by this appropriation.

The MAMOE appropriation has been dramatically reduced over the past decade, while at the same time it has been charged with managing a broad array of new program initiatives. Between FY 1982 and FY 1992 VHA staffing in Central Office was reduced from a high of 866 FTEE to 531 FTEE or a reduction of 40%. Also during this same time period, resources for such activities as travel for oversight purposes, training, education, contracts, consultants, and equipment were concurrently reduced. 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 been increased. Thirteen existing functional areas were also identified by VHA studies 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.

In an effort to address priority areas such as increased oversight to the Field for quality management functions, and to monitor licensing, credentialing, and house staff supervision, $3 million was reprogrammed from the FY 1992 Medical Care account to support 36 positions within MAMOE. The IBVSOs' anticipate that Health Care Reform will increase the need for such oversight and quality assurance activities and support efforts to fund these activities at a level which will ensure the delivery of quality services throughout the VA System.

During FY 1993 the Office of Construction Management became part of MAMOE. The original reorganization authorized an FTE level of 314. This reorganization was based upon the following principles of construction process improvement: 1. delegation of decision-making to the lowest possible level, 2. improved cost reduction utilizing design-build and construction management principles, 3. Field initiation of all projects with clear VACO direction, 4. establishment of dollar categories within the Major Construction Program to encourage the development of realistic project costs, 5. development of a nationwide construction database.

Critical budgetary shortfalls within the MAMOE account during FY 1993 spurred an organizational refinement of the Office of Construction Management. This has led to an in-depth organizational analysis of the Office with the establishment of twin goals of streamlining operations and improving service. The result has been a staffing reduction of 65 positions and a new FTE level of 249.

The IBVSOs' commend the innovative leadership of the Office of Construction Management for its far reaching and thorough analysis of the management and budgetary problems facing the MAMOE appropriation. The new reorganization of this office is a major step toward achieving the customer focus and responsiveness required of a competitive health care system under Health Care Reform. Potential benefits of this reorganization are the creation of interdisciplinary teams as a single point of contact for major construction projects; the

establishment of a single manager for Veteran Benefits Administration and National Cemetery System major construction projects; elimination of two levels of middle management and the concurrent flattening of the organization; creation of a Quality Support Office to ensure quality management; and a renewed commitment to customer service across the organization.

The new organization is expected to save over $4 million in personnel costs and allow the Department the flexibility to shift construction priorities to areas such as ambulatory care settings, design-build and lease-purchase projects, and joint-venture projects.

Over the years personnel cuts sustained by MAMOE have had a severe impact upon VHA's ability to effectively manage a headquarters operation responsible for a $ 16 billion budget, and over 200,000 employees located in over 400 health care delivery sites. Faced with the possibility of massive changes within the Nation's health care system, the IBVSOs' maintain a position of continued support to MAMOE to properly manage the impending yet unknown magnitude of change which is anticipated in the next fiscal year. The *Independent Budget* has consistently supported increased staffing level for MAMOE and continues to do so, reflecting an attitude that change can be resource and personnel intensive in the short-term and must be properly managed to ensure the desired outcomes of efficient management and quality patient care. Throughout the *Independent Budget*, the IBVSOs' have referenced the potential impacts upon the VA Health Care System. These impacts range from offering veterans a choice of health of health care providers; thereby, forcing the VA System into the competitive health arena, to allowing the Secretary of Veterans Affairs the discretion to offer services to veterans dependents. It is also anticipated that the VA Health Care System will undergo major change as it moves from a predominately hospital based system to a managed care system with emphasis upon service delivery in the ambulatory setting. Within the context of Health Care Reform the strategic planning and policy development role of MAMOE will take on critical importance. It is for these reasons that the IBVSOs' support a FY 1995 funding level of $79.2 million and a FTEE level of 848. This represents an increase of 24 FTEE over the 824 FTEE level projected for the appropriation at the end of FY 1994. It is the view of the IBVSOs' that

this level is the minimum from which the VA will be able to manage and effect changes to transform the System.

The IBVSOs' support the operational reorganization of VHA into 16 Veterans Service Areas (VSAs) in the hope that such a realignment will achieve the laudable goals of Field empowerment, resource and management flexibility, common service consolidation, and patient care excellence. However, such a change to the current system will present management and organizational challenges to MAMOE.

The FY 1994 shortfall estimated at $20 million for the MAMOE appropriation is of particular concern to the *Independent Budget* participants and reinforces past and current arguments for adequate funding of this important appropriation. IBVSOs' support restoration of funding to this account in the form of a supplemental appropriation to avoid the disruptive possibility of furloughs and the more serious consequence of a Reduction in Force (RIF).

Although no one can predict the final outcome of this year's Congressional debate on Health Care Reform, the independent role of the VA has been assured by its inclusion in the Administration's Health Security Act. It is not enough to legislate VA's continued existence in light of insufficient resources. The VA's ability to maintain its role as a viable, competitive resource not only for veterans' health care but for Medical Education and Research as well, will depend, to a large extent, on the ability of MAMOE to articulate the future direction and resource needs of the Department.

RECOMMENDATIONS

The *Independent Budget* supports a FY 1994 supplemental appropriation of $20 million to MAMOE to avoid the disruptive scenario of government furloughs and the more serious potential of Reductions in Force (RIF) to an account the has been historically under funded.

The IBVSOs' support an FY 1995 funding and FTEE level of $79.2 million and 848 FTEE to ensure that MAMOE is able to provide the policy,

planning, operational guidance, and oversight to ensure VHA's successful transition during this turbulent and uncertain era of health care reform.

The *Independent Budget* recommends that an in-depth study of the management, organization, funding, and role of MAMOE be undertaken by the Department. It is anticipated that legislative changes resulting from health care reform will place an increased burden upon MAMOE 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 to those veterans it serves.

Health Professionals Educational Assistance Programs

The Health Professional Educational Assistance Program (formerly the Health Professional Scholarship program) has served as a valuable recruitment and retention tool since the 96th Congress authorized it. The program offers grants that cover tuition and other reasonable educational expenses plus a monthly stipend to competitive, career-oriented nurses and allied health professionals finishing their academic training. In exchange, recipients must serve at a VA medical center experiencing personnel shortages for one year after completing their schooling.

Since FY 1991, the *Independent Budget* has suggested that VA use its authority under P.L. 100-32 to provide medical school scholarships to recruit physicians and scholarships for allied professional personnel. Thus far, VA has not done so. Because if its inability to recruit certain specialists, such as radiologists and anesthesiologists, VA resorts to expensive contracts with private sector physicians.

Since VA physician shortages seem limited to certain specialties, a program similar to the military medical services' Financial Assistance Program (FAP) could augment VA's recruiting strategy. As part of the Armed Forces Health Professional Scholarship Program, FAP allows the recruitment of civilian physicians in residency or fellowship training into the inactive Army, Navy or Air Force Reserve, with a deferred active duty obligation. Since these specialists are advanced in their chosen specialty training, FAP provides the military services with specialists much sooner than does the medical student scholarship program.

Congress should fund a pilot program, modeled on the military's FAP, to recruit specialists into VA health care. An additional $5 million could initiate this program for both medical students and post-graduate medical residents.

The IBVSOs recommend a $20,113,000 appropriation for the Health Professionals Educational Assistance Programs.

Grants to the Republic of the Philippines

These grants 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. It is now 39-years-old, so replacement and rehabilitation are major needs. The IBVSOs recommend the usual annual grant of $500,000.

Construction Program

Overview

The Major Construction appropriation which finances projects costing $3 million or more, and the Minor Construction appropriation funding smaller projects pay for most of VA's construction activities. VA receives a small appropriation from a Parking Garage Revolving Fund. Veterans Health Administration construction needs account for the majority of expenditures.

Grants for the Construction of State Extended Care Facilities and Grants for Construction of State Veterans Cemeteries are also Construction Program accounts.

Meeting The Challenge

The VA construction program was re-organized in FY '94 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 has allowed 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 $3.8 billion worth of construction projects. It has embarked on a philosophy of customer service. Central to the adaptation of this philosophy are 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 timeline 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.

A policy memorandum is awaiting approval to delegate authority to facility directors to lease up to 10,000 square feet of space, at up to $300,000 cost, to meet outpatient clinic needs. Should the Secretary grant such authority, facility directors will have more control in meeting their patients needs for accessible ambulatory care, better positioning facilities to compete as health care reform is implemented.

Additional Management Improvements Needed

The National Institute of Building Sciences (NIBS) carried out 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 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. Risk zone values are revised as the US 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. In addition to the seismic value, planning and application of these codes should be better coordinated on a priority basis with the VA National Health Care Plan (VANHCP). With all of the system requirements for accessible, attractive facilities which allow for enhancement of critical services (further discussed below), the IBVSOs question the high priority CM places on seismic corrections. For example, Memphis has received a high priority for seismic correction. This is problematic for two reasons. First, in light of the recent earthquake on the west coast, it could be argued that other sites are more vulnerable 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, will make other providers financially accessible to some veterans currently using VA medical care. VA estimates that of the 216,000 veterans now using VA medical facilities in the state, up to 11.6% (or 25,000) may choose the TennCare plan. VA should consider such factors in determining the need for replacement beds.

A review of both accessibility and natural hazard mitigation standards is necessary to determine if this is a realistic and appropriate policy for the clients served and for all VA facilities.

- 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.

  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, 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 be cost effective 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. 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.

The Dilemma of FY '95

Perhaps the most difficult problem facing CM is the coordination of mission and program planning for facilities and the Facility Development Program (FDP). IBVSOs continue to believe the FDP program should be discontinued until the VA National Health Care Plan is adopted and specific missions and types of facilities within the VA system's health plans are

determined. VA and Congress are likely to commit to an inappropriate structure from plans based on the present delivery system and mission if the current FDP remains in place. For example, a hospital authorized in FY 1995 may not be activated until 2001 or 2002. This is likely to result in a hospital with too many beds and support services.

The U.S. already has too many hospitals and too many beds. VA should not compound the problem. There is an urgent need to develop a short-term strategy to shift the delivery system in the direction of reform occurring in the health care environment outside VA. After reform is enacted, VA needs a refined long-term plan.

If VHA is to be competitive in health care reform, it must practice acute and some extended care medicine as the private sector does—substituting more appropriate care in community and ambulatory care settings for inpatient care. The *Independent Budget* co-authors believe VHA needs to begin extensive primary care outreach through more remote and satellite clinics in this fiscal year and in FY 1995. In the short-run, clinic activities must move closer to patients and potential patients. In keeping with the government's "one stop service" concept the IBVSOs believe some primary care clinics should be sited contiguous to or within veterans outreach centers (or "vet" centers). Expanding leasing authority is an essential, immediate need to allow VHA to reconfigure its delivery system expeditiously. In certain situations with smaller veteran user populations far from VA facilities, VA hospital directors should be granted authority to contract with private sector providers.

In light of the anticipated reform of health care delivery, the facility sizing model (bed sizing model) VA currently uses also 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 it once was. Non-VA hospitals and managed care organizations are reducing bed occupancy to an average of 66 percent nationwide, reducing staff by 20-24 percent, and moving to more outpatient activity, yet VA continues to place its emphasis on hospital inpatient care in construction priorities.

The present outreach and community clinic criteria in VA's facility sizing

model need to be reviewed to determine if distance and travel time from home to care site are too great. A two hour driving time criterion is not competitive with the 30 minute criterion established in other proposals. Ultimately, enactment of legislation for both national health care reform and VA eligibility expansions will facilitate a more realistic approach to setting priorities for future construction projects for the system.

VA should revise its planning models and guidelines to account for veteran demographics. Current and future populations' needs should determine system priorities and the allocation of construction resources. Added emphasis should be given for 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 population is declining, the strategic and facility development plans must include alternatives to provide needed care in different settings or organizations. The IBVSOs recommend revisions to strategic planning models and FDPs be started now, and completed as soon after legislative decisions on health care reform are accomplished.

FY '95 Budget

The IBVSOs are aware that the Administration has proposed a five year "appropriated" construction budget plan with annual targets of, on average, $165 million per year for major construction starting with FY 1995 and ending with FY 1999; the plan proposes average targets for VA Major Construction to be $175 million per year after FY 1997. Minor construction appropriations will average $154 million per year over the same time period.

The Administration plans to use money from the investment fund, a fund proposed by the *American Health Security Act*, to supplement resources for construction projects needed to improve the infrastructure. Because the legislation which contains the investment fund has yet to be enacted, the IBVSOs consider assurance of receiving it to rest on a tenuous base. As in the case of the ill-fated Economic Stimulus Package, desperately needed correction of infrastructure deficiencies is held hostage to an uncertain date.

Because VA has committed its limited construction funds to building or replacing hospitals it will not be until FY 1998 that construction funds are available for outpatient, infrastructure improvements and other needs. The IBVSOs consider the high priority of new hospital construction and replacement problematic. It prevents resources from moving to primary care and its support at a most crucial time. Emphasis on primary care, remodeling hospital beds to nursing home care and correction of infrastructure should be the highest priorities and projects should be funded immediately. Unless this happens, VHA cannot effectively compete in any kind of health care reform. VA's need for enhanced outpatient and extended care facilities and improvements in infrastructure far outweigh the need for additional hospital beds.

If VA decides that there is a significant need for new hospital beds, it should consider different alternatives to new construction to create them. Existing VA hospitals have empty and unused beds which could be activated—a least one hospital has yet to be activated in the VA system; acquisition and conversion of closed military facilities, like Orlando, is possible and far less costly than ground-up construction; and, leasing beds from underutilized facilities in the military system or the private-sector may allow VA to make beds available to veterans on a much speedier timeline than they are now activated. These options for increasing inpatient capacity should be carefully considered before major construction projects resulting in additional hospital beds are undertaken.

The Administration also plans to designate funds from the investment fund — if and when the it becomes available — for infrastructure needs such as patient privatization, including private and semi-private bathrooms. 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 patient privacy should not be a high, fixed priority system-wide. Some facilities prioritize funding differently. VA should allow flexibility in determining the needs of individual VA medical centers and service areas.

Independent Budget Funding Recommendations for FY 1995

Major Construction

The *Independent Budget* recommends a $294-million Major Construction appropriation for FY 1995. To achieve less funding in FY 1995 would be catastrophic given the extended replacement cycle for facilities, rapidly changing clinical requirements, and the existing plant's excessive age.

The majority of the *Independent Budget* recommended appropriation is for leases for outpatient clinics and nursing homes. In these uncertain times, the *Independent Budget* co-authors believe leasing is preferable to new construction. Leasing offers an affordable, expedient and non-permanent 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 twelve nursing homes. It also accommodates annual leasing costs for approximately 100 outpatient clinics. Funding for leased clinics complements *Independent Budget* recommendations for grants to VA medical centers in states with active reform schedules which offer alternatives for enhancing ambulatory care capacity (See Appendix D); plans to expand VA in-house capacity; and plans to 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. Orlando and other facilities available for acquisition offer VA an opportunity to realize substantial savings and activate beds more quickly than a "ground-up" construction project would. Should VA acquire Orlando funds will be needed to make it handicap accessible and improve infrastructure. The IBVSOs recommend that other selected replacement and modernization projects that provide natural hazard mitigation and modernize and upgrade the physical plant be dictated by an established set of priorities based on probable competition under health care reform plans impacting facilities and mission conversions for facilities in new veterans service areas.

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. Indeed, the aging veteran population necessitates nursing home construction through the 1990s. The *Independent Budget* 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 veterans 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. In the immediate future, VA must enter into 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 proposal also includes $16-million to acquire land for national cemeteries in states that have no available grave sites. 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 1995 *Independent Budget* recommends a $412-million appropriation for Minor Construction, which funds smaller facility construction projects. As Table 1 shows, the *Independent Budget's* FY 1995 recommendation significantly exceeds the FY 1994 appropriation. The requested increment reflects the IBVSOs' growing concern about VA facilities' urgent updating and repair needs. Most VA facilities were constructed during the 1950s and, therefore, update 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 priority, especially as VA medical centers enter into competition with private-sector providers. Of the total Minor Construction appropriation, $300-million should be allocated to these types of projects. Also 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 page **???**.

VA should use $80-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* co-authors emphasize conversion as the principal means of making nursing home care available to veterans. The IBVSOs recommend that VA convert the remaining 30 beds from its FY 1993 plan, accomplish those it plans for FY 1994, and convert 25 120-bed wards in FY 1995. While this strategy represents a tremendous rate of conversion, it is the only way VA can hope to keep pace with the demands of the aging veterans' community.

IBVSOs have requested $14-million within the Minor Construction appropriation to support VA regional office projects, such as recurring maintenance projects, collocation when it improves services, and improvement of handicapped accessibility. The FY 1995 *Independent Budget* recommends $18-million for existing National Cemetery System construction projects.

Parking Garage Revolving Fund

The FY 1995 *Independent Budget* recommends a $20-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. Currently, however, only a few revenue-producing projects exist, so VA needs limited new appropriations. Future funding requirements should diminish.

Grants for the Construction of State Extended Care Facilities

The state home program adds to 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 expansion, remodeling, or alteration of existing facilities, including state

home hospital facilities.

The Grants to State Extended Care Facilities is 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. States may also retain a portion 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 1995, the *Independent Budget* recommends a $200-million appropriation for these grants. This appropriation will fund all applications from the states for the state home programs.

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 1995.

MEDICAL CARE *INDEPENDENT BUDGET* RECOMMENDED APPROPRIATION		IB 1995
FY 1994 Current Services Level	**#1**	**$17,131,963,000**
FY 1995		
Payroll Related Increases		
Retirement Programs	**#2**	65,086,000
Annualization of 1994 Locality Pay	**#3**	111,244,000
Annualization of 1994 Federal Employee Health Benefit Program	**#4**	6,331,000
Pay Raise 1995	**#5**	121,580,000
Within Grade Pay 1995	**#6**	77,375,000
Federal Employee Health Benefit Program 1995	**#7**	15,323,000
Workday Change	**#8**	(38,586,000)
Other Personnel Costs	**#9**	50,000,000
Inflation	**#10**	216,075,000
Compensation for Inadequate Inflation from FY 1993	**#11**	19,034,000
Facility Activations (including Capital Investments)	**#12**	200,000,000
Property Rental	**#13**	1,254,000
Recurring Funding for FY 1994 Administration and Congressional Initiatives	**#14**	120,000,000
Adjustments to FY 1994 Program Base	**#15**	218,957,000
Adjustments for Rate Changes		
State Nursing Homes	**#16**	73,789,000
State Home Hospitals	**#17**	2,345,000
State Home Domiciliaries	**#18**	9,194,000
Community Nursing Homes	**#19**	27,691,000
Contract Hospitals	**#20**	12,502,000
FY 1995 Current Services Level	**#21**	**$18,441,157,000**
Additional Initiatives 1995		
Inpatient Workload Increase	**#22**	11,678,000
Outpatient Workload Increase	**#23**	66,271,000
Extended Care Programs Increase	**#24**	558,036,000
Community Psycho-Social Programs	**#25**	22,000,000
Homeless Initiatives	**#26**	20,000,000
Blinded Veterans Programs	**#27**	500,000
Spinal Cord Medicine Programs	**#28**	500,000
Prosthetics Programs	**#29**	7,700,000
Education and Training	**#30**	32,750,000
Decentralized Hospital Computer Program	**#31**	85,000,000
Equipment Backlog	**#32**	168,269,000
Non-Recurring Repair and Maintenance Backlog	**#33**	161,523,000
Pharmaceutical Unit Dose Program	**#34**	10,000,000
Facility Activations for Leased Clinics	**#35**	35,000,000
Facility Activations for Leased Nursing Homes	**#36**	31,500,000
FY 1995 RECOMMENDED APPROPRIATION	**#37**	**$19,651,884,000**

Appendix A-Medical and Prosthetic Research

MEDICAL AND PROSTHETIC RESEARCH		
INDEPENDENT BUDGET		
RECOMMENDED APPROPRIATION		IB 94
FY 1994 Current Services Level	#1	$317,832,000
FY 1995		
Payroll Related Increases		
Retirement Programs	#2	993,000
Annualization of 1994 Pay Raise	#3	1,794,000
Annualization of 1994 Federal Employee Health Benefit Program	#4	105,000
Pay Raise 1995	#5	1,876,000
Federal Employee Health Benefit Program 1995	#6	254,000
Within Grade Pay 1995	#7	678,000
Inflation	#8	5,051,000
FY 1995 Current Services Level	#9	$328,583,000
Other Initiatives		
Aging Initiatives	#10	5,000,000
Women's Issues	#11	4,000,000
Spinal Cord Medicine	#12	1,000,000
Health Services Research	#13	10,000,000
FY 1995 RECOMMENDED APPROPRIATION	#14	$348,583,000

Appendix A-Medical and Miscellaneous Operating Expenses

MEDICAL ADMINISTRATION AND MISCELLANEOUS OPERATING EXPENSES (MAMOE) INDEPENDENT BUDGET RECOMMENDED APPROPRIATION		IB 1995
FY 1994 Current Services Level	**#1**	**$88,781,000**
FY 1995		
Reduction in CM FTEE Level	#2	-12,114,719
Payroll Related Increases		
Retirement Programs	#3	340,000
Annualization of 1994 Pay Raise	#4	535,000
Annualization of 1994 Federal Employee Health Benefit Program	#5	24,000
Pay Raise 1995	#6	642,000
Federal Employee Health Benefit Program 1995	#7	58,000
Inflation	#8	960,000
FY 1995 Current Services Level	**#9**	**$79,225,281**
FY 1995 RECOMMENDED APPROPRIATION	**#10**	**$79,225,281**

CONSTRUCTION PROGRAMS
INDEPENDENT BUDGET
RECOMMENDED APPROPRIATION

FY 1995 Major Construction		
Medical Care Program		
Replacement and Modernization	#1	100,000,000
Nursing Home Care	#2	40,000,000
Leases for Nursing Homes	#3	12,000,000
Domiciliary Care	#4	10,000,000
Leases for Outpatient Care Clinics	#5	100,000,000
National Cemetery	#6	16,000,000
Regional Office	#7	6,000,000
Other	#8	10,000,000
TOTAL	#9	**$294,000,000**
FY 1995 Minor Construction		
Medical Care Program		
General Fund	#10	300,000,000
Nursing Home Care	#11	80,000,000
Regional Office	#12	14,000,000
National Cemetery	#13	18,000,000
TOTAL	#14	**$412,000,000**
FY 1995 Parking Garage Revolving Fund		
TOTAL	#15	**$20,000,000**
FY 1995 Grants for State Extended Care Facilities		
TOTAL	#16	**$200,000,000**
FY 1995 Grants for Construction of State Veterans Cemeteries	#17	**$6,000,000**
TOTAL FY 1995 CONSTRUCTION PROGRAMS RECOMMENDED APPROPRIATION	#18	**$932,000,000**

Appendix A
BUDGET EXPLANATORY NOTES
Medical Care

1. Funds required in FY 1994 to maintain the FY 1988 service level.
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 nationwide locality pay raise implemented in January, 1994. The average payraise for federal employees, nationwide, was 3.96%. Whereas the 1994 pay raise applied to only nine months of FY 1994, the amount here covers the rest of the calendar year which falls in FY 1995 (or the remaining three months).
4. The amount necessary to annualize the increase in health benefits cost increases that became effective January, 1994.
5. Estimated cost of a 1.6-percent pay raise effective January, 1995 for the remaining nine months of FY 1995.
6. Estimated longevity/performance increases for FY 1995.
7. Estimated increase in health benefits effective January, 1995.
8. Other personnel costs include stipends and compensation programs.
9. Estimated cost of inflation for items excluding personnel and some contract services.
10. Differential between IB-estimated inflation and actual inflation from FY 1993.
11. Personnel, equipment and other costs related to new or remodeled facilities activities through FY 1994. Already adjusted to include amounts obligated in FY 1994 for equipment and other capital purchases that will not recur in FY 1995.
12. Estimated increased cost of rental property.
13. Adjustment to the current services level for initiatives with recurring funding needs that the Congress or the Administration introduced in FY 1994 which the authors of the *Independent Budget* support.
14. Adjustments to the FY 1994 current services level to accommodate actual workload VA achieved in working toward *Independent Budget* targets.
15. Increased cost of state nursing home care for veterans.
16. Increased cost of state home hospital care for veterans.
17. Increased cost of state home domiciliary care for veterans.
18. Increased cost of community nursing home care for veterans.

19. Increased cost of contract hospital care for veterans.
20. Total of items 1 through 20.
21. Estimated cost of increasing inpatient workload to the IB target for contract hospital care.
22. 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.
23. Cost of essential improvements to the VA extended care programs, including funds for expanded nursing home workloads ($421 million) and domiciliary care workloads ($33 million) and, expanding programs such as: hospital-based home care ($55 million); adult day health care ($16 million); geriatric evaluation and management units; geriatric research, education and clinical centers ($28 million); respite; hospice; and, community residential programs ($5 million).
24. Increase in psycho-social programs in the community—such as, substance abuse programs ($10 million); veterans' industries programs ($10 million); and, post-traumatic stress disorder ($2 million).
25. Funds to expand homeless programs to develop veterans' independent living skills.
26. Amount necessary to expand blinded veterans programs to reduce waiting times.
27. Amount necessary to activate one new spinal cord outpatient clinic and increase funding for the Independent Living Fund.
28. Increased funding for additional prosthetics program personnel.
29. 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); Physician Re-training ($5 million); and, Dental Residency Stipends ($1.25 million).
30. Funds to provide staff for 24-hour Information Resources Management coverage in all VA medical centers ($65 million) and test 3 prototypes of the Automated Patient Record ($20 million).

31. Additional requirement to incrementally eliminate a critical $840-million backlog in VA medical equipment replacement over five years.
32. Funds required to incrementally eliminate $800-million backlog of non-recurring maintenance and repair needs specified by VA over five years.

33. Amount necessary to complete conversion of medical centers from ward stock to unit dose drug distribution at 10 remaining VA medical centers.
34. Personnel and equipment funds needed to activate 100 leased clinics.
35. Personnel and equipment funds needed to activate twelve leased nursing homes IBVSOs recommend to manage increased veteran demand for long-term institutional care.
36. The *Independent Budget* recommended appropriation to provide for an acceptable level of service to veterans in FY 1995.

BUDGET EXPLANATORY NOTES
Medical and Prosthetic Research

1. Funds required in FY 1994 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 1994) to VA in retirement programs, including the Federal Employment Retirement System and Social Security.
3. Amount necessary to annualize the nationwide locality pay raise implemented in January, 1994. The average payraise for federal employees, nationwide, was 3.96%. Whereas the 1994 pay raise applied to only nine months of FY 1994, the amount here covers the rest of the calendar year which falls in FY 1995 (or the remaining three months).
4. The amount necessary to annualize the increase in health benefits cost increases that became effective January, 1994.
5. Estimated cost of a 1.6-percent pay raise effective January, 1995 for the remaining nine months of FY 1995.
6. Estimated increase in health benefits effective January, 1994.
7. Estimated longevity/performance increases for FY 1995.
8. Estimated cost of inflation for items excluding personnel and some contract services.
9. Total of items 1 through 8.
10. Additional funding recommended for research in Alzheimer's; heart disease and other disorders disproportionately experienced in elderly populations.
11. Additional funding recommended for research in reproductive organ cancers disproportionately experienced by women veterans.
12. Additional funding recommended for research in spinal cord medicine.
13. Additional funding recommended for health services research.
14. The *Independent Budget* recommended appropriation to provide an acceptable level of service to veterans in FY 1995.

BUDGET EXPLANATORY NOTES
Medical Administration and Miscellaneous Operating Expenses (MAMOE)

1. Funds required in FY 1994 to maintain the FY 1988 service level.
2. Reduction in funding to reflect reorganization of the Construction Management Program within the Veterans Health Administration (resulting in approximately 134 fewer FTEEs than the FY 1994 *Independent Budget* recommended). Staff reductions were made to streamline process, eliminate overlap, and better coordinate decision-making—initiatives the *Independent Budget* co-authors support.
3. Increased cost (over FY 1995) to VA in retirement programs, including the Federal Employment Retirement System and Social Security.
4. Amount necessary to annualize the nationwide locality pay raise implemented in January, 1994. The average payraise for federal employees, nationwide, was 3.96%. Whereas the 1994 pay raise applied to only nine months of FY 1994, the amount here covers the rest of the calendar year which falls in FY 1995 (or the remaining three months).
5. The amount necessary to annualize the increase in health benefits cost increases that became effective January, 1994.
6. Estimated cost of a 1.6-percent pay raise effective January, 1995 for the remaining nine months of FY 1995.
7. Estimated increase in health benefits effective January, 1995.
8. Estimated cost of inflation for items excluding personnel and some contract services.
9. Total of items 1 through 8.
10. The *Independent Budget* recommended appropriation to provide an acceptable level of service to veterans in FY 1995.

BUDGET EXPLANATORY NOTES
Construction Programs

1. Replacement and Modernization costs for acquiring one hospital and renovating existing hospital facilities to increase bed capacity as an alternative to new hospital construction. Also includes some funds for mission conversions within VA service areas. The IBVSOs place priorities 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 12 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. These clinics augment the IBVSO grant plan for expanding primary and preventive care outlined in Appendix E.
6. Projected costs of necessary National Cemetery System Major Construction projects.
7. Projected costs of necessary Regional Office Major Construction projects.
8. Other costs include funds for the judgement fund and external construction program analysis.
9. Total appropriation to adequately provide for the Major Construction needs of VA in FY 1995.
10. 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.
11. Projected costs for Nursing Home Care includes funding to convert 3,000 hospital beds (or approximately 25-120 bed wards) to nursing home care beds.
12. Projected costs of necessary Regional Office Minor Construction projects.
13. Projected costs of necessary National Cemetery Minor Construction projects.
14. Total appropriation to adequately provide for the Minor Construction needs of VA in FY 1995.
15. Total appropriation to adequately provide for the Parking Garage Revolving Fund needs of VA in FY 1995.

16. Total appropriation necessary to satisfy pending grants received from States to build or augment state veterans extended care facilities.
17. Total appropriation necessary to construct three new state veterans cemeteries.
18. The *Independent Budget* recommended appropriation to undertake critical VA construction programs in FY 1995.

Entitlement and Eligibility Criteria For Department of Veterans Affairs Medical Care Benefits

There is unfortunately considerable confusion regarding, first of all, the definition of a veteran eligible for benefits under programs administered by the Department of Veterans Affairs (DVA) as well as the criteria for participation in various levels of VA health care delivery. Eligibility differs for hospital care, out-patient care and long-term care. It also differs according to the veteran's status. Thus there are many practical problems in the planning and delivery of health care for veterans, VA administrators and 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 references conditions where provision of care is mandatory.

Eligibility refers to situations where VA may provide medical care, under certain conditions, including space and resource availability.

DEFINITION OF A VETERAN

A major change in the definition of a veteran took place in September 1980. Individuals entering service since that time generally must have served 24 months (the minimum service requirement), or longer, in the armed forces in order to be eligible for full veteran benefits. Exceptions to this rule are those who were discharged from the service for medical reasons, as a hardship, or at the convenience of the government. A dishonorable discharge is disqualifying.

Members of the U.S. Coast Guard are given veteran status and become eligible for VA benefits if they served during periods of war (during which periods the Coast Guard is assigned to the Navy).

Members of National Guard and military reserve units are not eligible for veteran benefits unless they meet the above criteria.

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 principle criteria entitling veterans to treatment. All veterans have been, until recently, divided into three groups (Categories A, B, and C) in determining eligibility for hospitalization in VA medical centers. However, recent changes in the law 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 (P.L. 99-272) effective July I, 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 veteran qualified for Category A or the "all other" classification. Service-connected and exempt veterans do not undergo the income-based eligibility assessment.

Listed below are the criteria for in-patient (hospital) and out-patient care, nursing home care, beneficiary travel and certain other benefits.

HOSPITAL CARE

CATEGORY A:

(1) The Secretary of the Department of Veterans Affairs (DVA) is required to provide hospital care to:

(a) Veterans with service-connected disabilities;

(b) Former prisoners of war;

(c) Veterans exposed to certain herbicides and ionizing radiation;

(d) Veterans disabled as a result of VA treatment or vocational rehabilitation;

(e) Veterans of the Mexican border period, or World War I;

(f) Non-service-connected veterans whose income does not exceed the means test cap (the cut-off is currently in the $15,000 to $20,000 range).

(2) Income for purposes of non-service-connected medical care eligibility will be determined on the same basis used for determining eligibility for non-service-connected pension benefits. The income limits for medical care purposes are increased effective January I of each year by the same percentage as non-service-connected pension rates.

(3) The VA health care system treats some 600,000 in-patients a year, representing about one million discharges. Some 93 percent are Category A.

ALL OTHER CATEGORY:

(1) Veterans outside the Category A net continue to be eligible for in-patient care as space and resources permit, but they must pay a part of the cost for in-patient, out-patient or nursing home care. Currently the veteran is charged the lesser of the cost of care received or $592 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 would be required to pay the lesser of the cost of hospital care received or one-half of the amount of the in-patient deductible ($296). For nursing home care for each 90 days of care, the veteran would be required to pay the lesser of the cost of furnishing care or the in-patient deductible ($592).

(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) The provision of law allowing veterans 65 years of age or older to receive care in DVA medical facilities regardless of income was repealed by Public Law 99-272.

OUT-PATIENT CARE

(1) The Secretary shall furnish on an ambulatory or out-patient 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; and,

(c) Any veteran disabled as a result of DVA treatment or in pursuit of vocational rehabilitation.

(2) The Secretary shall furnish out-patient or ambulatory medical services reasonably necessary in preparation for or to obviate the need for hospital admissions, or as follow-up to hospital care for a period not to exceed 12 months, for any disability to:

(a) Any veteran with a service-connected 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 $10,824 for a single veteran and $12,922 for a veteran with one dependent) for any disability.

(3) The Secretary may furnish on an ambulatory or out-patient basis medical services which the Secretary determines are needed to veterans in the following priority order:

(a) Any veteran who has a service-connected disability rating of less than 30 percent or any veteran for a compensation or pension examination;

(b) Former prisoners of war and veterans with eligibility based on exposure 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;

(c) Veterans of the Mexican border period or World War I whose annual income exceeds the maximum annual rate of pension; and,

(d) Veterans in receipt of increased pension or compensation based on the need of regular aid and attendance or by reason of being permanently housebound, but whose income is below the Category A threshold.

(e) Veterans who are eligible for hospital care, but who are not specified in paragraphs (a)-(d) above, for any disability, if reasonably necessary in preparation for, or to obviate the need for, hospital admission, or as a follow-up to hospital care for a period not to exceed 12 months.

A payment is required of non-Category A veterans, seeking non-service-connected out-patient treatment, for each visit, of 20 percent of the estimated nationwide average cost of the Department's out-patient visits during the current fiscal year, but not to exceed, during any 90-day period, the amount of the current in-patient payment ($592).

MISCELLANEOUS

(1) In addition to medical treatment, certain veterans are eligible for dental services, prosthetic appliances and home health care services.

(2) The Secretary may provide skilled or intermediate type nursing care and related medical care in DVA 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 connection with examinations, care or treatment (i.e., hospital, nursing home, domiciliary or out-patient treatment) for which the veteran is eligible to:

(a) Veterans for scheduled compensation and pension medical examinations;

(b) Veterans for service-connected disability;

(c) Veterans, with a service-connected disability rating of 30 percent or more, for treatment of any non-service-connected disability.

(d) Veterans in receipt of pension;

(e) Veterans whose annual income does 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, and the Secretary determines that the veteran is unable to bear the cost of such transportation (no deductible applies);

(g) Veterans whom the Secretary determines to be 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 DVA 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 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.

PVA **Memorandum**

PARALYZED VETERANS
OF AMERICA

TO: Frank Morrone, Associate Executive Director HPD
Richard Fuller, Dir., Health Policy Program Development
Dr, Donald L. Custis, Consultant

FROM: Fred Cowell, Sr. Health Policy Analyst

SUBJ: Report on VA National Health Care Reform Program

DATE: January 14, 1994

The purpose of this report is to provide an up-date on the progress of the Health Care Reform Task Force that has been assembled by VA from across the country.

The task force has been organized into a cluster and working group format. The reporting process includes both oral and written presentations from the working groups which are delivered to a cluster panel and are called Tollgates. The following list of Cluster and Working Groups are:

I. **CULTURE/EXTERNAL MARKET CLUSTER, Leader Barbara Gallagher Director Region I**
   1. Marketing/Marketing Benefits, Leader Tom Mullon
   2. Veteran Service Organizations, Leader Krista Ludenia
   3. Medical Community, Leader Daniel Winship
   4. Congress, Leader Charles Clark
   5. Consumer Service Orientation. Leader Leonard Rogers

II. **PRODUCT CLUSTER, Leader Bob Roswell, COS, Birmingham, Al.**
   1. Primary Care, Leader Tom Parrino
   2. Managed Care, Leader Joan Cummings
   3. Benefits, Leaader Bob lynch
   4. Research, Leader Dennis Smith
   5. Education and Training, Leader Libby Short
      A. Medical School Affiliations/Graduate Medical Ed.
      B. Assoc. Health Professions Ed./Employee Ed.
   6. Quality Management, Leader Jeannette Post
   7. DOD Contingency

801 Eighteenth Street, N.W., Washington, D.C. 20006
(202) USA-1300 Fax: (202) 785-4452 TDD: 800-795-4327

III. MANAGEMENT SYSTEMS CLUSTER, Leader Terence Johnson

1. VHA Organizational Structure, Leader Dan Deykin
2. Financial Systems, Leader Fred Malphurs
3. Network/Medical Community Contracting Leader Tom Carson
4. Infrastructure/Equipment
5. Human Resources, Leader Larry Deal
6. Administration, Leader Bob Perrault
7. Data/Information Systems, Leader Carol Ashton

The meetings held during the first two weeks involved brainstorming sessions that generated a vision statement, goals and objectives for each working group. To date there have been three Tollgate reports as the product of the working groups becomes more refined.

The following overarching assumptions form the foundation of the Task Force recommendations:

1. H.R. 3600 or a Clinton like plan will be enacted
2. VA will be a nation-wide network of local health plans
3. VA must move quickly to become a full participant in every health care market
4. VA must position itself to optimize its competitive advantage in each health care market
5. Delay and inaction seriously reduces VA's chances of success
6. Failure in this endeavor jeopardizes, the very existence of VA
7. The full participation of every level of the organization is required to achieve success

STATE HEALTH CARE REFORM

STATE	COMPREHENSIVE REFORM PLAN	EMPLOYER MANDATE	MANAGED COMPETITION AND/OR PURCHASING COOPERATIVES	MEDICAID EXPANSIONS/GOVERNMENT PROGRAMS FOR UNINSURED	SMALL MARKET REFORMS	HIGH RISK POOLS
ALABAMA	NO	NO	NO	NO	YES	NO
ALASKA	NO	NO	NO	NO	YES	YES
ARIZONA	NO	NO	NO	YES	YES	NO
ARKANSAS	NO	NO	NO	NO	YES	NO
CALIFORNIA	NO	NO	YES	YES	YES	YES
COLORADO	NO	NO	NO	NO	YES	YES
CONNECTICUT	NO	NO	NO	YES	YES	YES
DELAWARE	NO	NO	NO	YES	YES	NO
FLORIDA	YES	NO	YES	YES	YES	YES
GEORGIA	NO	NO	NO	NO	NO	YES
HAWAII	YES	YES	NO	YES	NO	NO
IDAHO	NO	NO	NO	NO	YES	NO
ILLINOIS	NO	NO	NO	NO	YES	YES
INDIANA	NO	NO	NO	NO	YES	YES
IOWA	NO	NO	NO	NO	YES	YES
KANSAS	NO	NO	NO	NO	YES	YES
KENTUCKY	NO	NO	NO	YES	NO	NO
LOUISIANA	NO	NO	NO	NO	YES	YES
MAINE	NO	NO	NO	YES	YES	YES
MARYLAND	NO	NO	NO	YES	YES	NO
MASSACHUSETTS	YES	YES-1995	NO	YES	YES	NO
MICHIGAN	NO	NO	NO	NO	NO	NO
MINNESOTA	YES	NO	YES	YES	YES	YES
MISSISSIPPI	NO	NO	NO	NO	YES	YES
MISSOURI	NO	NO	NO	YES	YES	YES
MONTANA	NO	NO	NO	NO	YES	YES
NEBRASKA	NO	NO	NO	NO	YES	YES

STATE	COMPREHENSIVE REFORM PLAN	EMPLOYER MANDATE	MANAGED COMPETITION AND/OR PURCHASING COOPERATIVES	MEDICAID EXPANSION/GOVERNMENT PROGRAMS FOR UNINSURED	SMALL MARKET REFORMS	HIGH RISK POOLS
NEVADA	NO	NO	NO	NO	NO	NO
NEW HAMPSHIRE	NO	NO	NO	NO	YES	NO
NEW JERSEY	NO	NO	NO	YES	YES	NO
NEW MEXICO	NO	NO	NO	NO	YES	YES
NEW YORK	NO	NO	NO	YES	YES	NO
NORTH CAROLINA	NO	NO	NO	NO	YES	NO
NORTH DAKOTA	NO	NO	NO	NO	YES	NO
OHIO	NO	NO	NO	YES	YES	NO
OKLAHOMA	NO	NO	NO	NO	YES	NO
OREGON	YES	YES-1997/98	NO	YES	YES	YES
PENNSYLVANIA	NO	NO	NO	YES	NO	NO
RHODE ISLAND	NO	NO	NO	YES	YES	NO
SOUTH CAROLINA	NO	NO	NO	NO	YES	YES
SOUTH DAKOTA	NO	NO	NO	NO	YES	NO
TENNESSEE	NO	NO	NO	YES	YES	YES
TEXAS	NO	NO	YES	NO	YES	YES
UTAH	NO	NO	NO	NO	NO	YES
VERMONT	YES	NO	NO	YES	YES	NO
VIRGINIA	NO	NO	NO	NO	YES	NO
WASHINGTON	YES	YES-1995-97	YES	YES	YES	YES
WEST VIRGINIA	NO	NO	NO	NO	YES	NO
WISCONSIN	NO	NO	NO	NO	YES	YES
WYOMING	NO	NO	NO	NO	YES	YES

December 27, 1993

The Honorable William Jefferson Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

Dear Mr. President:

As veterans service organizations representing over five-million veterans, we are deeply concerned about recent threats to reduce the employment levels for veterans health services. One reduction which will affect FY 1994 staffing will reduce the approximately 206,188 FTE now answering veterans medical care needs to 205,188 FTE. The reduction is apparently the result of good management! Hospital directors were able to find qualified individuals to perform necessary tasks at lower salaries than VA originally projected. Unfortunately, because of the FTE ceiling, veterans will not be able to benefit from VA's ability to hire more staff at lower wages, even though VA has not added a penny to its costs.

A pending reduction recommended in the Vice President's *Report of the National Performance Review* would decrease 12-percent from VA's FY 1993 FTE level of 209,000 (or 25,080 FTE) from VA health care services over five years. We have heard that these cuts will amount to 2,700 FTE in FY 1995. Ironically, preparation for a competitive role under national health care reform simultaneously challenges the VA medical care system. This new challenge will require additional personnel to support enhancement of VA health care services. Contrary to what is commonly claimed, the inevitable price of sizeable staff reductions is a loss of clinical workload.

The inconsistency of VA staff reductions is underlined by the precipitous impact of direct market competition on multiple VA medical centers in states where implementation of reform programs is already underway. For those VA facilities the future is now.

The *Independent Budget* co-authors have conducted a telephone survey of VA hospitals in six states where comprehensive health care reform is imminent. Some of the states will offer veterans an opportunity to enroll for coverage through a provider other than VA for the first time. In these six states, consistent reports were obtained of prolonged clinic waiting times and appointments commonly delayed for three to nine months. Throughout the facilities surveyed, there was a professed inability for any increased commitment to ambulatory services or the promotion of primary care due to the lack of available personnel.

Such barriers to patient access can only defeat any VA effort to recruit veteran patients in competition with a better staffed and more readily accessible private medical sector.

We believe that the attached plan is one way of helping VA remain competitive *today*. We all support the general concept of your health reform plan as it pertains to the role identified for VA, but whatever the future may hold for the nation's health care system, it is imperative that some VA facilities have relief from restrictive legislation and impossibly deficient budget and personnel allocations which undermine their ability to compete.

The undersigned respectfully request that you exempt the VA health care system from any further reduction in personnel and attempt to secure immediately the basic requirements in funding and personnel VA facilities need to become competitive providers under state or national health care reform.

Sincerely,

James J. Kenney
AMVETS

Arthur H. Wilson
Disabled American Veterans

John C. Bollinger
Paralyzed Veterans of America

Larry W. Rivers
Veterans of Foreign Wars of the United States

Ronald L. Miller
Blinded Veterans Association

Grants for States With Active Implementation Schedules for Health Care Reform

INDEPENDENT BUDGET **PROPOSAL:**

Grant funding that will allow the VA to compete and waive authority that restricts competitive efforts in states where reform is either being implemented or about to be implemented. Use the experience with six states (FL, MN, OR, TN, VT, WA) in FY 1994 to enhance planning for VA to prepare for national health care reform. Grants will allow VA medical services to "move" with the rest of the state. Other states, Washington, DC and Puerto Rico will be phased-in. Specifically, the pilot sites should be able to:

a. Enroll all veterans in VA facilities (including non-state-residents using VA facilities in those selected states) to enhance planning and resource allocation for that state's VA facilities;

b. Waive eligibility criteria to allow all entitled veterans to access the standard benefits package designed by their state plus any additional benefits to which they are now entitled through Title 38 in VA facilities at no out-of-pocket cost;

c. Augment primary/preventive care services to reflect those available to other state residents--develop clinic space and staffing to allow this capability to develop OR allow VA to contract with established private-sector primary care providers (such as health maintenance organizations or preferred provider organizations) to provide these services for veterans enrolled in VA;

d. Receive grant funding for marketing and customer service-training activities to adapt to a competitive market place; and,

e. Use workloads to identify the projected impact of universal coverage on other states.

JUSTIFICATION

Many states are in various stages of implementing health care reform which will provide universal coverage for a portion or all of their residents. At the

present time, a state with an active reform schedule will be able to bring some veterans into a system that potentially offers him more benefits at less expense than a VA facility in that state.

For example, Florida is implementing a universal coverage program much like the "American Health Security Act". Florida's plan will require that employers join community health purchasing alliances if access goals are not met voluntarily. It will also expand access to state residents under 250% of the poverty level (approximately $23,580/year for a family of two) to "buy into" the State's Medicaid program (on a sliding scale) based only on their income level. Such programs, which many veterans would be qualified for, would offer a richer benefits package than they are currently entitled to in VA. The impact for VA might be particularly adverse in terms of losing non-service connected veterans who are not entitled to ambulatory services in VA, but would be under the state's MedAccess program.

Under such reform plans, VA must act quickly to retain and recruit its veteran patient base. VA's restrictive eligibility criteria are a severe impediment, as is its lack of a preventive/ primary care capacity. Creating a program that corrects these problems will allow VA to identify its residual caseload after implementation of universal access. It will allow VA to assess whether veteran need justifies creation of programs in other states (ie, if, under a optimal circumstances veterans decide to remain in the system or use services, like primary care, they have not previously used). For example, if Florida VAs implement community primary care clinics, waive eligibility criteria to make, at least, outpatient care available to all core veterans, and do some marketing, will veterans choose VA? Florida's veterans' choices might be indicative of veterans' choices in other states given the same circumstances. This information would give VA more ability to plan its service delivery under any universal coverage program.

Grants would also give VA a better chance to retain workload. Once veterans opt for a state plan with the same or better benefits, the chances of them returning to VA may be slim. It is easier to keep people in a system by providing better services than to win them back to a system they have previously decided to leave. In short, VA has a better chance of surviving universal coverage if it makes needed changes today than if it waits until tomorrow to recapture its market.

SCHEDULE

Selected states would be the start of a system-wide phase-in as follows:

FY 1994: Six states mentioned above (FL, MN, OR, TN, VT, WA)
FY 1995: Twelve more states designated as Category I or II by VA's National Health Care Reform Program (AZ, CA, CO, DE, IA, HI, MD, MN, NY, PA, PR, and RI)
FY 1996: Seventeen states
FY 1997: Seventeen states

Following this implementation schedule all states will be activated by 1998 when the President's reform plan schedules universal coverage to be fully implemented.

ALTERNATIVE 1-Providing Primary/Preventive Services in VA Operated Satellite Clinics

COSTS

A rough estimate of the grant requirements of each state are based on the following formula if VA were to operate the program:

3 clinics for each medical/surgical hospital (>250,000 vets in primary service area) in the state: 2-7,000 visit or "SMALL" clinics and 1-15,000 visit or "LARGE" clinic.

These funds should, in no way, preclude the availability of individual hospitals to borrow from any "Investment Fund" specified by enacted health care legislation.

RESOURCE REQUIREMENTS OF SMALL CLINIC

Activation and rental costs:	$700,000
Staff (10 @ $60,000):	$600,000
TOTAL	$1.3 million

RESOURCE REQUIREMENTS OF LARGE CLINIC

Activation and rental:	$1.1 million
Staff (30 @ $60,000):	$1.8 million
TOTAL	$2.9 million

TOTAL FUNDING FOR CLINICS AT DESIGNATED HOSPITALS
(2 "small" and 1 "large") $5.5 million

MARKETING FUNDS FOR EACH STATE
$2 million*

*In rural areas or elsewhere, where demand does not dictate the establishment of primary care facilities, these funds may be used to buy mobile clinics, establish more generous contract and/or beneficiary travel programs, or provide "fly-in" clinics to remote sites.

TOTAL COSTS

FY 1994: $50.5 million 7 Hospitals/6 States

(FL-Bay Pines, Gainesville, Miami, Tampa; MN-Minneapolis; OR-Portland; TN-Nashville; VT-0; WA-Seattle)**

FY 1995: $128.5 million 19 Hospitals/11 States and Puerto Rico

(AZ-Phoenix; CA-Loma Linda, Long Beach, Palo Alto, San Diego, San Francisco, Sepulveda, W. Los Angeles; CO-Denver; DE-0, HI-0; IA-0; MD-Baltimore; MT-0; NY-Bronx, Brooklyn, NY, Northport; PA-Philadelphia, Pittsburgh (2), Wilkes Barre; PR-0; and RI-0)

FY 1996: $89 million 10 Hospitals/16 States and Washington, DC

(AL-0; WY-0; AR-0; WI-Milwaukee; CT-West Haven; WV-0; DC-Washington, DC; VA-0; GA-Atlanta; UT-0; ID-0; TX-Dallas, Houston, San Antonio; IL-Chicago (Lakeside), Hines; SD-0; IN-Indianapolis; SC-0; KS-0)

FY 1997: $78 million 8 Hospitals/17 States

(KY-0; LA-0; ME-0; MA-Boston, Brockton/West Roxbury; MI-Allen Park; MS-0; MO-St. Louis; NE-0; NV-0; NH-0; NJ-East Orange; NM-0; NC-0; ND-0; OH-Cleveland, Dayton; OK-Oklahoma City; AK-0)

FY 1994-1997: $346 million for 44 Hospitals/50 states, Puerto Rico, and Washington, DC

ALTERNATIVE 2-Providing Primary/Preventive Services in VA Contracted Clinics

COSTS

A rough estimate of the grant requirements of each state are based on the following formula if VA were to operate the program:

Contracts for ADDITIONAL visits to community-contracted clinics for each medical/surgical hospital (>250,000 vets in primary service area) in the state based on the same number of enrollees who would constitute the need for satellite clinics to deliver 19,000 visits (as discussed above in Alternative 1). The average VA patient makes 8 visits to VA clinics a year. Enrolling these veterans in a private health maintenance organization would allow 2375 patients per designated hospital to recieve an average of 8 visits. VA officials claim that primary/preventive care services could be purchased on a capitated basis for about $1000/individual.

MARKETING FUNDS FOR EACH STATE
$2 million*

*In rural areas or elsewhere, where demand does not dictate the establishment of primary care facilities, these funds may be used to buy mobile clinics, establish more generous contract and/or beneficiary travel programs, or provide "fly-in" clinics to remote sites.

TOTAL COSTS

FY 1994: $28.625 million 7 Hospitals with 2375 enrollees each/6 States

(FL-Bay Pines, Gainesville, Miami, Tampa; MN-Minneapolis; OR-Portland; TN-Nashville; VT-0; WA-Seattle)**

FY 1995: $69.125 million 19 Hospitals with 2375 enrollees each/11 States and Puerto Rico

(AZ-Phoenix; CA-Loma Linda, Long Beach, Palo Alto, San Diego, San Francisco, Sepulveda, W. Los Angeles; CO-Denver; DE-0, HI-0; IA-0; MD-Baltimore; MT-0; NY-Bronx, Brooklyn, NY, Northport; PA-Philadelphia, Pittsburgh (2), Wilkes Barre; PR-0; and RI-0)

FY 1996: $57.750 million 10 Hospitals with 2375 enrollees each/16 States and Washington, DC

(AL-0; WY-0; AR-0; WI-Milwaukee; CT-West Haven; WV-0; DC-Washington, DC; VA-0; GA-Atlanta; UT-0; ID-0; TX-Dallas, Houston, San Antonio; IL-Chicago (Lakeside), Hines; SD-0; IN-Indianapolis; SC-0; KS-0)

FY 1997: $53 million 8 Hospitals with 2375 enrollees each/17 States

(KY-0; LA-0; ME-0; MA-Boston, Brockton/West Roxbury; MI-Allen Park; MS-0; MO-St. Louis; NE-0; NV-0; NH-0; NJ-East Orange; NM-0; NC-0; ND-0; OH-Cleveland, Dayton; OK-Oklahoma City; AK-0)

FY 1994-1997: $208.5 million for 44 Hospitals/50 states, Puerto Rico, and Washington, DC

APPENDIX F

GLOSSARY

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*:
One organization whose responsibilities include establishing standards for teaching hospitals' treatment of its 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 a requisite 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 co-author of the *Independent Budget*.

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 recommended by the VSOs to maintain a current information base, which would enable VHA to determine needs for major construction projects.

Category A Veterans:
Those 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; see Appendix B.

CIARDS *Central Intelligence Agency (CIA) Retirement and Disability System*

CIRO *Chief Information Resources Officer*:
Veterans benefits official responsible for departmental information resources management activities.

CMD *Chief Medical Director*:
Former title of head of the Veterans Health Administration (VHA) (now 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.

CVA *The United States Court of Veterans Appeals*:
An Article 1 court, established under PL 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; cost of this care is paid by the veteran.

CSRS *Civil Service Retirement System*

DAV *Disabled American Veterans*:
A veterans service organization and co-author 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, inpatients per 1,000 veterans.

DoD *Department of Defense*

Eligibility *(for VA medical care system treatment)*:
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 7 for entitlement and eligibility criteria.

Enhanced Use:
A leasing agreement whereby unoccupied or under-occupied VA facilities lease space to an external party for an activity that will benefit VA.

Entitlement:
Benefits—VA is required to provide benefits to those veterans who are entitled to programs under Veterans Benefits Administration criteria.
Medical Care—VA is required to provide inpatient and some forms of outpatient care to veterans entitled to VA medical care system treatment; see Table 7 or Appendix B for entitlement and eligibility criteria.

FDPP *Facility Development Planning Program*:
A component of the current Medical Care Construction Program used by VHA to identify individual medical centers' current and projected facility needs.

FERS *Federal Employees Retirement System*

FTEE *Full-time Employee Equivalent*

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*:
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. The principal objective of the fund is to encourage and facilitate extension of favorable credit terms by private lenders to veterans for the purchase, construction or improvement of homes to be occupied by veterans and their families.

GOE *General Operating Expenses*:
The appropriation account for the administration of all VA non-medical benefits and support functions for the entire Department; includes the Veterans Benefits Administration, the National Cemetery System and the 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.

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 to identify and serve 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 Veterans Affairs*

IBVSOs:
Veterans Service Organization co-authors of the *Independent Budget*, including AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars of the United States.

Inpatient Services:
Those services which require patient admission to a health care facility.

Intermediate Care:
A medical bed section in a VA hospital which serves as a reservoir for patients with intensive care needs or chronic illness.

IRM *Information Resources Management*:
An entity responsible for managing the system 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.

JCAHO *Joint Commission on Accreditation of Health Care Organizations*:

Provides criteria and surveys hospitals for accreditation. Accreditation affirms that an organization has met standards which are associated with quality health care delivery. VA voluntarily complies with JCAHO standards.

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, sale of loans and a funding fee.

Long-term Care:
Non-acute care services requiring treatment of more than 30 days.

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.

Medical Care Cost Recovery:
Program to collect veteran co-payments and reimbursable costs from third-party insurers for medication and health care services.

Minor Construction:
VA construction projects costing less than $3 million; also refers to the appropriation account that funds such projects.

NCS *National Cemetery System*:
The VA agency responsible for the management of the national cemetery system and for interment of and 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.

OASDI *Old Age, Survivors and Disability Insurance Benefits*:
Social Security Benefits Program.

OBRA *Omnibus Budget Reconciliation Act of 1990*:
An act to meet 1995 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 the development of 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 the total number 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&SAS *Prosthetics and Sensory Aids Service*:
The entity within VHA whose goal is the timely and appropriate provision of prosthetic and orthotic appliances and sensory aids to veterans.

Pensions
The appropriation account that provides for 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.

***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 co-author of the *Independent Budget*.

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.

RAM *Resource Allocation Model*:
Formerly, 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, as well as special assistance to disabled veterans.

Respite Care:
Programs under which elderly or disabled persons are institutionalized periodically to allow a relief period for the patients care-giver.

RO *Regional Office*:
Benefits—An office in one of fifty-eight 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 consistent with the VA National Health Care Plan.

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.

SERP *Systematic External Review Program*:
VA's ongoing system of peer review used to evaluate quality.

Service-Connected Patient:
A veteran with conditions resulting from illness or injuries sustained during military service.

SSA *Social Security Administration*:
The governmental entity responsible for the administration of SSI (see below).

SSI *Supplemental Security Income*:
Social Security counterpart to veterans' Pension Program.

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 turnaways and unmet needs.

SCVA *Senate Committee on Veterans Affairs*

Tertiary Care:
Definitive therapy for major illness or injury, utilizing specialized professional skills and techniques.

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 converted insurance issued under War Risk Insurance Act of September 2, 1914, as amended. Closed to new issues April, 1951. Income is derived from interest on investments and transfers from Veterans Insurance and Indemnities appropriation.

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 co-author of the *Independent Budget*.

VHA *Veterans Health Administration*:
The VA agency responsible for delivery of 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, 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.

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.

VSO *Veterans Service Organization*
An organization advocating the rights of veterans.

	VA APPROPRIATIONS BY ACCOUNT (in thousands)									
	FY 1994 APPROPRIATION	FY 1995 IB CURRENT SERVICES LEVEL	FY 1995 IB RECOMMENDED APPROPRIATION	FY 1995 ADMINISTRATIVE REQUEST	FY 1995 HOUSE BUDGET COM RECOMMENDATION (BA)	FY 1995 SENATE BUDGET COM RECOMMENDATION (BA)	FY 1995 NCVA/SCVA RECOMMENDATIONS	FY 1995 HOUSE APP RECOMMENDATION	FY 1995 SENATE APP RECOMMENDATION	FY 1995 CONFERENCE REPORT
GENERAL OPERATING EXPENSES (GOE)										
General Operating Expenses	826749	1224222	1350522	847153						
Office of the Inspector General	31436	32065	37915	32536						
National Cemetery System	70507	81000	81000	72863						
TOTAL GENERAL OPERATING EXPENSES	$928,692	$1,337,287	$1,469,437	$952,412	$0	$0	$0	$0	$0	$0
BENEFITS PROGRAM										
Compensation, Pension, and Burial Benefits	17527146	17627592	17627592	17627592						
Readjustment Benefits	1050600	1286600	1286600	1286600						
Veterans Insurance & Indemnities	15370	24760	24760	24760						
Veterans Job Training Fund	0	0	0	0						
Loan Guaranty Program Account	95852	78035	78035	78035						
Guaranty and Indemnity Program Account	522473	433520	433520	433520						
Direct and Other Loan Programs Accounts	36	2059	2059	2059						
Native American Veteran Housing Loan Program Account	156	218	218	218						
TOTAL BENEFITS	$19,215,421	$19,452,784	$19,452,784	$19,452,784	$0	$0	$0	$0	$0	$0
MEDICAL PROGRAMS										
Medical Care	15622452	18441157	19651884	16122452						
Medical & Prosthetic Research	252000	328583	348583	211900						
Medical Admin and Miscellaneous Operating Expenses	68500	73225	73225	69780						
Health Professionals Educational Assistance Programs	10286	10905	10905	10286						
TOTAL MEDICAL PROGRAMS	$15,952,338	$18,853,870	$20,085,597	$16,413,218	$0	$0	$0	$0	$0	$0
CONSTRUCTION PROGRAMS										
Construction, Major Projects	363000	294000	294000	115465						
Construction, Minor Projects	153540	412000	412000	153540						
Parking Garage Revolving Fund	1353	20000	29000	1400						
Grants for Cons. of State Vet. Cemeteries	5242	6000	6000	5378						
Grants for Cons. of State Extended Care Facilities	41080	200000	200000	37392						
Grants to the Republic of the Philippines	500	500	500	500						
TOTAL CONSTRUCTION PROGRAMS	$570,715	$932,500	$932,500	$313,680	$0	$0	$0	$0	$0	$0
TOTAL APPROPRIATION	**$36,668,166**	**$40,582,441**	**$41,960,318**	**$37,132,094**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Non Commissioned Officers Association of the United States of America

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STATEMENT OF

LARRY D. RHEA

DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS

BEFORE THE

COMMITTEE ON VETERANS AFFAIRS

UNITED STATES HOUSE OF REPRESENTATIVES

ON THE

DEPARTMENT OF VETERANS AFFAIRS

BUDGET REQUEST

FOR FISCAL YEAR 1995

FEBRUARY 10, 1994

Chartered by the United States Congress

The Non Commissioned Officers Association of the USA (NCOA) appreciates the opportunity today to comment on the Department of Veterans Affairs (DVA) budget proposals for Fiscal Year 1995. It is impossible though to offer the Committee substantive comments without having seen and analyzed the administration's proposal. Necessarily, NCOA will address the DVA Budget in general terms and express our position on veterans programs of principal concern to the Association's more than 160,000 members.

PREFACE

Mr. Chairman, one of the prevailing themes during the 1992 Presidential campaign and throughout the budget and legislative activities of the 1st Session of the 103rd Congress was that of "shared sacrifice." As NCOA indicated before this Committee on March 18, 1993, few people know more intimately the meaning of sacrifice than those who are serving or have served in the Armed Forces. Yet, despite the freely given sacrifices just for the privilege and high honor of serving in the Nation's Armed Forces, NCOA indicated to you last year that the patriotic veterans of this country were willing to continue to carry their share of the load. The one question NCOA laid before this committee was to be mindful of and to carefully consider "what is fair" in the difficult deliberations that confronted the Committee and the Congress during the First Session. NCOA specifically requested that veterans not be singled out for a special series of cuts just because they were veterans.

CHANGE

Mr. Chairman, it is abundantly clear, the rhetoric notwithstanding, that veterans remain the convenient, politically correct target of opportunity. It is an understatement to say that the continuing trend to lay at the feet of veterans, those who have honorably, faithfully, and dutifully served this Nation in peace and war, a disproportionate burden to cure the Nation's financial ills is disturbing. More accurately, the continuing imposition on rightfully and justly earned veterans benefits and programs should be characterized as sorrowful and a breach of the faith that, up until recent years, had bonded the Nation with its veterans.

In addition to "shared sacrifice" and doing "what is fair", another theme has been echoing across the country for more than two years. It occupied the political landscape throughout the 1992 Presidential campaign and it has been the predominate contention of political speeches and posturing since that time. All about we have heard and are continuing to hear the clamor for "change".

With regard to veterans Mr. Chairman, NCOA respectfully submits that change is also in order. Veterans, their dependents and survivors are indeed ready for and would welcome change. Change from the annual attacks on their pay, benefits, and programs that were promised and earned through their blood, sweat and tears. Change from being the politically correct whipping post for a national deficit and debt that veterans did not create nor cause to happen. Veterans would welcome, with deep gratitude, a change back to the place of honor, dignity, and esteem that was once accorded by a grateful Nation for honorable service in the Armed Forces.

Mr. Chairman, as you and the distinguished members of the Committee debate the difficult work before you during 1994, NCOA requests again that you not forget the sacrifices already made by veterans. NCOA requests that veterans benefits and programs not be held hostage to new initiatives and social programs for groups and individuals who have sacrificed far less than veterans, or not at all, for this Nation. Above all, NCOA requests during the upcoming months that the Committee's efforts be guided by a philosophy and purpose that will restore pride, dignity, and honor to the term "veteran". Finally, NCOA requests that the "special covenant between the Nation and veterans", which existed at one time in our Nation's history, be restored and honored with alacrity.

BETRAYAL - THE TREND

To understand why veterans have become caustic in their assessment of the spoken word and the actual action taken, an examination of the trends over the past 15 or more years is

enlightening. When the trend that has marked veterans programs and benefits is displayed, it also lends understanding as to why veterans have a jaundiced view and are somewhat skeptical regarding the promises associated with reform initiatives that are being contemplated.

Since 1965, a decreasing priority has been placed on veterans spending. Since 1977, there has been a constant spending reduction in veterans programs while the outlays for other national programs (social security, income security, Medicare, non-veteran health care and non-veteran educational benefits) have risen dramatically. Today, overall veteran spending, as a factor of total federal outlays, is less than 3 percent.

Over the past ten years, virtually every major support program for veterans has been cut. User fees have been added in education, home loan guaranty and medical care programs. Restrictions have been placed on eligibility for medical care services, vocational rehabilitation, burial and grave marker eligibility. Shamefully, even the benefits for veterans disabled through military service have been eroded.

The trends indicated above have been imposed in the veteran medical care arena also, but with, perhaps, much greater impact and consequence. Eligibility based on old age was terminated in 1986 leaving many elderly veterans to fend for themselves. Medical care for other veterans is now means tested. Literally, hundreds of thousands of veterans have been denied promised medical care while those eligible are confronted with a system degraded by infrastructure deficiencies, insufficient funding and staffing shortages.

There should be no doubt as to why veterans believe they have been betrayed. Also, there should be no question that veterans have already sacrificed. The sacrifice associated with their service in uniform was freely and unselfishly given. Nonetheless, veterans are continuing to sacrifice as the programs, benefits, and care, that was promised in recognition of and appreciation for their service to the Nation, are constantly diminishing or have become non-existent for some.

Budget deficits and the national debt are of concern to every taxpaying citizen and veterans are no exception. The solution to the problem, however, should not be a continuance of the disproportionate burden already imposed on veterans for many years.

THE FUTURE

As indicated earlier, it is impossible to comment with specificity and substance on the FY95 DVA Budget Proposal because of the time restraints for submission of this statement to the Committee. However, many signals have already been sent by the Administration that have an ominous boding for veterans. With apparent disregard to the facts of the last several years, the Clinton Administration has indicated that veterans will be asked to sacrifice more and in the process get less.

The National Performance Review (NPR) provides some sterling examples of the Administration's intent. Among several proposals pertaining to DVA and veterans, the Administration has stated its intention to: increase fees for VA home loans; require costs of some veterans' insurance programs to be recovered by increasing premiums or reducing dividends; and, make the savings provisions of OBRA 90 permanent, provisions that have already taken $5 billion from veterans.

On veteran health care, as a part of National Health Care Reform, the message emanating from the Administration is murky and confusing. On the one hand, the President has stated that he will honor the long-standing covenant with veterans. On the other hand, the NPR has recommended that VA medical care cost recovery be restricted. The goal of reducing the federal work force has been universally applied to the DVA with utter disregard to the staffing shortages already confronting VA medical care. Previously authorized medical construction and facilities improvement is being delayed. All of these occurring or being sought at a time when the DVA must position itself as an attractive alternative for veterans in a nationally competitive health care environment. The 'best thing since sliced bread' assurances aside, there is more

than ample reason for veterans to be cautiously concerned.

As much as anything that is said or done, oftentimes that which is not said or not done is equally disconcerting. In what has been regarded by many as a masterful State of the Union Address, it did not go unnoticed that the Nation's 27 million veterans did not warrant even a casual comment by the President on January 25, 1994. Veterans cannot help but entertain that such an omission speaks volumes about the value that this President places on their past service as well as what the future holds in recognition of that sacrifice.

A COMPASS

Many veterans believe that the crossroad to the future for veteran benefits and programs has been reached. Some believe that it has already been crossed and that the future will be nothing more than a continuation of past trends. NCOA sincerely hopes that this Committee will prove the latter assumption invalid.

NCOA commends to the Committee's review the Independent Budget of Veterans Organizations, a document that this Association has enthusiastically endorsed. NCOA suggests this report as a studious, factually presented effort to guide the Committee's DVA budget debate for Fiscal Year 1995.

CONCLUSION

Regrettably, this statement cannot reflect on details in the FY95 DVA Budget Request. NCOA's statement is, however, an accurate portrayal of the feelings and beliefs held by far too many veterans. The trends, although briefly stated herein, are indeed factual.

NCOA is sincerely grateful for the invitation to testify today. There is no question in the mind of the Association's membership that this Committee will strive to do what is right for the Nation. NCOA only requests that the distinguished Committee do what is right and fair for the Nation's veterans while being mindful of the sacrifices already made and continuing to be made.

Thank you.

STATEMENT OF JOHN HANSON, DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
FEBRUARY 10, 1994

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 for Fiscal Year 1995. Having had a limited time to review the budget proposal, we hope to offer more detailed views at subsequent opportunities.

For Fiscal Year (FY) 1995, funding for the Department of Veterans Affairs calls for $37.8 billion in budget authority to operate VA programs. The budget proposal provides $17.6 billion for benefit programs, $16.1 billion for medical care operations, $211 million for medical and prosthetic research, $296.4 million for construction activities, and $73 million for the national cemetery system. The budget proposal provides for average employment levels of 13,203 full time equivalent employees (FTEE) in the Veterans Benefits Administration, a reduction of 622 FTEE below the FY 1994 employment level, and 201,508 FTEE for Veterans Health Administration operations, a reduction of 3,680 from FY 1994 employment levels.

FISCAL YEAR 1995
DEPARTMENT OF VETERANS AFFAIRS BUDGET PROPOSAL

	Percent Change
Medical Care - $16.1 billion	3.2%
Medical Research - $211 million	-16.3%
Construction - $296.4 million	-45.0%
National Cemetery System - $73 million	2.8%
Compensation and Pension - $17.6 billion	2.4%
Veterans Benefits Administration - $756 million	3.0%
Total VA FY 1995 Budget - $37.8 billion	3.5%

MEDICAL CARE PROGRAMS

There appears to be a dichotomy between the Administration's expectations of what VA health care must be, and the way the same system is funded. Can the Veterans Health Administration (VHA) meet the expansion and reform expectations made of it while funding is insufficient to maintain a current level of services? We think not.

While it is true that moving to a primary care-based, outpatient-focused health delivery system will eventually provide veterans with quality, locally available health care at a lower overall cost, this transition can not happen overnight. If the Administration truly wants VHA to become a player in the health care reform arena, the way to prove that to the Department and our veterans is to assure adequate funding for provision of services during the transition. Without this assurance, veterans will lose faith. While The Health Security Act places the VA medical system's future at risk by competing with the private sector, we can not afford to create an even greater risk by setting VA up to fail before the transition to health care reform begins.

The impact of FTEE cuts of 5,793 to "re-engineer" VA health care by making management improvements and streamlining and purchasing services as well as implementing National Performance Review as described in the budget package, could reduce the VHA's chances of surviving reform. Although this blow appears to be softened by the addition of 2,048 FTEE for

activation of already constructed new facilities, these FTEEs are already committed, and, therefore, it still amounts to a 2 to 3 percent reduction in the work force while key medical workloads increase by only 27,000 patients. Also, the total inpatient volume is expected to drop by only one-half of 1%, while the outpatient volume is expected to increase by 1%. Any implication that the Veteran Service Area (VSA) concept will be approved by Congress or will be "up and running" to save 852 FTEE and $50 million in FY 1995, is sheer conjecture.

Providing goods and services under contract can reduce the costs of delivery of those services overall. However, we should not be lulled into complacency with the idea that those costs magically go away. The numbers of variables in this scenario are enormous. Frequently the contracting idea, although a valid way to remove the costs from patient-care accounts, sometimes amounts to mere cost shifting. Caution should prevail in these assumptions.

The American Legion gets the feeling that hidden somewhere behind the scenes is a reliance upon the "seed money" to be provided under The Health Security Act to compensate for the reductions in the FY 1995 budget. If true, that demonstrates a clear misunderstanding of the purpose of the HSA funds and an even more frightening idea that the failure of VA as a competing national health care provider and its eventual demise, becomes a self-fulfilling prophesy.

While we are focusing on the FY 1995 budget proposal, let us not forget that VHA is under a mandate to reduce roughly 2,500 FTEE during the current fiscal year, due to unfunded locality pay raises. To absorb up to another 25,000 FTEE reductions over the next five years under the National Performance Review plan will further weaken the system's ability to compete under national health care reform.

MEDICAL AND PROSTHETIC RESEARCH

It is ironic to The American Legion that at a time when the Administration recommends reducing VA's FY 1995 medical and prosthetic research budget by $41 million and 830 FTEE, it also recommends investing close to $30 million in new and existing research facilities. We do not imply that this action represents misplaced priorities, however, we do question the need for two new research buildings in a very constrained budget.

Why must we fight the research budget battle every year? Is there not a way to establish a mechanism which would allow VA medical and prosthetic research programs to receive a predictable amount of resources each and every year? For the FY 1994 budget, Congress appropriated $46 million more for VA research programs than proposed by the Administration, thereby averting a significant dismantling of the Department's research efforts. Now, we once again face an uphill struggle to maintain the viability of the highly effective and widely respected research programs of the Department of Veterans Affairs.

The Administration's FY 1995 VA research proposal can not be justified rationally. We believe the current year research appropriation of $252 million must be maintained and represent the baseline figure for future year appropriations. Adding a three to five percent inflationary adjustment to the current year research budget would provide the impetus to continue all high priority research activities. How will VA fund mandated research programs for Desert Storm veterans, women veterans, mental health and behavioral sciences programs, among other high priority agenda items, when facing a reduction of $46 million and 830 FTEE? What programs are to be sacrificed? In our view, any amount of funding representing less than current year research activities will create lasting consequences.

CONSTRUCTION

The American Legion supports a FY 1995 budget that addresses priority major and minor construction needs within VA. It seems odd to us that two new research facilities are proposed when VA's research program is again recommended for funding and staffing reductions. Of the $115 million recommended in new major construction funding authority for FY 1995, $62.3 million is targeted to one facility for seismic corrections. With all of VA's important construction needs, we find it astonishing that major construction is only proposed at a funding level of $141.5 million for FY 1995 ($26 million is reprogrammed from previous year funds).

The American Legion has long advocated a strong VA construction budget to meet current infrastructure and future care medical requirements. We see little in the budget which will support VA's long-term strategic plans to develop additional community-based ambulatory clinics and long-term care programs. Although The Health Security Act's Investment Fund (Phase One), calls for developing or improving eight ambulatory care and one nursing home projects in FY 1995, in the amount of $225 million, at this time that proposal is subject to modification.

The American Legion recommends that the $225 million for the health investment fund be included in VA's major construction budget for FY 1995. Outpatient modernization and improved access to care are critical components of VA's efforts to compete under health care reform. None of the Phase One health investment fund ambulatory care projects address the needs of rural veterans. Instead of providing access to care in remote geographic areas, all identified clinics are located in urban locales. The Legion objects to VA using the Health Security Act Investment Fund to meet regular and normal construction requirements.

We question the need for moving ahead at this time with both proposed new research facilities and believe that the proposed seismic correction project should be reviewed in relation to overall system-wide priorities. Additionally, we propose that several additional major construction projects be funded in FY 1995: The Hawaii VA medical center/regional office project; and the Gainesville, FL long-term care psychiatric building.

NATIONAL CEMETERY SYSTEM

The Administration budget calls for a slight increase in full-time employees - from 1,315 to 1,340 - and an increase of $2.1 million to $73 million to operate and maintain the National Cemetery System for FY 1995. Additionally, $10.6 million is requested for construction of a new national cemetery in the Seattle/Tacoma area of Washington. An additional $1 million is requested for the national cemetery system design fund for future construction activities.

Although additional FTEE are critically needed to maintain operations and maintenance standards, the National Cemetery System has fallen further behind during FY 1994 in meeting new and replacement equipment requirements. In the current fiscal year, some of the available funding which was earmarked for purchasing new equipment had to be reprioritized to cover unfunded locality pay. The cumulative equipment backlog is projected at $6.7 million by the end of FY 1994 and will rise to approximately $7.8 million by the end of FY 1995, without increased funding.

BENEFITS PROGRAMS

There are many important and diverse issues in the Federal budget this year, such as health care reform, deficit reduction,

defense spending, etc. which Congress must address. However, we are firmly convinced that debate on these and other subjects must not be allowed to overshadow the true crisis which exists in VA's claims adjudication and appeals process and impact this is having on the lives of tens of thousands of veterans and their families.

Appropriations for all VA benefits program will be $17.626 billion. This is an increase of approximately $100.4 million over the FY 1994 funding level. This change represents both an increased number of benefit claims being filed over FY 1994 and a higher average payment. The increased volume of new claims reflects the continued military downgrading, and additional benefits authorized for veterans exposed to Agent Orange and mustard gas. There is also an increase is the average degree of disability associated with these claims.

The Administration is recommending a decrease in overall employment in VBA of 622 FTEE. Staffing in the adjudication divisions in the regional offices will be reduced by 342 FTEE from the FY 1994 estimated employment level of 4,505 FTEE. The reduced employment is based in part of a projected decrease in the workload associated with the matching requirements of OBRA 1992, plus VA's contribution to the reduction in Federal employment. This means there will be far fewer workers in the regional offices to handle not only the thousands of new and reopened disability and death claims, but to continue processing the existing backlog of pending claims which is of monumental proportions.

The effect of the continued reduction in staffing levels over the past twelve years is graphically clear in the fact that the pending compensation and pension caseload is expected to jump from about 531,000 to 712,000 between FY 1993 and FY 1994, the span of only one year. This backlog is expected to grow by another 159,000 cases to 870,000 cases, under the FY 1995 budget. This does not include 223,000 education claims which will also be pending at the end of FY 1995. That totals to well over 1 million benefit claims that are either in process or just sitting in the regional offices waiting to be worked. It is no comfort that since early last year Secretary Brown has publicly predicted this would occur.

This surely is a major administrative crisis for the Department of Veterans Affairs by any standards or definition. It did not, however, just arise overnight. The American Legion has repeatedly spoken to this and other Congressional Committees of the consequences of the Administration's unrealistic budget requests and funding levels. In comparison, The American Legion is not aware that other Federal agencies charged with the administration of financial assistance programs for the disabled and needy have experienced similar long-term reductions in personnel and resources. Nor have we received complaints from beneficiaries under other Federal assistance programs concerning delays of months and oftentimes years in receiving benefits, such as veterans continue to experience with their VA claims.

We are especially concerned that this situation represents a personal crisis for at least a million veterans and their families who need and deserve the financial assistance reflected in these benefit programs. It is no wonder that many of them are surprised and justifiably outraged that Congress and VA have allowed the level of service to deteriorate to the point where most can expect to wait upwards of a year or more for a decision. If it should be necessary to seek an appeal to the Board of Appeals, a decision will take several years in coming. What does a widow who just lost her veteran husband do to live on until VA acts on her claim for DIC or death pension? How can a severely disabled veteran take care of his family while VA tries to determine what is wrong with him and then process his claim for service connection? How is a veteran who is pursuing a college education to make the required payments to stay in or

enter school? While a veteran is waiting for a benefit decision, he/she is not receiving the care or other services that they require.

The effect of the continued lack of personnel and ADP resources for VBA operations is also reflected in the increasing amount of time veterans must wait for a decision on their claim. With disability compensation claims which make up the majority of the overall workload, in FY 1991, it took on average 151 days to complete processing. In FY 1993, it was taking more than 6 months (188 days) and by the end of FY 1995 it will be taking over 7.5 months with no indication or prospect of any significant improvement in this trend (other than rhetorical). Processing times for all other types of claims have also increased significantly with pension and DIC claims taking over 4 months on average.

Current and planned initiatives may eventually help VBA stem the long-standing decline in timeliness, but at what level? The personnel cuts slated for FY 1995 together with insufficient resources in other key areas, such as support for various ADP and management initiatives strongly suggest that the Administration has given up trying to do anything substantive to slow or stop the rising backlog and allow VBA to begin the slow process of bringing processing times down to some reasonable and fair level.

With respect to the recommendations of the Secretary's Blue Ribbon Panel on Claims Processing, the Panel's 43 recommendations have been approved by the Secretary. These initiatives, when fully implemented over the next 12-18 months are expected to have a favorable impact on both the way claims are physically handled and adjudicated in the regional offices and the amount of time required to complete processing. We believe it is imperative that VBA be able to make the necessary organizational and administrative changes in regional office operations, reprioritize certain parts of its ADP modernization program, and streamline its regulations and procedures which have been set forth in these recommendations. We are deeply concerned that the cuts imposed on VBA under the FY 1995 budget will seriously undercut and delay the Department's efforts to finally do something concrete about the backlog.

As in past budgets, once again personnel will be cut from the Vocational Rehabilitation Program in FY 1995. Average employment will drop 29 FTEE from 714 to 685. This comes at a time when there will be an increasing number of service disabled veterans seeking vocational rehabilitation, employment services, and vocational and educational counseling. VA reports it is taking longer and longer for the applications of these disabled veterans to be acted upon. In FY 1993, it took an average of 71 days. In FY 1995, it estimated this will be 90 days. For all types of services provided through this program, there are too few Vocational Rehabilitation Specialists and Counselors to assist veterans in a timely or an effective manner. The demands on their time and available resources are overwhelming. Disabled veterans seeking entrance into a training program as well as those completing their program face increased delays which jeopardize their chances of a successful rehabilitation and entrance or reentrance into the job market.

The Vocational Rehabilitation Program has come under severe criticism in recent years for delays in providing disabled veterans needed services, including employment assistance and follow-up. It clearly remains a question of trying to do too much with too few resources. The net result of the FY 1995 budget request is to further penalize these disabled veterans who need and can benefit by the services which are provided by law.

We also would like to address the GI Bill. You all know of the Legion's concern that the current level of compensation is far too low for students to be able to use for education. The low participation by those who have contributed to the program speaks volumes. If we are serious about investing in our future, shouldn't we be serious about funding educational benefits at a rational level?

The Board of Veterans Appeals is experiencing its own crisis resulting from an overwhelming backlog of pending appeals. Although in FY 1995 the Board's staffing level will be reduced by only 3 FTEE, it still faces a workload problem stemming from the fact that approximately 33,700 appeals were pending at the end of FY 1993. It is estimated that by the end of FY 1994, this number will have increased to over 48,500 cases and if nothing changes, the backlog will reach 56,500 cases. In FY 1993, the Board's average response time was 466 days. In FY 1994, it will be 733 and in FY 1995 662 days. These times reflect those appeals in which a final decision was rendered - an allowance or denial. The response time does not take into account the fact that some 68% of the Board's decisions currently are remands back to the regional office for additional development and reajudication.

The declining level of production at the Board as well as the extraordinarily high remand rate reflects the direct and profound impact of the decisions of the Court of Veterans Appeals on the Board's decision-making process. The Board is now to required to meet new legal standards and procedural requirements which oftentimes necessitate double work on hundreds of cases to conform to the Court's precedent decisions.

In response to this crisis, the Chairman recently announced plans to temporarily suspend all personal hearings before the Board, including Field hearings by the Traveling Board. The Board is also not transferring in any more cases which have been certified by the regional offices until such time as the backlog has been substantially reduced. These are extreme measures in response to a very real and difficult problem. Legislation has been proposed to authorize single member decisions which if enacted is estimated to increase the Board's production by 27%. The American Legion supports this initiative as a necessary step toward resolving the unacceptable delays facing veterans seeking appellate review of their claims and believe Congress should give it a high priority. Veterans seeking appellate review by the Board should not be forced to wait years to have their case heard.

***** SUMMARY *****

The American Legion is well aware that the Deficit Reduction Agreement of 1993 places severe cost constraints on federal discretionary spending. We also believe that the funding of various VA programs has been problematic for many years. The funding proposals and staffing reductions for the Department of Veterans Affairs for FY 1995, as outlined in this statement, will place serious barriers in the way of the effective delivery of health care services, benefits programs, and medical and prosthetic research activities.

We have heard from the Administration that it is committed to improving VA services to veteran beneficiaries and to their dependents. In order to maintain the recent progress VA has made in delivering timely, quality services in spite of continous funding deficiencies, now is not the time to prescribe a further degradation of services, which is what we fear will happen if the Administration's budget proposals are embraced. Serious consideration must be given to maintaining the current level of health care services, medical research activities, and benefits service delivery, before these programs are irreversibly unable to perform their assigned missions in an acceptable manner. The American Legion believes our veterans and their dependents deserve no less than the best medical and benefits services obtainable.

BLINDED VETERANS ASSOCIATION
477 H STREET, NORTHWEST • WASHINGTON D.C. 20001-2694 • (202) 371-8880

TESTIMONY

PRESENTED BY

THOMAS H. MILLER

FOR THE RECORD

ON BEHALF OF THE

BLINDED VETERANS ASSOCIATION

BEFORE THE

HOUSE COMMITTEE

ON VETERANS AFFAIRS

FEBRUARY 22, 1994

CHARTERED BY THE CONGRESS OF THE UNITED STATES

Mr. Chairman and members of the committee, on behalf of the Blinded Veterans Association (BVA), I want to express our appreciation for the opportunity to submit our views on the Presidents' FY 1995 Budget Request for Department of Veterans Affairs (DVA) for the record of the hearing conducted on 2-10-94. I regret time did not allow for review of the budget request and preparation of testimony in time to appear before the hearing. Nevertheless, we feel compelled to share our reaction to the budget with you in terms of the potential impact on blinded veterans.

To say BVA is extremely concerned over this budget submission is a gross understatement. This budget request dramatically illustrates the conflicting messages coming from the White House and the confusion they are generating amongst the veteran community. Under the umbrella of National Health Care Reform (NHCR), President Clinton has advocated his intention for VA to remain an independent health care delivery system for our nations veterans and prescribes a mechanism for VA to compete in NHCR. Simultaneously, the Administration is championing the National Performance Review (NPR) which calls for the elimination of 252,000 full time employees from the Federal government and expects the VA to absorb its share of that reduction effort. On one hand they want VA to survive and compete in NHCR while at the same time they propose to take away resources. If the administration is series regarding the future of VA as a viable health care provider for veterans, how can they proceed to take away essential resources that enable VA to position itself to compete with the private sector.

President Clinton campaigned on the notion of investment in our people and has continued this theme with various legislative initiatives. Frankly, Mr. Chairman, the FY 95 budget request for DVA does not reflect any real investment in veterans. In fact, veterans are again asked to make sacrifices disproportional to many others and to voluntarily relieve the government of its obligation "to care for those who have born the battle, their widows and orphan." The $38.8 billion budget proposal is a giant step backwards in terms of adequately addressing our nations veterans needs, both in terms of health care and benefits delivery.

VA Medical Care Request

How can any one support or even defend the $500 million dollar increase for VA medical care program? This request does not even meet the FY 94 current services level at a time when demand for care is increasing due to the aging of the veteran population as well as the military downsizing. According to the Administration the $111 million shortfall can be absorbed through management efficiencies. We have been hearing that song for the past decade or more and have seen little to suggest meaningful efficiencies will be initiated that will result in no further erosion of existing programs and services or increased damage to staff moral continuously being expected to do more with less.

Mr. Chairman, we can not find anywhere in this budget request dollars dedicated to improving VAs capacity to deliver blind rehab services to blinded vets. This is a time when blinded veterans are required to wait up to a year or more for admission to one of the existing eight Blind Rehabilitation Centers/Clinics (BRC). The average number of blind vets on waiting lists during the 1993 calendar year was 1,251. There are no plans in this budget to address these unacceptable waiting times and lists. Mr. Chairman, how can VA proclaim that their expertise and excellence in providing high quality comprehensive special disability programs be taken seriously as an incentive for blinded veterans to enroll in a VA health care plan when VA cannot manage their existing workload under current eligibility rules. Clearly there is no excess capacity to market to induce blinded veterans to enroll in the VA health care plan. This budget will further restrict VAs ability to expand capacity for services delivery and contribute to an ever increasing backlog of blind veterans seeking rehabilitation. This budget fails miserably to invest in or make a meaningful commitment to programs that really work.

Also absent from this budget is any commitment of resources to increase the number of full time Visual Impairment Services Team (VIST) Coordinator positions. The VIST Coordinator is the care manager for blinded veterans and is an excellent example of the managed care primary care model of service delivery of which the VA speaks so highly. In fact, the VA health care reform plan is deeply committed to primary managed care delivery. Another initiative requested by VACO Blind Rehabilitation Service (BRS) is resources for the capacity to deliver outpatient blind rehab assessment and training. This initiative would insure completing the continuum of care so essential to well being. This innovative concept has proven to be extremely effective in a pilot project conducted at VAMC Phoenix, AZ., that has been funded by a bequest from a veteran in that area. Mr. Chairman, all these initiatives blend perfectly into NHCR and the primary managed care model envisioned by VA. They will help to reduce waiting times, and lists and provide comprehensive care that will significantly improve the lives of blinded veterans.

Can such a system truly be competitive when being denied basic tools to operate? BVA understands that if programs and services for blinded vets are to survive and remain viable the system as a whole must survive and have sufficient resources to address basic as well as rehabilitative needs. This budget places VA health care at serious risk and offers little encouragement regarding VAs ability to position itself as a provider in a competitive health care environment.

Mr. Chairman, BVA could not believe the proposed reductions in VA Medical and Prosthetic research. Obviously the Administration did not get the message last year when we fought this same battle. Congress made it crystal clear last year that VA medical research was an absolutely essential mission for VA and would not let it be reduced. In fact, the appropriation was increased above requested levels. Mr. Chairman, we trust Congress will aggressively pursue that same position again this year and categorically reject the administrations ridiculous proposal.

Benefits

As bleak as the budget proposal is for medical care, the outlook is not any better for benefits. Again the Veterans Benefits Administration (VBA) is expected to take major reductions in FTEE in the face of unconscionable delays in claims processing, applications for Vocational Rehabilitation and Education Benefits as well as having to answer telephone inquiries. The projected delays in claims processing are frightening in the context of the impact this has on the lives of those veterans in need of the benefits to which they are entitled.

We commend the Secretary for attempting to protect adjudication from further cuts but VBA just cannot sustain further cuts without compromising other functions over which they have responsibility. Additionally, we agree the computer modernization program will be extremely helpful in claims adjudication and processing but that will be in the future and the future of our disabled veterans awaiting decisions is now. The only conclusion we can draw from this budget proposal is the Administration has no plans to invest in veterans or to assure viability of the VA as an independent health care provider for veterans. BVA was guardedly encouraged by the introduction of the Health Security Act (HR 3600) because it was the only health care reform plan that addressed veterans at all. It calls for the VA to remain an independent health care system dedicated to veterans. Unfortunately, this budget gives VA little opportunity to continue current services let alone prepare for participating in a competitive environment. BVA agrees that deficit reduction must be a high national priority, we strongly disagree that those reductions must be accomplished at the expense of sick and disabled veterans.

In fact Mr. Chairman, this budget endangers all four of VAs missions; Health Care, Education, Research, and DoD contingency. Without question, DVA is a national asset that must be preserved, not written off as this budget proposes.

Again Mr. Chairman, I want to thank you and the committee for holding this important hearing and affording BVA opportunity to submit our comments for the record. We look forward as always to working with you to improve this budget in an effort to realistically meet the needs of our nations veterans.

Thomas H. Miller
Director Governmental Relations
Blinded Veterans Association
February 22, 1994

United States
Court of Veterans Appeals
625 Indiana Avenue, N.W., Suite 900
Washington, D.C. 20004

February 7, 1994

Honorable G.V. Montgomery
Chairman, Committee on Veterans' Affairs
House of Representatives
Washington, D.C. 20515-6335

Dear Mr. Chairman:

Enclosed is the budget request of the United States Court of Veterans Appeals for fiscal year (FY) 1995.

In constructing its budget request for FY 1995, the Court has been mindful of ongoing Presidential and Congressional efforts to reduce government spending. Excluding rent, which increases 3.4 percent, the Court's FY 1995 budget represents a 7-percent reduction from 1994 funding levels in the Court's administrative overhead. The Court's request includes $790,000 for continued funding of the Pro Bono Representation Program. This represents full funding of the Program at no increase over the FY 1994 appropriation for the Program.

Should you or your Committee members have any questions, please do not hesitate to contact me on (202) 501-5980.

Sincerely,

Robert F. Comeau
Executive Officer and
Clerk of the Court

Enclosure

UNITED STATES COURT

OF

VETERANS APPEALS

FISCAL YEAR 1995

BUDGET ESTIMATES

TABLE OF CONTENTS

UNITED STATES COURT OF VETERANS APPEALS

INTRODUCTION

The United States Court of Veterans Appeals is a Court of record established under Article I of the Constitution of the United States. The Court is composed of a chief judge and six associate judges. The judges of the Court of Veterans Appeals are appointed by the President, by and with the advice and consent of the Senate, for 15-year terms. Certain decisions by the Court are reviewable by the United States Court of Appeals for the Federal Circuit and, if certiorari is granted, by the Supreme Court.

The Court's principal office location is Washington, D.C.; however, it is a national court, empowered to sit anywhere in the United States.

UNITED STATES COURT OF VETERANS APPEALS

APPROPRIATION LANGUAGE
SALARIES AND EXPENSES

For necessary expenses for the operation of the United States Court of Veterans Appeals as authorized by 38 U.S.C. $$ 7251-7292, [$9,159,000] **$9,523,000**; *[Provided,* That such sum shall be available without regard to section 509 of this Act;] ***Provided [further],*** **That of the funds made available to the Court in this appropriation, not to exceed $790,000, to remain available until September 30, [1995] 1996, shall be available for the purpose of providing financial assistance as described, and in accordance with the process and reporting procedures set forth, under this head in Public Law 102-229.** *(Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1994.)*

UNITED STATES COURT OF VETERANS APPEALS

NARRATIVE STATEMENT

The Veterans' Judicial Review Act, Pub. L. No. 100-687, (1988), codified in part at 38 U.S.C. §§ 7251-7292, established the United States Court of Veterans Appeals under Article I of the United States Constitution. The Court is composed of a chief judge and six associate judges. Judges of the Court are appointed by the President, by and with the advice and consent of the Senate, for 15-year terms of office.

The Court is empowered to review decisions of the Board of Veterans' Appeals (BVA) and may affirm, modify, revise, or remand such decisions as appropriate. The type of review performed by the Court is similar to that which is performed in Article III courts under the Administrative Procedure Act, 5 U.S.C. §§ 551 *et seq.* In actions before it, the Court has the authority to decide all relevant questions of law, to interpret constitutional, statutory, and regulatory provisions, and to determine the meaning or applicability of the terms of an action by the Secretary of Veterans Affairs. The Court, having been created by an act of Congress may, under 28 U.S.C. § 1651, issue all writs necessary or appropriate in aid of its jurisdiction.

The Court is empowered to: compel actions of the Secretary that are found to have been unlawfully withheld or unreasonably delayed; and set aside decisions, findings, conclusions, rules, and regulations issued or adopted by the Secretary, the BVA, or the BVA Chairman that are found to be arbitrary or capricious, an abuse of discretion, or otherwise not in accordance with the law, contrary to constitutional right, in excess of statutory jurisdiction or authority, or without observance of the procedures required by law. The Court may hold unlawful, or set aside findings of material facts, if the findings are clearly erroneous.

Court Caseload Trends and Variations:

The Court commenced operations on October 16, 1989. During FY 1990, 1,261 appeals were filed. The number of new cases increased from month to month at a relatively uniform rate during FY 1990, giving rise to an expectation of a continued increase in caseload. During the following years, while fluctuating dramatically from month to month, new cases increased to 2,223 in FY 1991, then dropped to 1,742 in FY 1992 and to 1,265 in FY 1993.

Appeals to the Court come from the pool of cases in which the BVA has denied some or all of the benefits sought by claimants. That pool has become smaller as the BVA issues fewer decisions (46,556 in FY 1990, 45,308 in FY 1991, 33,483 in FY 1992, and 26,400 in FY 1993) and remands a greater percentage of those cases

to VA regional offices for further development (23.5 percent in FY 1990, 29.7 percent in FY 1991, 50.5 percent in FY 1992, but down slightly to 44.0 percent in FY 1993).

Forecasting caseload from short-term data is risky, particularly when the VA administrative claims process continues its complicated adjustment to the Court's existence. The current volatility of the BVA statistical picture gives the Court great pause in projecting the new cases it will receive in FY 1995. The BVA Chairman predicts a 25-percent increase in BVA productivity if pending legislation, which has been passed by the House and is now pending in the Senate, to permit decisions by single BVA members (H.R. 3400, 103d Cong., 1st Sess., § 12302) is enacted. If that occurs, the Court may expect a concomitant increase in its caseload.

The percentage of appeals filed in the Court by unrepresented appellants rose from 61 percent in FY 1990, to 67 percent in FY 1991, to 75 percent in FY 1992, to 82.5 percent in FY 1993. This is substantially higher than the 46.3-percent unrepresented appeal rate in civil cases before U.S. courts of appeals. It is not so surprising, however, when one notes that about 46 percent of the claimants who are denied all benefits by the BVA are either unrepresented there or are represented by organizations which do not practice before the Court. The increasing rate of unrepresented appeals filed in the Court seems to indicate an increased awareness of the Court's existence among veterans, and an increased determination to "go it alone" in seeking review before the Court. This increasing pro se rate at the time appeals are filed makes continuation of the Pro Bono Representation Program even more important.

Pro Bono Representation Program:

In an effort to address the growing rate of unrepresented appellants, the Congress approved the Court's request in 1992 to create a pilot Pro Bono Representation Program (Program) by authorizing the reprogramming of $950,000 from the Court's FY 1992 budget for this purpose. Pub. L. No. 102-229 (1991). The following year's Appropriations Act extended the availability of these funds through September 30, 1994. Pub. L. No. 102-368 (1992). The reprogrammed funds permitted the establishment of a grant pilot program administered by the Legal Services Corporation (LSC) to provide pro bono representation and legal assistance to those Court appellants who may not be able to afford representation.

Grant funds were awarded in September 1992, and the Program began operating in October 1992. The primary grant was awarded to an organization known as the Veterans Consortium ($703,000) (Consortium), composed of the American Legion, Disabled American Veterans (DAV), National Veterans Legal Services Project (NVLSP),

and Paralyzed Veterans of America (PVA). Three expansion grants were awarded to DAV (($50,000), PVA/NVLSP ($85,000), and Swords to Plowshares (a California-based veterans' rights organization) ($62,000). (The DAV grant never became operational.)

The Consortium is responsible for screening cases; recruiting, training, monitoring, and mentoring volunteer attorney representatives; and referring cases to volunteer attorney representatives or to expansion grantees. The expansion grantees received funds to expand their existing no-cost representation programs, primarily by accepting cases referred by the Consortium's screeners where assignment to pro bono attorneys or representatives was impracticable. A one-year status report on the program was provided to Congress on October 18, 1993.

LSC completed an evaluation of program grantees during the past calendar year, and issued final evaluation reports on December 20, 1993. As promised by the Court, these reports were forwarded to Congress under separate cover on February 3, 1994. The evaluation reports on two of the three operating grantees were very favorable.

During the first full year of operations, the pilot Program has been successful in a number of ways. As of September 30, 1993, the grantees had recruited 185 volunteer attorneys, and had provided 140 of them with formal training in veterans law and Court practice and procedure. (In addition, 21 volunteer attorneys who were unable to attend a formal training course have viewed a videotape of the course.) This recruitment and training effort continues.

In keeping with the Congressional purpose that federal funds be used to leverage private funds, it is estimated that the $900,000 expended in FY 1993 for the three grants produced $2,350,262 in donated funds and services. In other words, for every FY 1993 federal dollar spent, $2.50 worth of non-federal funds or services was generated. The value of FY 1993 volunteer-attorney donated time is estimated at $2,125,200. Put another way, for each case completed in FY 1993, donated volunteer attorney services valued at $13,000 were provided at a cost in federal dollars of only $2,208.94. Of 52 cases completed by volunteer attorneys in the first year, more than 80 percent of the attorneys have agreed to accept another case.

The Program's goal of significantly reducing unrepresented appellants in the Court was achieved as to appeals filed in FY 1993. Legal advice or representation is provided through the Program to every pro se appellant with a viable appeal who requests assistance and who cannot afford an attorney. Only 17.5 percent of those filing appeals in the Court in FY 1993 were represented at the time of filing. From the 82.5 percent of FY 1993 unrepresented appeals at the time of filing, the Program completed in FY 1993

screening of those appeals filed through June 1993. As a direct result of the cases placed with attorneys by the Program during FY 1993, the represented FY 1993-appeals rate was then more than doubled -- to 42.5 percent. Finally, taking into account the FY 1993 appellants provided only legal advice as well as those provided full representation by the Program, fully two thirds of those filing appeals in FY 1993 had received some form of legal assistance by the end of the fiscal year.

The success of the Program, as demonstrated by the statistics above, in providing assistance to unrepresented appellants would be lost if the Program were not continued. The Court is thus requesting continuation of the Program in FY 1995 at the FY 1994 level.

The Court's FY 1994 appropriation authorized the Court to provide funds, not to exceed $790,000, to continue funding for the Program. Pub. L. No. 103-124 (1993). In view of the Program's accomplishments and the results of the LSC evaluation reports, LSC has renewed the grants of the Veterans Consortium and NVLSP/PVA for FY 1994. The grant amounts are being finalized.

In seeking the FY 1994 funding level, the Court notified the Congress that it tentatively had agreed with LSC that in FY 1995 the Court and LSC each would request 50 percent of the funds deemed necessary for the continuation of the Program, and that thereafter future requests would come directly from LSC in total. The Court's notice to Congress was based on an understanding reached with LSC's former President, who served at the pleasure of LSC's former Board of Directors. The new LSC Board, appointed by President Clinton and confirmed by the Senate in November 1993, is assessing the needs of the legal services program and is grappling with the many competing demands it must address as it begins preparation of its own budget for FY 1995. The new LSC Board has advised in a letter sent to the Appropriations Committees on February 4, 1994, that, although it is highly supportive of the Program, it is not in a position at this juncture to commit to any specific funding partnership for FY 1995. Consequently, the Court's FY 1995 request includes $790,000 for continued funding of this Program. The Corporation has promised to continue to work closely with the Court on the question of future funding.

Staffing Requirements:

As a decrease in cases during FY 1993 became apparent, the Court requested funding for 83 full-time equivalent (FTE) positions in FY 1994, a reduction of 4-FTE positions from FY 1993 authorized staffing. This reduction has been made beginning in FY 1994. It constituted a 5-percent reduction which also meets the FTE-reduction target recommended by the Office of Management and Budget (OMB) through FY 1995 in response to the President's order implementing the suggestions of the National Performance Review.

The Court is committed to cooperating with the President and the recommendations of the National Performance Review which propose a 5-year 12-percent FTE reduction through attrition and early retirement.

The complexity of the Court's caseload and case-related procedural work has more impact on the Court's staffing needs than does the size of the caseload. To some extent, this workload has increased as a result of attorney-fee applications filed under the Equal Access to Justice Act (EAJA), made applicable to the Court by Pub. L. No. 102-572, § 506 (1992).

The Court continues to request a staffing level of 83 FTEs in FY 1995 to maintain the provision of high-quality case-related services to a persistently high, and apparently still growing, percentage of appellants who are unrepresented when they file appeals. Although the Pro Bono Representation Program currently provides excellent legal assistance to most all appellants desiring it, a substantial number of appellants continue to be unassisted either because their appeal is not viable or because they opt not to accept the Program's services. As long as this number of unassisted appellants continues to be significant, there will be a heavy demand on Court personnel for these case-related services.

A second reason for keeping the FY 1994 staffing level is to complete the entry of case data into the Court's automated case-management system. This system has been under development since FY 1990 but, before it came on line, actions pertaining to cases filed in FY 1990 through FY 1992 could not be entered. The Court is now entering those data in order to create a complete record of Court proceedings and to provide a basis for accurate statistical analysis. FY 1989 data-entry is complete. FY 1990 through 1992 data are being processed along with current-year information, and data-quality checks are being made on Court caseload data being entered into the computer base for these years in order to verify data accuracy. In addition, the Court is still in the process of implementing software programs and the necessary software links between the Clerk's Office and soon-to-be-implemented systems modules for the Central Legal Staff and Judges' Chambers. The Court expects to complete this computer-entry process in FY 1995.

The Court's staffing level will be reevaluated during the FY 1996 budget-building process in light of the recommendations of the National Performance Review and OMB; the anticipated elimination of the computer-entry backlog and completion of the data quality analysis of caseload information for FY 1990 through 1992 data; the impact of a mature pro bono Program; and the impact of EAJA applicability.

FISCAL YEAR 1993 ACTIVITY

The Court continued to increased its average monthly case-termination rate from an average of 65 cases per month in FY 1991, to 158 cases per month in FY 1992, to 183 cases per month in FY 1993. The Court held 23 oral arguments during FY 1993, and it decided 2,197 cases. Additionally, the Court held its first oral argument outside of Washington, D.C., on January 21, 1993, in Phoenix, Arizona.

The Court has continued contractual arrangements with the U.S. Marshals Service for court security, and with the Department of Agriculture's National Finance Center (NFC) for the provision of some administrative and financial support functions. The Court began using the NFC funds control automated system to automate its tracking of obligations and expenses. The Court continued the 5-year computer task plan to include development and expansion of automated systems to improve case management.

FISCAL YEAR 1994 PROGRAM

The increase in the Court's budget request from FY 1993 to FY 1994 reflected the continued funding of the Pro Bono Representation Program, offset in part by reductions in the Court's operating expenses. The Court's FY 1994 budget program includes:

1. Continued monitoring of caseload and workload data to respond to the constantly changing operating needs of the Court, and to improve case services to the public as well as to improve the Court's case management and processing efforts.

2. Continuation of contractual arrangements with the U.S. Marshals Service, the Department of Agriculture, and the NFC, for various required services such as security, contracting, and the processing of pay, personnel records, and financial documents.

3. Completion of the 5-year computer task plan to include development and expansion of automated systems to improve the management and processing of cases. Institution of an assessment process for a second five-year plan to address future computer systems and program development needs, and identification of systems improvements.

4. Contracting for necessary actuarial services in connection with the Judges' Retirement Fund.

5. Holding one hearing outside the Washington area.

6. Continuation of the Pro Bono Representation Program under a memorandum of understanding with Legal Services Corporation.

FISCAL YEAR 1995 BUDGET REQUEST

For FY 1995, the Court requests $8,733,000 to fund normal personnel and operating requirements. In addition, the Court requests $790,000 for continued operation of the Pro Bono Representation Program. The Court reduced staffing by 4-FTE positions from FY 1993 to FY 1994, a 4.6-percent reduction in the Court's overall staffing level. As previously discussed, no further personnel reductions are planned for FY 1995. The increase in the Court's FY 1995 budget reflects pay adjustments of a 2-percent cost-of-living increase for judicial and non-judicial staff, and a 2-percent locality-pay adjustment for eligible non-judicial staff. The FY 1994 base used to estimate personnel compensation assumed the 4.23-percent locality-pay adjustment for non-judicial personnel in FY 1994. Excluding rent, which increases by 3.4-percent, the Court's FY 1995 budget represents a 7-percent reduction from FY 1994 funding levels in the Court's administrative overhead.

There are no new or otherwise significant funding requirements in the Court's FY 1995 budget request. The Court will continue its functions as described in the attached summary.

SUMMARY OF FISCAL YEAR 1995 BUDGET REQUEST
(Costs in Thousands)

A summary of the FY 1995 funding requirements for conducting the Court's activities follows:

	1994	1995	Difference
Positions.....	83	83	-0-
Personnel Compensation and Benefits.....	$5,256*	$5,530*	+ $ 274
Subtotal	$5,256	$5,530	+ 274
Other than Personal Services	$3,113	$3,203	+ $ 90
Total	$8,369	$8,733	+ $ 364
Grants, Subsidies and Contributions ..	$ 790**	$ 790**	+ $ 0
Budget Authority/ Appropriation.....	$9,159	$9,523	+ $ 364

* The FY 1994 and FY 1995 compensation figures include an estimated Court contribution to the Judges Retirement Fund of $320,583 for FY 1994 and $295,000 for FY 1995.

** The Court is requesting $790,000 in FY 1995 to continue the funding of a Pro Bono Representation Program, pursuant to P.L. 102-229, through reimbursable payments to the Legal Services Corporation.

FISCAL YEAR 1995 PROGRAM CHANGES

The FY 1995 budget request of $9,523,000 represents an increase of $364,000 in funding from the FY 1994 operating requirements of $9,159,000. The Court includes $790,000 in its FY 1995 budget for the continuation of the Pro Bono Representation Program. This effort began in FY 1992 with $950,000, reprogrammed from the Court's FY 1992 appropriation with Congressional approval, for which multi-year availability was provided. The Court's FY 1994 budget continued to support the program with $790,000 from its FY 1994 appropriation to remain available through FY 1995. The Court's FY 1995 request also reflects necessary funds to continue Court functions as follows:

Personnel Compensation and Benefits:

Pay raises and a locality-pay using as a base an FY 1994 pay figure reflecting a locality-pay adjustment of 4.23 percent -- +$274,000

Other Objects:

Increases in rent and security officer services and decreases in other administrative and overhead expenses -- +$90,000

Grants, Subsidies and Contributions

No Change -- +$0

Total Changes: +$364,000

The following is a brief description of the changes from the FY 1994 Budget:

PERSONNEL COMPENSATION AND BENEFITS ..... **+$274,000**

The Court staffing level remains at 83 FTE for FY 1995. The request for personnel funding includes funding for a pay adjustment for nonjudicial staff and for judges, and a locality-pay adjustment for nonjudicial staff, in conformance with Office of Management and Budget economic assumptions. It also includes necessary funding for within-grade increases, promotions, and benefits. The base used to calculate FY 1995 personnel compensation was the FY 1994 compensation budget, including the 4.23-percent locality-pay adjustment for eligible personnel.

OTHER OBJECTS ..... **+ $90,000**

TRAVEL: (- 0 -)

Only one hearing outside Washington is planned for FY 1994, and that number is not expected to increase in FY 1995. Inflationary increases will result in reduced travel.

TRANSPORTATION OF THINGS: (- 0 -)

The Court budgets for no increase in the transportation of things in FY 1995.

RENTAL PAYMENTS TO GSA: (+61,000)

This increase is based on GSA estimates for FY 1995.

COMMUNICATIONS: (-39,000)

Court communication expenses have been less than anticipated.

PRINTING AND REPRODUCTION: (-12,000)

Costs associated with printing and circulating decisions have decreased since Court decisions are now published by West Publishing Company on a subscription basis. Purchases of Government Printing Office materials have decreased.

OTHER SERVICES: (+93,000)

This increase reflects inflationary increases in the costs of maintenance contracts for automation, security, and copy equipment, and of reimbursable agreements for security personnel and employee assistance/health services.

SUPPLIES AND MATERIALS: (-10,000)

This decrease reflects actual performance in prior years coupled with an effort to reduce discretionary spending.

EQUIPMENT AND FURNISHINGS: (-3,000)

This decrease reflects the fact that capital equipment and furnishing purchases are essentially complete and that the Court has a need for fewer new books for the library.

GRANTS, SUBSIDIES, AND CONTRIBUTIONS: (- 0 -)

The Court requests $790,000 for continued support of the Pro Bono Representation Program in FY 1995. This reflects no increase over FY 1994 funding.

UNITED STATES COURT OF VETERANS APPEALS

SALARIES AND EXPENSES

Program and Financing (in thousands of dollars)

		1993 actual	1994 estimate	1995 estimate
Program by activities:				
10.00	Total obligations	8,189	9,159	9,523
Financing:				
21.40	Unobligated balance available, start of year	...	-315	-315
24.40	Unobligated balance available, end of year	315	315	315
39.00	Budget authority	8,504	9,159	9,523
Budget Authority				
40.00	Appropriation	8,480	9,159	9,523
43.00	Appropriation Total	8,480	9,159	9,523
50.00	Reappropriation.....	24		
Relation of obligations to outlays:				
71.00	Total obligations	8,189	9,159	9,523
72.40	Obligated balance, start of year	1,652	1,229	1,766
74.40	Obligated balance, end of year	-1,229	- 1766	-1,919
90.00	Outlays	8,612	8,622	9,370

UNITED STATES COURT OF VETERANS APPEALS

SALARIES AND EXPENSES

Object Classification (in thousands of dollars)

		1993 actual	1994 estimate	1995 estimate
Personnel Compensation:				
11.1	Full-time permanent	3,960	4,079	4,325
11.5	Other personnel compensation	35	25	25
11.9	Total personnel compensation.....	3,995	4,104	4,350
Personnel benefits:				
12.1	Civilian personnel benefits.....	1,060	1,152	1,180
13.0	Benefits for former personnel.....	33	--	--
21.0	Travel and transportation of persons	70	40	40
22.0	Transportation of things..	1	10	10
23.1	Rental payments to GSA ...	1,732	1,776	1,837
23.3	Communications, utilities, and miscellaneous charges	59	139	100
24.0	Printing and reproduction.....	15	32	20
25.2	Other services.....	612	878	971
26.0	Supplies and materials ...	180	135	125
31.0	Equipment	422	103	100
41.0	Grants, subsidies, and contributions.....	10	790	790
99.9	Total obligations.....	8,189	9,159	9,523

UNITED STATES COURT OF VETERANS APPEALS

PRACTICE REGISTRATION FEES

This fund was established under 38 U.S.C. § 7285. The Court is authorized to collect a periodic registration fee not to exceed $30.00 per year from its practitioners. The Court's rules provide for assessment of this fee only upon a practitioner's initial admission to practice. The fund will be used by the Court to pursue disciplinary matters involving practitioners admitted to practice before the Court and to defray costs for implementing the standards of proficiency for practitioners.

UNITED STATES COURT OF VETERANS APPEALS

PRACTICE REGISTRATION FEE

Program and Financing (in thousands of dollars)

		1993 actual	1994 estimate	1995 estimate
Program by Activities:				
Financing:				
21.40	Unobligated balance available, start of year.....	-21	-28	-32
24.40	Unobligated balance available, end of year.....	28	32	36
60.25	**Budget authority (appropriation)** (special fund, indefinite)	7	4	4
Relation of obligations to outlays:				
71.00	Total obligations			
90.00	Outlays			

UNITED STATES COURT OF VETERANS APPEALS

COURT OF VETERANS APPEALS RETIREMENT FUND

This fund, established under 38 U.S.C. § 7298, will be used to pay retired pay to judges and annuities to surviving spouses and dependent children. Participating judges pay 1 percent of their salaries to cover creditable service for retirement annuity purposes and 3.5 percent of their salaries for survivor annuity purposes. Additional funds needed to cover the unfunded liability are transferred to this fund from the Court's annual appropriation. The unfunded liability is estimated annually by an accounting firm retained by the Court. The fund is invested in government securities.

UNITED STATES COURT OF VETERANS APPEALS

COURT OF VETERANS APPEALS RETIREMENT FUND

Program and Financing (in thousands of dollars)

		1993 actual	1994 estimate	1995 estimate
Balance, Start of Year:				
01.00	Treasury Balance.....	6	18	--
01.01	U.S. Securities: Par Value	1,000	1,316	1,655
01.02	Unrealized discounts.....	-20	-30	-30
01.99	Total Balance, start of year	986	1,304	1,625
02.00	Receipts	318	321	350
04.00	Total, excluding unrealized discounts.....	1,304	1,625	1,975
Balance, End of Year:				
07.00	Treasury balance.....	18	--	--
07.01	U.S. Securities: Par Value	1,316	1,655	2,015
07.02	Unrealized discounts.....	-30	-30	-40
07.99	Total Balance, end of year	1,304	1,625	1,975
Budget Authority:				
60.05	Appropriation (indefinite)	318	321	350
60.45	Portion precluded from obligation	-318	-321	-350
63.00	Appropriation	...	...	...

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Stephen L. Morgan, CCE
Executive Vice President

March 7, 1994

The Honorable G.V. Montgomery
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
335 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Montgomery:

The American Cemetery Association respectfully submits these comments regarding the proposed budget for the U.S. Department of Veterans Affairs for fiscal year 1995. In the past, we have presented our views as testimony before the House VA Subcommittee on Housing and Memorial Affairs. However, this year we have been informed that the Subcommittee will not be holding a hearing on the proposed budget.

The American Cemetery Association ("ACA") represents over 2,000 members including private, religious, and municipal cemeteries. For many years the ACA has expressed concern over plans to expand the National Cemetery System in the absence of studies projecting the significant long-term costs for maintaining gravesites in perpetuity. ACA has also expressed its opposition to the growing disparity in burial benefits between veterans choosing burial in national/state veterans cemeteries and those preferring private or religious cemetery interment.

The proposed VA budget for fiscal year 1995 seeks construction funds for a new national cemetery in the Seattle, Washington area. However, demographics provided by the VA itself shows a sharp decline in the interment rate after the year 2010. Yet the obligation to maintain all national cemeteries will be a perpetual one accompanied by ever-escalating labor and maintenance costs.

The ACA believes it fiscally irresponsible to fund the construction of new cemeteries without an established method of providing future maintenance, i.e., care trusts, short of sticking taxpayers with the bill.

The steady erosion of equitable burial benefit is also of great concern to the ACA. The 1990 Veterans Benefits and Services Reconciliation Conference agreement significantly curtailed the eligibility of veterans to receive the $150 plot allowance. In particular, wartime veterans who were not otherwise receiving VA compensation or benefits were no longer eligible for the plot allowance unless they are interred in state veterans cemeteries. The Conference agreement also eliminated the marker reimbursement allowance.

The justification given for these cutbacks was the need to reduce the federal deficit - at the expense of these relatively modest benefits. The curtailment of the plot allowance only resulted in the discrimination against veterans who choose to be interred in non-governmental cemeteries for personal, ethnic or religious reasons .

The VA has admitted as much. Last year, the VA Benefits Administration Chief of Staff, Mr. Harold F. Gracey, acknowledged this disparity before the House VA Subcommittee on Housing and Memorial Affairs. Commenting on a bill which would extend plot allowance payments to state veterans cemeteries which inter any veteran, Mr. Gracey stated, "...this modification of the eligibility criteria for the plot allowance would unfairly discriminate against peacetime veterans buried in private cemeteries, who are not eligible for a plot allowance, and would further exacerbate the existing disparity between veterans buried in state and private cemeteries." (Emphasis added). We understand that this proposed legislation (H.R. 951) was subsequently enacted into law.

The National Cemeteries Act of 1973, P.L. 93-43, created the National Cemetery System and became the basis for the current administration of veterans' burial benefits including the plot allowance and a $300 burial allowance. This law was carefully drafted to establish a balance between the obligation of the federal government to provide burial benefits and to respect the veterans' freedom of choosing a final resting place.

Thus, eligible veterans could choose between interment in a national or state cemetery, or where location, existing family burial sites, or ethnic and religious considerations were important factors, elect to receive benefits facilitating interment in private, religious, or municipal cemeteries. The Omnibus Reconciliation Act of 1981 abolished the $300 burial allowance to wartime veterans not otherwise receiving

compensation or pensions. The 1990 budget agreement, referenced above, continued the erosion of equitable burial benefits.

The ACA estimates that Congress has effectively disqualified approximately 70 percent of the veterans originally entitled to receive these burial benefits. We also believe that such discriminatory criteria may force a reliance on national cemeteries by some veterans which will ultimately drive up the overall cost of providing any form of burial benefits and place fiscal demands on the National Cemetery System which were never intended.

For example, the one-time payment of the $150 plot allowance served about 85 percent of veterans applying for burial benefits prior to its curtailment in late 1990. However, burial in national cemeteries entails an ongoing and continually escalating cost to the federal government and taxpayers to provide maintenance and related cemeterial services indefinitely. The anticipated cost savings through curtailment of the plot allowance wrongly assumed that affected veterans will not collect such benefits through a much more costly method of entering the National Cemetery System instead.

For these reasons, the ACA advocates the re-establishment of the plot and marker eligibility requirements to pre-1990 standards, and to restore funding for these basic veterans benefits in a fair, equitable manner. We believe such action will reduce the long-term operating costs of the NCS including the interminable expenses of maintaining in excess of one million gravesites in perpetuity.

We also recommend the formation of a blue-ribbon commission of government and private sector experts to study the issues involved in providing a fiscally sound veterans' burial policy prior to further expansion of the National Cemetery System.

Sincerely,

Stephen L. Morgan, CCE
Executive Vice President

SLM:mws

POST-HEARING QUESTIONS
HOUSE COMMITTEE ON VETERANS AFFAIRS
ASSISTANT SECRETARY FOR VETERANS EMPLOYMENT AND TRAINING
FY 1995 BUDGET
FEBRUARY 10, 1994 HEARING

1. In your personal opinion, is the funding for the Veterans' Employment and Training Service included in the Administration's fiscal year 1995 budget request adequate? Can you and your staff fully meet your obligations to our nation's veterans with this funding level?

In my opening statement at the February 10, 1994 hearing, I said that the "DVOP/LVER grants, JTPA IV-C grants, and VRR programs will be maintained at funding levels sufficient to support their integrity". As the person responsible for administering these programs, I wanted to assure the Committee that sufficient agency administrative funds would be available in FY 1995 to enable the VETS' staff to administer these programs. By that, I mean sufficient funds to conduct Employment Service office evaluations and follow-up reviews, conduct JTPA IV-C grantee reviews, and process grant applications and modifications and process veterans' reemployment rights cases.

The Transition Assistance Program (TAP) is the VETS' program most impacted by the agency's FY 1995 budget request. We would like to provide transition assistance to all eligible individuals separating from the military who seek these services; however, based on our current projections, the FY 1995 budget may result in a slightly smaller proportion of eligible individuals being served by TAP (43% vs. 46% in FY 1994). We are placing a greater responsibility on the State employment security agencies and our DVOPs and LVERs for delivering TAP workshops and we are reducing our reliance on contractors. However, military installations are not necessarily located near DVOP and LVER staff, so travel and other logistics may affect our ability to deliver TAP workshops to all who seek them. We will continue to explore various means of assuring that TAP services are available.

As we begin to reduce VETS' staffing levels as part of the government-wide downsizing effort now underway, we are in the process of reinventing the agency through the efforts of ad hoc committees. The committees are: the Disabled Veterans' Outreach Program/Local Veterans' Employment Representative (DVOP/LVER) Program Design Committee; the Job Training Partnership (JTPA) Title IV, Part C(IV-C) Committee; the Customer Surveys and Employer Participation Committee; the VETS Internal Review Committee; the Transition Assistance Program (TAP) Committee; the Automation Steering Committee; and the Training Needs Assessment Steering Committee. These committees are charged with developing better, more efficient ways of focusing VETS' available resources to accomplish our mission. Out of this process will come recommendations for internal organizational changes, realignment of staff, training needs, program and operational changes, and other improvements to enable VETS to do more for veterans despite budgetary constraints.

2. The President's budget request for disabled veterans' outreach program specialists (DVOPs) and local veterans' employment representatives (LVERs) does not comply with the statutory staffing-level formulas contained in chapter 41 of title 38. In fact, the President's budget would result in at least 400 fewer DVOP and LVER positions than would be provided under the Congressionally-mandated staffing level. Additionally, the Administration budget would reduce DVOPs and LVERs by 240 positions from the fiscal year 1994 level.

In recent years the duties of DVOPs and LVERs have increased significantly due to the downsizing of the military, yet the number of these veterans' employment specialists is decreasing.

Under the reduced staffing levels, what responsibilities will DVOPs and LVERs be unable to fulfill? How many veterans

will not receive the assistance they need and have earned? Which veterans will not be served?

We do not envision that the reduced staffing levels will change the duties or responsibilities of the veterans' employment specialists. It is our expectation that their efforts will be more focused on the veterans who most need the intensive services that DVOPs and LVERs are specially trained to provide. Those veterans who are job ready will have to be served by other personnel in the local offices. As you know, this Administration is proposing to increase the efficiency and effectiveness of the employment and training service delivery system by implementing the One Stop Career Center concept, by improving the programs for dislocated workers and by making available to the public high quality labor market information. Thus it is envisioned that all veterans will receive the assistance they need and to which they are entitled.

3. How will the reduced staffing levels affect the ability of DVOPs and LVERs to participate in the Transition Assistance Program (TAP)?

The number of DVOP/LVER staff available to the SESAs obviously is a factor in their ability to carry out increased TAP responsibilities. However, currently we estimate that less than 2% of the total DVOP specialist and LVER staff hours are expended in the conduct of TAP workshops. At this level of DVOP/LVER involvement in TAP support, there does not appear to be a significant impact from TAP on the overall workload and performance of the DVOP specialists or LVER staff. Thus, at the requested staffing levels, we will be asking some States to devote a slightly higher percentage of DVOP/LVER staff time to TAP activity. Additional facilitator training of SESA staff should be accomplished by the end of FY 1995, which should enhance the ability of more DVOPs and LVERs to participate in TAP.

4. In budget documents provided to the Committee, you stated that 350 fewer TAP workshops will be conducted in fiscal year 1995 than in fiscal year 1994.

How many separating service members will be unable to take advantage of TAP training because of the reduction in workshops? Is there any evidence that the need or demand for TAP training has diminished?

We anticipate that 15,000 fewer separating service members will be able to attend TAP workshops in FY 1995 as compared with FY 1994.

The demand for TAP workshops--as measured by gross estimates of the numbers of separating service members--will be diminished by a similar amount in FY 1995, with 300,000 service members projected to separate as compared with 317,000 in FY 1994.

It is also important to note that TAP attendance is voluntary. Some servicemembers choose not to participate in TAP because they already have a job waiting upon discharge, are retiring and not seeking a job, or for a host of other reasons. In FY 1994, we expect to serve about 145,000 individuals in TAP, about 46% of those separating. There are admitted difficulties in serving all who would like TAP assistance. The primary difficulty is in serving those servicemembers stationed overseas or on board ships. Many are discharged directly from those duty stations; others are discharged in the continental United States but are separated within such short time of arriving Stateside that they do not have an adequate opportunity to participate in the Department of Labor's TAP. In addition, individuals assigned to smaller bases in the United States may not have the opportunity, prior to separation, to travel to larger bases where DOL TAP is currently offered.

For these reasons, we are not able to provide transition assistance to all we would like to help even in the best of circumstances. We are now working with the Department of Defense and the Department of Veterans Affairs to determine if there are other ways of providing at least some TAP services to these servicemembers who do not attend the workshops.

One alternative method already developed for delivering TAP assistance is a set of six videotapes and an accompanying workbook developed last year by VETS through the National Veterans' Training Institute (NVTI). We believe that anyone who uses the interactive workbooks in conjunction with these videos would acquire most, if not all, of the information and skills he or she would obtain if able to attend a workshop in person. These videos and the workbook were delivered to the Department of Defense at the beginning of FY 1994 for their internal distribution.

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