DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2002

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

MARCH 6, 2001

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DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2002

TUESDAY, MARCH 6, 2001

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

The committee met, pursuant to notice, at 1 p.m., in room 334, Cannon House Office Building, Hon. Chris Smith (chairman of the committee) presiding.

Present: Representatives Smith, Stump, Bilirakis, Stearns, Moran, Gibbons, Baker, Simmons, Crenshaw, Evans, Filner, Brown, Peterson, Reyes, Snyder, and Hill.

OPENING STATEMENT OF CHAIRMAN SMITH

The CHAIRMAN. The hearing will come to order. Good afternoon to everybody and on behalf of the Veterans' Affairs Committee, I want to welcome all of our witnesses to our hearing today, interested guests, the media, and C-Span, for its broadcast of our proceedings.

The hearing on the budget is one of our committee's most important functions. We have usually worked in a bipartisan manner to address budget needs for veterans' programs.

When there were deficits as far as the eye could see, we worked together to present the best advice and the best document we could possibly produce on what was needed, and I am confident that we will do no less today.

This year's budget hearing is reminiscent of the hearings we had in 1993 and 1989, both presidential transition years.

Despite the absence of the usual specific information about how the proposed budget for the Department of Veterans Affairs would affect ongoing programs, we are required by the Rules of the House and the congressional budget process to present our committee's views no later than March 12, which is next Monday.

Fortunately, we know what issues must be addressed in this hearing—for example, the aging and seriously ill veterans who require world-class health care services, and the hundreds of thousands of pending disability compensation claims that must be addressed. We must continue to honor those who have died, out of respect for the veterans themselves, their families, so that future generations may learn of their faithful service.

Mr. Secretary, your appointment begins a new chapter. However, you will be asked to address some of the problems which your predecessors did not solve.

The most serious problem is one of accountability. The Congress has been careful to assure that veterans programs are adequately funded. Even when the funds were not included in the President's request, Congress has often, but not always, stepped in and provided what was needed.

In accepting these resources, administrators throughout the Department have found reasons not to apply them to the purposes for which they were provided.

I am talking specifically about funds to provide long-term care, care for veterans with Hepatitis C, chronic mental illness, and spinal cord injuries. This is a very serious breach of their obligation to faithfully carry out the laws which Congress enacts.

I would point out that the Vietnam veterans in their testimony make an interesting observation. Richard Weidman, says the so-called specialized care services at VHA, that is to say, spinal cord injury, blind and visually impaired services, post-traumatic stress disorder programs and services, have all been dramatically eroded in the past 5 years.

When the Veterans' Eligibility Reform Act was enacted in 1996, Congress mandated that the level of resources and the capacity to deliver the specialized services, which is really the heart of the VHA mission, be maintained at least at the fiscal year 1996 level of effort.

That has not happened, he goes on to say. Rather, such services have been diminished and truncated due to both lack of resources and a poor job of emphasis on these programs by key managers at the Veterans Health Administration, at the local care delivery level, and the Veterans Integrated Service Network level, and at the national level. He will testify later on today.

Over the next few months, I believe we will have additional hearings that will make some of these administrators uncomfortable, particularly those who have closed nursing home beds or spinal cord injury beds in defiance of both the spirit and the letter of the law requiring the Department to maintain a minimum number of these beds.

Mr. Secretary, the World War II generation is popularly known, as you know so well, as "the greatest generation." Yet this committee has evidence that VA health care administrators are closing nursing home care beds and otherwise curtailing access to the long-term care services these veterans desperately need.

One of the reasons cited for these actions is that there isn't enough money to maintain these services. This is simply not true.

I appeal to you to adopt a firm policy. We all know you've only been on the job for a very short period of time. But we appeal to you to adopt a firm policy on this issue, to honor their sacrifice, and to comply what law that requires the Secretary to ensure these services do not fall below the 1998 level.

As I said at the outset, the President's budget has few details, and that I know will be forthcoming, but it is easy to discern that it's a very tight budget, perhaps a little too tight in some areas.

However, I like to think of it as a work in progress. Choosing the programs deserving an increase is indeed a difficult task, and it is made complicated if a program has been ignored or its funding slashed for several years in a row.

That is why I'm very pleased to say that Mr. Evans and I have introduced H.R. 801, the Veterans' Opportunities Act of 2001 and H.R. 811, the Veterans' Hospital Emergency Repair Act last week.

The VA has a long list of buildings that it knows are seismically unsafe, including several that suffered damage last week in the Seattle area. Yet OMB has squelched funding for repairs and strengthening. The Emergency Repair Act would authorize funds to be used at the Secretary's discretion for these types of vital and much overdue projects.

Similarly, the benefits for families of veterans who died of a service-connected cause have not been raised in many years. The Veterans' Opportunities Act sends the message that we care about these veterans and their families.

In the next week or so, I will be asking all of my colleagues to join me in introducing a bill which will substantially increase payments to veterans attending school under the Montgomery GI Bill. By their faithful service, these veterans earned a decent chance to improve their prospects in life.

We will need to make the funds, or find the funds, Mr. Secretary, to make these proposals a reality, and I know personally how near and dear the Montgomery GI Bill is to you on both a professional and a personal level.

Together, we can make this budget, this work in progress, something that we all can be proud of.

Let me also note here that there has been a tremendous change in the VA in the last few years—with the bad, there's always much good—particularly in its health care system, and we need Members to understand that this change has been mostly for the better.

In testimony he will present later on, Jim Fischl, the director of the Veterans' Affairs and Rehab Commission for the American Legion points this out, and I quote him in part, and he has challenges and some criticism in his testimony, obviously, but he points out that change within the VHA over the past several years has been the results of a series of small steps.

The American Legion acknowledges that the progress made within the VHA has been extraordinary.

Mr. Secretary and members of the committee, we all know that the Veterans Health Administration is often depicted as inefficient and inaccessible to all but a few veterans. That's a myth. It's simply not true.

In the past few years, the VA has opened more than 300 community-based outpatient clinics, and veterans recently responded to this effort by rating the VA 10 points higher than private sector hospitals in an independent customer satisfaction survey.

Veterans are seeking VA health care in record numbers—they're voting with their feet, in other words—with more than 3.6 million receiving care last year, a 15 percent increase over the number in 1997.

At the same time, the VA has reduced the average cost per patient by 16 percent compared to 2 years ago.

While the media always reports incidents in which the VA has failed to treat patients—and there are those instances—the VA is using technology and changed procedures to lead the Nation in efforts to prevent medical errors.

Examples include a bar code system for medications and electronic entry of prescriptions to overcome illegible handwriting.

The VA has also substantially exceeded national standards for disease prevention and early intervention so that hundreds of thousands of veterans diagnosed with diabetes, heart disease, or mental health problems are receiving better care than they would receive from most private health care providers.

Few recognize that the VA is the Nation's largest single provider of care for patients who are infected with HIV. Almost 50,000 veterans and their families know well how the VA delivers this care.

VA has also recently established two centers of excellence to deal with the increased incidence of veterans infected by the Hepatitis C virus.

It sometimes, as we know, took hours to complete a phone call to the Veterans Benefits Administration, but a focus on this problem has reduced the rate at which callers get a busy signal from 52 percent to just 3 percent in less than 3 years, while the number of veterans who hang up before reaching the VA representative has been cut in half.

VA has also established 31 outpatient claims processing centers at military discharge centers, resulting in rapid decisions on disability claims for tens of thousands of new veterans, and I want to thank Joe Thompson for his great work in this regard.

We've seen a gradual expansion of the VA National Cemetery system, and we're looking for the opening of six new cemeteries in the next several years.

Annual interments have increased by 41 percent over the last 10 years, and there are projected to be 88,000 interments this fiscal year, while the number of employees has only grown by about 17 percent. The VA also has provided funds so that 11 new State veterans' cemeteries will open by the end of this year.

Improved management of the VA's home loan and insurance operations has led to the same or better service with almost 20 percent fewer staff.

Although there is still much to be done, and I wouldn't quite call it "e-loans" yet, the VA is increasingly using electronic means to gather and process benefit applications to speed up decisions that have taken longer than they should.

Probably the least-appreciated improvement over the last several years has been the increased attention on measuring how veterans perceive the services that VA provides and what effect these benefits have on their lives.

While it may be several more years before there are real "outcome-driven" budgets, the backbone of the VA management structure is incorporating performance measures at a rate that is perhaps unsurpassed in the rest of the Federal Government.

Mr. Secretary, you know as well as I do about the compassion and devotion of many of our VA employees, and we recognize their spirit of service and their zeal for improvement.

People make the difference in much of what the VA does, so we'll do whatever needs to be done to ensure that we continue to attract and retain dedicated employees to serve our Nation's veterans.

[The prepared statement of Chairman Smith appears on p. 71.]

The CHAIRMAN. I would like to yield to my good friend and colleague, the gentleman from Illinois, Mr. Evans.

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. EVANS. Thank you, Mr. Chairman. Again, this week I'm agreeing with you and associating myself almost 100 percent with the remarks that you've made.

I appreciate your leadership on this issue, and I look forward to the testimony of our Secretary of Veterans Affairs, Tony Principi.

I have had the pleasure of meeting with the Secretary several times since we've been back in session, and your accessibility is the best I've ever seen out of any Cabinet-level official.

You've got great enthusiasm, and I know you're committed to improving the delivery of benefits and services to our veterans. You're going to be a great Secretary of Veterans Affairs.

Mr. Chairman, you have said on more than one occasion that the budget proposed by the administration for VA next year is a foundation, a beginning. You have clearly indicated a willingness to consider recommending added resources if needed. I welcome your willingness to do so.

I believe everyone in this room believes that the $1 billion increase in discretionary spending proposed next year for VA is fundamentally inadequate. With your leadership, we can recommend additional funding to better serve the veterans of our country.

The proposed administration budget contains few details, but I expect the testimony of the Secretary will provide us additional information.

I also want to thank the organizations which have prepared the Independent Budget for the detailed assessment and recommendations they have provided. I look forward to their testimony, as well, to be presented on behalf of the American Legion and the Vietnam Veterans of America.

Again, Mr. Chairman, thank you for your leadership in holding the hearing today.

The CHAIRMAN. Thank you very much, Mr. Evans.

I'd like to now introduce our very distinguished Secretary for Veterans' Affairs, Anthony Principi, and let me just very briefly introduce him to the committee, although most of us know him and have known him for a number of years.

He is the fourth Secretary of Veterans Affairs, and he is accompanied by his staff, who have appeared before this committee on numerous occasions. This is his first appearance as Secretary before our committee.

Prior to becoming Secretary, Mr. Principi undertook the task of chairing a distinguished group looking into the future of benefits for servicemembers leaving service.

It was a diverse and experienced group that comprised the Commission on Servicemembers' and Veterans' Transition Assistance, but Mr. Principi was able to put together a number of meaningful recommendations for change which were adopted unanimously by the Commission.

Mr. Principi is a U.S. Navy veteran who served as an officer in Vietnam. He is a 1967 graduate of the U.S. Naval Academy and first saw active duty aboard the destroyer the USS *Joseph P. Kennedy*. He later commanded a river patrol unit in the Vietnam Mekong Delta.

He earned his law degree from Seton Hall University in 1975 and was assigned to the Navy's Judge Advocate General Corps in San Diego, California.

In 1980, he was transferred to Washington as a legislative counsel for the Department of the Navy.

Mr. Principi has served as the staff director of the Senate Committee on Veterans' Affairs, so therefore he knows very well how this process occurs, and as deputy secretary and acting secretary of Veterans Affairs in a prior Bush administration, that of the father of our current President.

He has private business experience as well as Capitol Hill experience, and has demonstrated a life-long commitment to honoring the service of America's veterans and their families.

Mr. Secretary, you're very welcome to the committee. We look forward to your testimony.

STATEMENT OF HON. ANTHONY J. PRINCIPI, SECRETARY OF VETERANS AFFAIRS; ACCOMPANIED BY: JOSEPH THOMPSON, UNDER SECRETARY OF BENEFITS, VETERANS BENEFITS ADMINISTRATION; MARK CATLETT, ASSISTANT SECRETARY OF MANAGEMENT; THOMAS GARTHWAITE, UNDER SECRETARY OF HEALTH, VETERANS HEALTH ADMINISTRATION; AND ROGER RAPP, ACTING UNDER SECRETARY FOR MEMORIAL AFFAIRS

Secretary PRINCIPI. Thank you, Mr. Chairman. Thank you for those very kind remarks.

Mr. Chairman, Mr. Evans, members of the committee, it's a great privilege to be back before the committee.

I commit to you that one of the hallmarks of my tenure as Secretary will be to work very, very closely with each and ever member of this committee and your staff, as we work to improve the benefits and services for those who have richly earned them.

I am pleased to have with me today members of our senior leadership: Mr. Joseph Thompson, Under Secretary of Benefits, the Veterans Benefits Administration; Mr. Mark Catlett, Assistant Secretary of Management; Dr. Thomas Garthwaite, our Under Secretary of Health, Veterans Health Administration; and Mr. Roger Rapp, Acting Under Secretary for Memorial Affairs.

Thank you for inviting me to discuss the President's fiscal year 2002 budget proposal for the Department of Veterans Affairs.

As you know, the President released his budget blueprint last week. We will provide you with information regarding all of the specific funding levels for each of our programs as soon as possible, but certainly no later than early next month. At that time, I will address the details of our overall request.

Today, however, I will discuss VA's overall budget request and our priorities for the next fiscal year.

Our Department is requesting more than $51 billion for veterans' benefits and services; $28.1 billion for entitlement programs; and

$23.4 billion for discretionary programs, such as medical care, burial services, and the administration of veterans' benefits.

VA's budget increases our discretionary funding by $1 billion, or 4.5 percent over the fiscal year 2001 level. Along with an increase in medical care collections of approximately $200 million, our total increase in funding is $1.2 billion, or 5.3 percent more than fiscal year 2001.

Our budget ensures that veterans will continue to receive high-quality health care, that we will keep our commitment to maintain veterans' cemeteries as national shrines, and that we will have the resources to tackle the challenge of providing veterans with more timely and accurate benefit claims determinations.

President Bush has promised a top-to-bottom review of our benefits claims processing. It is a key budget initiative for our Department, and certainly one of my top, top priorities. We must restore the confidence of veterans who have lost faith in VA's ability to fairly and promptly decide their benefit claims.

Mr. Chairman, VA is not completing work on benefits claims in as timely a manner as our veterans deserve. This budget, I believe, will rejuvenate VA's efforts to process compensation claims promptly and accurately.

It will allow us to implement new legislation that strengthens VA's "duty to assist" role to help veterans prepare their claims, and it will enable us to carry out the new policy of adding diabetes to the list of presumptive conditions associated with exposures to herbicides.

Our funding will allow us to establish a task force that will address claims processing issues and develop hands-on practical solutions to the problems we face, and it will allow the Veterans Benefits Administration to consolidate its aging data centers into VA's core data center in Austin, Texas. This an important step in realizing our vision for the future.

For veterans' health care, our budget request reaffirms our primary commitment to provide high-quality medical care to veterans with service-connected disabilities or low incomes.

VA provides comprehensive specialty care that other health care providers do not offer, such as services related to spinal cord injury, post-traumatic stress disorder, prosthetics, and addiction programs. I am proud of our accomplishments in the area of specialty care and will insist on full funding to continue our leadership role in these areas.

We recognize the need to improve access to health care for eligible veterans. The budget supports the President's recommendation for a health care task force, which will make suggestions for improvements in this area.

The task force will be made up of representatives from VA and the Department of Defense, service organizations, and the health care industry.

This budget request also ensures that our national cemeteries will be maintained as shrines, dedicated to preserving our Nation's history, nurturing patriotism, and honoring the service and sacrifice of our veterans.

We will use available funds to renovate gravesites and cemeteries throughout the Nation, and to clean, raise, and realign headstones and markers.

Mr. Chairman, our 2002 budget is not simply a request for additional funding. It also reflects opportunities for cost savings and financial reform.

VA will do its part to ensure that we use our limited resources as efficiently as possible while maintaining the highest standards of care and service delivery.

The National Defense Authorization Act for Fiscal Year 2001 established a new Department of Defense benefit for military retirees over the age of 64 who have Medicare coverage. These retirees will be able to use their own private doctors for free care and will receive a generous drug benefit.

Currently, 240,000 of the some 550,000 of these retirees are enrolled in VA's health care system. Our budget assumes that 27 percent of them will switch to the DOD benefit in 2002, which will shift $235 million in VA medical liabilities to the Department of Defense.

This recent legislative change underscores the critical need for better coordination between VA and DOD and, I might add HHS, as well.

This administration will seek legislation to ensure that DOD beneficiaries who are eligible for VA medical care can choose only one of these agencies as their health care provider. We will work with DOD to avoid duplication of services and to enhance the quality and continuity of care each agency provides.

Restructuring efforts in our health care system will also continue in 2002. VA has begun an infrastructure reform initiative that will enhance our ability to provide health care to eligible veterans living in underserved geographic areas.

We will be able to redirect funds from the maintenance of underused facilities to patient care with savings from this effort.

As we await the results of this assessment, referred to as "CARES," we will continue to expand our sharing agreements and contracting authorities with other health care providers.

Our budget also includes legislation for several proposals that will yield mandatory savings totaling $2.5 billion over the next 10 years. Most of these proposals will extend previously enacted mandatory savings authorities that would otherwise expire over the next several years.

Finally, we will continue to reform our use of information technology. New technology clearly offers VA opportunities for innovation. It also offers a means to break down the bureaucratic barriers that impede service delivery to veterans, divide VA from other Federal Government departments, and create inefficiencies within VA itself.

I will not initiate any new technology related activities until an integrated strategy for addressing our information systems and telecommunications is developed.

We will continue to improve coordination among our three administrations in this area. Is it vitally important that we do so.

We will initiate reforms, including developing a common architecture, establishing common data definitions, and coordinating information systems across VA.

Mr. Chairman, that concludes my overview of VA's 2002 budget request.

I might add and reinforce some of the statements you made, that although I recognize we have enormous challenges ahead, I also want to point out, as you have, the enormous accomplishments that have taken place at the VA over the past several years: pre-separation activities, which clearly reduce the time it takes to rate a claim of a servicemember who is leaving the military; some of the quality and patient safety improvements that are taking place in VHA.

There are very many exciting initiatives that are ongoing, that will improve the services and the benefits to our Nation's veterans, and at the same time, we do have challenges that we need to address, and I'm confident that we are prepared to address them and will do so over the next 4 years.

But there's an awful lot to be proud of. This agency provides an awful lot of good to an awful lot of deserving veterans, their families, widows, and orphans.

Thank you and the members of this committee for your dedication to our Nation's veterans. Clearly, my department could not do it without you, the support that we have received from this committee and from the veterans' service organizations working with us as partners.

I certainly look forward to working with you. At this time, my staff and I will be pleased to answer any questions.

I have asked my senior staff to remain for the entire hearing, to hear the testimony of the veterans' service organizations.

I think we need to know their position, and recommendations on how we can improve service to our Nation's veterans, so all of our administrations and staff officers will be represented here during the balance of the hearing.

Thank you, Mr. Chairman. Thank you, Mr. Evans.

[The prepared statement of Secretary Principi appears on p. 76.]

The CHAIRMAN. Mr. Secretary, thank you for your excellent testimony.

[Applause.]

The CHAIRMAN. We also know that, since the moment you undertook this important position, you have been fighting the good fight within the Administration, especially vis-a-vis OMB. We all know every Secretary has a devil of a fight with that agency, and we know that you didn't get all that you wanted.

We ourselves, in looking at the Independent Budget that has been put out by the VSOs, which has gotten more exact, and I think more credible as time has gone on, because they can justify numbers.

We will be looking to very significantly ratchet up the amount of money based on need, not on politics, not on anything but need and how we can justify those funds.

But I know that you will be a very faithful steward of all of the money and all of the policies that are entrusted to you, and we know you have already fought the good fight with OMB.

We will be operating under, as I just said to my colleagues, the 5-minute rule, and it applies to the Chairman as well. We will go for a second round, because we do have a good attendance here today of members who want to speak to you.

I pointed out in my opening statement that the Congress is very concerned about the erosion of VA's long-term care capacity.

In 1998, the VA had an average daily census of about 13,400 veterans in VA-operated nursing home beds. The President, as you know, signed a law in 1999, which requires the VA to maintain that level of service.

Yet it appears that right now the VA is treating 13 percent fewer veterans.

Can you explain what you plan to do about this situation?

Secretary PRINCIPI. Yes, certainly. I certainly recognize the importance of long-term care, you know, extended care, and the various ways to provide it to an aging veteran population.

Clearly the World War II population, as well as my own generation, the Vietnam era veterans and Korea are certainly approaching the 60–65 year point, so the VA is ahead of the curve in our society with regard to the percentage of aging veterans compared to the private sector, the non-veteran sector, if you will.

Yes, the number of nursing home beds have declined from about 13.3 thousand to about 11,000, but at the same time, the number of veterans we have cared for, either through extended care beds or non-institutional settings has increased.

The number of veterans cared for has jumped from 53,000 in 1998 to 82,000 in 2001. That's the estimated number of veterans who would be cared for either through a VA nursing home, a State nursing home, non-institutional hospital-based home care and, respite care, adult day care.

So I think as the VA transitions, if you will, from a hospital-based system to a veteran-focused system, I think we're looking for other ways to provide that care.

Tom, could you please—anything you might add.

The CHAIRMAN. I thank you for that explanation. Let me ask you about an issue that many of us have become increasingly concerned about, and that is Alzheimer's disease.

One of the untold stories of the VA is how well it is at least attempting to mitigate some of the pain of Alzheimer's patients and their families. If my understanding is correct, there are about 600,000 veterans who are being treated with Alzheimer's out of the 4 million patients currently in the United States.

The Bedford Division of the Boston Geriatric Research, Education and Clinical Center, the GRECC, has what seems to be a model program.

The Dominici Special Care Units, the DSCUs, as they're called, from what I've been reading and learning about, are a model for the rest of the VA and maybe even the country.

Last Congress, Ed Markey and I formed an Alzheimer's caucus and we've been trying to ratchet up the amount of money that's being focused for NIH spending. What we have not focused on sufficiently, is what the VA is doing and can do, and hopefully the committee can also do more in this regard during this Congress.

If you could speak to the Bedford model and what plans are foreseen for Alzheimer's.

Secretary PRINCIPI. May I have Dr. Garthwaite, please?

The CHAIRMAN. Yes, Dr. Garthwaite.

Dr. GARTHWAITE. Mr. Chairman, while I was in Bedford several months ago to give them an innovations award for the work they're doing in a homeless program, I had an opportunity to walk through the Alzheimer unit there.

It is a remarkable unit, for a couple of reasons.

First of all, it maintains a home, family-like atmosphere in terms of the amenities and the physical surroundings, but in addition to that, the staff is trained, dedicated, and proactive about working with families in dealing with the desire of the families for aggressive treatments for medical illness, should that occur.

Often, we promote—in all of our units—the development of advance directives, but that requires a special education and sensitivity among our staff members to work with families to make sure that we understand their needs and desires with regards to how aggressively we should treat their loved ones if they become acutely ill.

The evidence, the early evidence from reports they've put into the medical literature would suggest that this is very beneficial for the families and the relationship with the families, and overall tends to save money.

It tends to save money because we send the patients for acute care less often, but that's right in direct correlation to what the patient's family wants.

So we're very interested. The reason we have GRECC's is to learn about new models of care and then to export those across the country, and we're going to be taking a good, hard look at it to see whether this is a model that we could replicate.

The CHAIRMAN. Thank you very much, Dr. Garthwaite. Members of the committee and I will look forward to working with you as we go forward.

On the issue of specialized programs, which I mentioned earlier, and the September 30 date that we're supposed to at least meet, could you address briefly, and perhaps during the course of this hearing elaborate even further, on what can be done to beef up what we're doing for the spinal cord victims and the others who seem to have been significantly disadvantaged by the cuts over the last 5 years?

Secretary PRINCIPI. As a general proposition, Mr. Chairman, I believe strongly in the specialized programs. I think the VA has been a leader, from spinal cord injury to blind rehabilitation to PTSD to Alzheimer's to drug and alcohol abuse programs, across the spectrum.

That's where we can really make a difference in health care in this Nation, because we do it better, and in some cases we're the only ones who are out there really, really undertaking these important specialized programs.

I read the Millennium Act. I know what your mandate is. You want us to make sure we have the capacity there. I think in just about all categories we have, in fact, improved, increased the number of patients who are treated, and increased the dollars.

One area we are a little concerned about is the substance abuse programs. We've seen a 12 percent decline there. We need to address that.

There has been a shift from inpatient to outpatient care, which accounts for part of that. We've seen a dramatic increase in homelessness programs, increased 40 percent, and serious mental illness has increased dramatically, as well.

We think some of that workload is being reflected in those categories.

But I agree with you. They're important. You have spoken on the issue, and we'll make sure that the mandate of the Millennium Act is complied with.

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

Mr. EVANS. Thank you, Mr. Chairman.

Mr. Secretary, I believe that you personally supported comparability between educational benefits today that would be comparable to veterans returning from World War II.

What improvements in GI Bill education benefits has the administration included in its proposed budget for veterans?

Secretary PRINCIPI. Sir, there are none. Let me speak to the issue.

I have been an advocate, as you well know, for improved GI Bill benefits. I think it's one of the best benefits we can provide to active duty men and women leaving the service, for them to succeed in this modern information technology age. The opportunity to get the best education possible, I believe, is one of the finest benefits we can give to them.

I believe, just as the World War II GI Bill built a modern America, a generation of leaders that propelled America to greatness, I think we could do the same thing in this new century.

So, I am a strong advocate. Obviously, some of the recommendations I strongly propose pertain to the Department of Defense and not just to VA with regard to increasing educational benefits.

In the 5 weeks that I've been Secretary, we have not had the opportunity, sir, to really address educational benefits in this budget, but I intend to do so.

I intend to work closely with the committee and with the Executive Branch, and with my counterparts at Defense and OMB, and with the President, to see what we can do to improve educational benefits, to look at some of the modern trends in education so to allow accelerated payments and transferability. Some of those issues I believe, really need to be addressed.

But, sir, quite honestly, in the first few weeks of this new administration, I haven't had that opportunity, but I intend to do so.

Mr. EVANS. The administration has proposed a $1 billion increase in appropriations for discretionary spending for the next fiscal year. The Independent Budget has proposed a $3.5 billion increase in discretionary spending for the VA for the next fiscal year.

Which of these proposals for increased discretionary spending do you support?

Secretary PRINCIPI. I'm sorry, sir?

Mr. EVANS. Which Independent Budget—I'm sorry— proposal for discretionary spending do you oppose?

Secretary PRINCIPI. I know it's not clearly, not nearly as high as the Independent Budget, and I applaud the veterans' service organizations for laying a benchmark on the table for all of us to consider.

I am gratified with the $1 billion increase in discretionary spending. I believe it is a healthy increase.

I don't know if there's a Cabinet Secretary who would say that they're happy, they would not want more resources to help them get the job done.

Based upon where I started and where I wound up, I am pleased. I believe, most importantly, that this budget will allow us to provide high-quality health care to veterans who seek care from us.

It will give us the resources necessary to allow us to begin the process of bringing down this enormous backlog of claims, which is growing out of control, as we all know.

So it's certainly, I believe, a budget that I can work with, my under secretaries, and whole team can work with; and we'll do what we can to make it go as far as possible.

I also believe that we need to do a better job in medical care cost recovery. You've given us the right to retain those dollars in the VA medical care system, and every dollar we leave on the table, that we don't collect because of poor management or whatever the case might be, is a dollar that doesn't go to VA health care, and to me that's unacceptable.

You know, we've been at this now for over 10 years. I just believe that we haven't quite got it right. It's something that was never part of our core mission, never part of the culture, the institution of the VA, and we simply have not been aggressive enough in collecting the dollars.

We need to look to a new model as to how we can improve our cost accounting systems that allow us to bill and collect those dollars from third party insurers.

So I think that's part of it.

I do believe, you know, we're collecting about $600 million now, which is, you know, in addition to the budget that we have before us. I believe we can collect another $200 million, as well.

Mr. EVANS. Thank you, Mr. Chairman.

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

OPENING STATEMENT OF HON. BOB STUMP

Mr. STUMP. Thank you, Mr. Chairman.

Let me commend you, Mr. Chairman, for the job you've been doing as our new chairman, in getting us underway.

Mr. Secretary, congratulations to you. You did a fine job under a previous administration, and I would hope you will do the same, and I think you will, with this administration.

Secretary PRINCIPI. Thank you, Mr. Stump.

Mr. STUMP. Let me commend you also for the recent job you did in chairing up our Transition Commission, a very fine job.

I've forgotten the term you used, exactly, a while ago when you said something about our claims processing, but to me it borders on the edge of being a complete disaster, and I think most of the people in this room have to admit that.

It would be my hope, at least, that this will be one of the first things that you focus in on, because it's just almost totally unacceptable, the number of claims that we're processing over there.

If it takes money or if it takes personnel, I know this committee is ready to help, but we need to do something and do something desperately.

Thank you, and thank you for your statement.

Secretary PRINCIPI. Yes, sir, and I certainly agree with you about the claims issue. It is at crisis levels, I believe, and we are going to begin to take steps immediately to bring that backlog down.

It's the highest priority I have right now as Secretary of VA, to reduce that enormous backlog down to workable levels.

My goal over the next several years is to get it down to 250,000, an inventory of 250,000 claims that would allow us to maintain the timeliness of about 3 months. I think that's a reasonable period of time within which a veteran should have to wait to get an evaluation and get a rating on that claim.

But waiting at current projections of 600,000 claims and almost 9 months or more to have a claim evaluated, is way too long, and we're going to work on that.

Mr. STUMP. Thank you, sir.

The CHAIRMAN. Mr. Stump, thank you, and as former Chairman of the Veterans' Affairs Committee, again let me commend you and thank you for the great leadership job you provided us and continue to provide as Chairman of the Armed Services Committee.

I'd like to recognize Collin Peterson, the gentleman from Minnesota.

OPENING STATEMENT OF HON. COLLIN C. PETERSON

Mr. PETERSON. Thank you, Mr. Chairman, and Mr. Secretary, welcome to the committee, and I look forward to working with you.

I don't know if I have a question, exactly. I want to follow on what former Chairman Stump was talking about.

I just was back home recently, and had some veterans' meetings in my district, and came away, I guess, more than a little bit concerned about what I'm hearing.

I know you fought the fight and tried to get the resources that you need, but frankly, I really have to wonder whether the additional billion dollars that's been allocated is going to be adequate, given what I heard out there in these meetings that I had in my district.

First of all, I want to say that one of the positive things is these outpatient clinics have been very successful. In a rural area like mine, where we got huge distances, it's helping, and we're looking forward to getting some more of those established out there. It's been a very positive thing, and probably the most welcome of anything that's happened.

But within the other areas, the health and hospital area, you know, we've been hearing about waiting periods, but it seems like it's getting worse.

Every time I go out and have meetings, every 6 months, it seems like I'm hearing stories that the wait is taking longer, or the waiting periods are getting longer in all these different hospitals, and I don't know how we get this turned around.

In our particular VISN, you may or may not be aware, but I guess because of this VERA funding or whatever, we've been getting very small increases and other areas have been getting larger ones. I don't have anything against the other areas. I'm sure they have these needs.

But what's been happening out our way is we've been seeing the waiting periods extending in the hospitals, and we had to get some kind of an emergency appropriation the last couple years to keep operating, and now we were told, as I understand it, that out of the 40-some million that we got this time, that 31 million was considered to be a loan, and that somehow or another we have to pay this back.

And frankly, looking at what's going on there, I don't have any idea how we're going to be able to pay this back, and you know, do anything about these waiting periods.

So, you know, I'm probably not telling you anything that you haven't heard before, but I'm concerned about it, obviously.

The other thing I keep hearing about out there is these patient service lines, whatever they're called, which I had some questions about when it was set up.

You know, I come from an area where we have these huge distances, from Fargo to Minneapolis to Rapid City, and from what I'm hearing out there, they're spending a lot of time.

Your manager is traveling around trying to meet, and I think you're spending more money trying to make this thing work than you're saving, with any administrative, you know, streamlining or whatever is happening with that.

So I would hope you would take another look at it.

I'm hearing, in the claims area, the same thing that Representative Stump was saying, that we're now over 9 months in all of the areas.

It used to be 30 days, according to the people out in my area, and they're saying that the only way they can see that this is going to be improved is if we get more personnel out there to process these claims. Again, I'm not sure if there's adequate money in this budget to do that.

The other thing that concerned me is that apparently there's an effort in putting some of these forms on the Internet or putting them into electronic form, ostensibly to, you know, save money, I guess.

But what I was told is that these new forms you've come out with are horrific and are discouraging veterans from actually applying for benefits that they qualify for, and are taking way longer than the old forms used to take.

I'll make some examples of this available to you. They're getting this to me. But I don't know exactly what this form is, but apparently it was a fairly succinct form that they used to know how to deal with and all of a sudden it's like 20 pages on the Internet or something, and it's causing a lot of problems, at least out in my area. Maybe we're behind the times out there, I don't know.

In any event, you know, I just want you to know that I am concerned, and I, for one Member, will be there to try to help you get more resources.

I understand that we want to try to keep the budget 4 percent, but, you know, I don't think we've been funding the needs out there the last few years the way that we should have, and adding 4 percent onto an inadequate budget is not going to cut it, I don't think.

So I look forward to working with you, and I will get you some of this information.

Secretary PRINCIPI. Thank you, Mr. Peterson, and I would be happy to follow up and respond to some of those concerns you have. I think they're legitimate, and I want you to know some of the things we're trying to do to address them.

Mr. PETERSON. Thanks very much.

The CHAIRMAN. Thank you, Mr. Peterson. Now, the chair recognizes Mr. Gibbons.

OPENING STATEMENT OF HON. JIM GIBBONS

Mr. GIBBONS. Thank you very much, Mr. Chairman and Mr. Principi, or Secretary Principi. Welcome. Glad to have you before us today and look forward to working with you in the future.

I guess, principally, just talking about these issues that we just heard Mr. Peterson and Mr. Stump discussing with the claims, that is a prevalent issue that is even dominating out in Nevada, where we have one of the fastest-growing populations of veterans.

My question is, would you support some type of direct access for these claimants on these benefits to the appeals court, rather than the process through the administration?

Secretary PRINCIPI. Hmm. I've never thought of that concept before. Rather than file a claim for disability benefits, just have them file it with the Board of Veterans' Appeals? Is that the——

Mr. GIBBONS. At some point, giving them some type of direct access.

Secretary PRINCIPI. I believe they have direct access. Maybe Mr. Thompson can help me out on this one, Mr. Gibbons.

Mr. THOMPSON. Are you asking, sir, whether they should be allowed to go right to the Court of Veterans' Appeals, as the final stage?

Mr. GIBBONS. Yes.

Mr. THOMPSON. I don't think we have considered that. We've never had a discussion on that.

It would, of course, impose an enormous issue of volume. The court deals with hundreds of claims a year. In regional offices, we decide in the millions, so there is an issue of volume.

I can say that we recognize the concerns. All the committee members have spoken to how long it takes to process claims and of the backlogs; we are being as aggressive as we know how in trying to deal with them.

It stems from reasons that are both internal to VA as well as external, and we're trying to be very aggressive to build up the capacity of our regional offices to deal with the claims.

That would be our preferred approach right now.

Mr. GIBBONS. Thank you. Let me ask a question, getting back to the financial stability of the VA.

In your presentation, of course, you talked about reimbursements for health care that's provided by third parties. That, of course,

under the current plan, is an offset, is it not, in the budget, the reimbursement, or is that——

Secretary PRINCIPI. No, sir. That's just an add-on. That's just an add-on that we——

Mr. GIBBONS. Your budget isn't reduced by third-party reimbursements?

Secretary PRINCIPI. That's correct. We get our budget and all of the recoveries from this program are added on to our budgets.

Mr. GIBBONS. What dollar amount are we talking about? Do you have an idea that you could——

Secretary PRINCIPI. Right now, it's about $600 million, and I believe it's woefully low for the amount of money we spend on health care, and the treatment provided.

I don't have a figure, whether it's 1 billion or 2 billion, that we could collect, but I believe we could do substantially better, given that almost 20 percent, if not more, of our patient population today in the VA health care system are non-service-connected, higher-income veterans.

The lowest priority now make up 20 percent of our workload. By definition, they would be more inclined to have some type of health insurance that we could receive.

So, I think we just need to look at that to see how we can improve on our processing of those claims.

Mr. GIBBONS. Thank you very much. Mr. Chairman, I have no further questions, and like the rest of the members here, we're very interested in our veterans and the veterans budgets, look forward to the rest of the testimony.

The CHAIRMAN. Thank you very much, Mr. Gibbons. Dr. Snyder.

OPENING STATEMENT OF HON. VIC SNYDER

Dr. SNYDER. Thank you, Mr. Chairman. Good afternoon, Mr. Secretary, appreciate your and appreciate your service.

Over the weekend, I had one of those evenings where I went first to Camp Robinson, our National Guard State Headquarters in Arkansas and was part of a group saying goodbye to over 200 Guardsmen that were heading off to Bosnia, and then went directly from there and spoke at the awards banquet at the Little Rock Air Force Base, which is a C–130 base.

It really brought home that, you know, veterans are not a bunch of old guys like you and me, but we're creating new veterans every day, and a lot of them are young, and I appreciate your work here.

I want to talk about the budget number a little bit. I know we don't have any details at all, and I hope, Mr. Chairman, I hope we'll have a chance for the Secretary to come back after we do have the details.

But, you know, 2 years ago, we had to go through trying to, you know, read the minds of the Secretary and where he was really at on the number, and was it going to be adequate, and I hear words like, "Well, I can work with it."

I'm not very good at reading facial expressions and I know it's a new administration, but 4.5 percent, given that we've laid some mandates on you, you've got additional workload.

You can't just look on this as cost-of-living increase, because you've got more things to do, whether it's a duty to assist or Hepatitis C, some of these other things.

We've got energy costs that are sitting out there, and I don't think anyone can say reasonably, just a routine, you know, cost-of-living increase is going to take care, given what you've got to take care of.

So I need you to help me read between the lines. Does this 4.5 percent—are you just holding your own, treading water where you've been in past years? Is that going to keep you right where you were, you hope, if everything goes well with these new duties you have, or is there real increase in dollar there?

For example, I'm told that in these specialty items like spinal cord injury effort, and the mental illness, substance abuse, that in constant dollars, in real dollars, those programs have, in fact, stayed the same for several years.

Secretary PRINCIPI. Mr. Snyder, we're holding our own. Unfunded mandates from the Congress—I've spoken with Ranking Member, Mr. Evans, about the importance of emergency care, a new health care benefit that was added, because veterans, primarily in rural areas, who could not reach a VA medical center, went to a community hospital emergency room, and received a bill for the care in that emergency room and couldn't pay it. That's $500 million.

If we continue the growth, this spike in Category 7s, we will have a problem to enroll all the Category 7s who want to come into the system, no question.

Hepatitis C, very, very expensive treatment, as you know. The drugs are very, very expensive.

So we're going to need to balance all of that. I mean, if I'm told in the final analysis $1 billion is what we have to manage to, we'll manage to that, and try to make it as equitable as possible, to ensure uniform access to high-quality health care.

You know, there are areas where we should increase some co-payments, and there are some areas where we should reduce the co-payments, like in outpatient care. It costs $50 for an outpatient visit. I think that that should come down to a more realistic level.

At the same time, if you go into an outpatient clinic and get some sophisticated testing or outpatient surgery, then it should be more than $50, but just a routine examination should be more like $15, not $50.

Prescription drugs. I think that $2 for prescription drugs is very, very low. We need to raise that, to a level that's certainly affordable, but that allows us to retain some of those dollars in the system so that we can provide more veterans with more drugs.

Now, those are some of the decisions that I think we have to make.

Your question, I agree. We can maintain where we are today, but if we continue to see this big spike in enrollment and demand for care, and unfunded mandates for new programs that the Congress would like us to take on, we'll have difficulty.

Dr. SNYDER. Mr. Secretary, this committee tries to work very hard in a bipartisan manner, and most of the time we're successful, and, you know, we would be glad to work along with you, I speak

for all the members, in terms of going to bat if you need some help in raising that number.

I saw a press report over the weekend that wasn't from the President but from someone in the administration talking about potential veto threat for any numbers that went above the 4 percent or so.

I would hope that if this Congress is successful in augmenting the VA budget, that there would be a strong disincentive for the President to veto an increased number in the VA budget.

I wanted to ask about one specific number, and we don't have numbers, but I'm told that the research line item in the VA is going to be the same.

I see I'm running out of time. If you can comment—maybe you don't have the information—comment on this at that point.

But in the President's State of the Union, he talked about the National Institutes of Health and how we're going to continue on our path to increase that funding, but we're starting to get information that throughout different budgets that, in fact, research dollars are not going to be increased.

As you know, VA research dollars, medical research dollars is a very, very important part of the research infrastructure in the United States.

As a sidebar story to that, I don't think we've done a very good job, either, on VA infrastructure, buildings, and those kind of things.

Secretary PRINCIPI. The current research budget has grown from $250 million in 1996 to $350 million today. I think that's a low level. You're right. I think research is absolutely critical to our mission.

We have a tremendous legacy in research. I wish the American people understood all the advances that the VA has made that not only have benefitted veterans, but have benefitted the people of this Nation, and the world, in drugs for schizophrenia, high blood pressure, the CAT scan, kidney transplants. I can go on and on and on.

I do intend to increase the VA research budget line. I would like to keep it as close to inflation as I possibly can. It won't grow dramatically, you are absolutely correct, but I believe it is important.

The $350 million, plus whatever we can add to the budget this year, is about one-third of all the research that comes into the VA research dollars. About two-thirds are funded by the Institute of Medicine.

We have to compete for the money that the President has put to the Institute of Medicine, which is fine, but a good part of that comes back to the VA in research dollars, so the VA research appropriation really only represents, sir, one third of our research effort.

The CHAIRMAN. Thank you, Doctor. Mr. Reyes.

OPENING STATEMENT OF HON. SILVESTRE REYES

Mr. REYES. Thank you, Mr. Chairman, and welcome, Mr. Secretary, and again, congratulations on your appointment.

I can tell you that I really enjoyed our session last week. I know that you've got the interests of the veterans at heart, and I really appreciate that.

There are a couple of areas that I'm concerned about, and one of them is the administration's proposal that would eliminate the VA's vendee loan program.

This program allows the VA to offset the cost of property acquisition and resale by packaging the vendee loans and selling them to investors.

It's my understanding that this program generates revenue for the home loan program, but in the President's budget, this is portrayed as the elimination of the program, and it's identified as a cost savings.

I would like for you to comment on that.

Some of the additional concerns that I have since coming to Congress are those of contracting out, because my experience in the Border Patrol showed that the A–76 type program didn't always save money, and in some cases, increased the cost and provided much inferior services.

If you can comment on those two areas, I would appreciate it.

Secretary PRINCIPI. I would be happy to, Mr. Reyes. Thank you for your kind comments.

Every year, as long as I can remember, the administration proposes to eliminate the vendee loan program, and every year, the Congress rejects that proposal.

Mr. REYES. I think I understand.

Secretary PRINCIPI. I can't speak against an administration proposal. (Laughter.)

But anyway, let's leave it at that.

Mr. REYES. Okay.

Secretary PRINCIPI. I believe whatever can result in greatest savings to the VA should be the avenue we pursue.

With regard to contracting out, I believe there's a role for the private sector.

I believe we have some of the most dedicated employees in Government, people who are really hard-working, but I believe that there are some skills especially in information technology, for example, that it's tough to have people in-house, and, to compete for those types of people and to get them to come to work for the Government at the salary rates we can pay is very, very difficult.

I think we need to work with the private sector. I think the VA has been a model in performance-based contracting, sir, and it's got to be a win-win situation.

The VA has to be committed to the contract, working with the private sector, and the private sector needs to work carefully with the VA.

I think, when you look across Government, DOD and all the other agencies, I'm very proud of what the VA has done in performance-based contracting, where you are incentivized for good quality work and you're penalized when you fall below the standard.

I also agree that A–76 is not always the panacea that everybody thinks it is. We need to pick and choose those contracts that should be put out, that work that should be put out to bid.

So I certainly will look at all of those, very very carefully, to make sure that we're not eliminating the infrastructure, and then the private sector comes back and there's no infrastructure, and they can raise the cost of services provided to the VA.

On the other hand, I think we need the private sector to work with us.

Mr. REYES. If I can get you to—can you provide me whatever studies you have on the A–76 program from the Veterans' Administration?

I'm particularly interested in the use of private contractors in the vocational rehabilitation and employment program, because I think——

Secretary PRINCIPI. Certainly.

Mr. REYES (continuing). We need to really closely monitor those.

Secretary PRINCIPI. I'll be happy to do that, sir.

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

The CHAIRMAN. Thank you very much, Mr. Reyes. Mr. Crenshaw.

Mr. CRENSHAW. Thank you, Mr. Chairman. Mr. Chairman, as a member not only of this committee but the Budget Committee as well, I appreciate your holding this hearing today.

Mr. Secretary, I really want to thank you for your candid advice, both as a veteran and as a representative of the Veterans' Administration.

In your testimony, you indicate an interest in maintaining and improving our national veterans' cemeteries as shrines to our Nation's veterans, and I wanted to let you know, in my part of Florida, which is northeast Florida, we have an even more pressing problem than the upkeep of the cemeteries. Our veterans are in desperate need of a cemetery in the first place.

As you probably know, in Florida, we have the second largest veteran population. We have the largest veteran population of people 60 years and older.

Right now, we've got four national cemeteries in Florida, and they're almost without space. Two are closed completely; one is allowing only cremated remains; and a fourth is being expanded a little bit to include some new gravesites.

In the last session of Congress, they directed a new cemetery be built in Florida. That's going to take a while, and it's also going to be in South Florida, which is about 350 miles from where the veterans I represent live—it's a long way. It's almost, really, too far for a widow to have to go down to visit a loved one.

So, I want to ask you: The President says that we've got a big surplus, but that doesn't absolve us of making tough choices, and I agree with that.

He also said that we're going to have to adjust some things up and down within the budget, and I agree with that.

But he doesn't make any specific recommendations for our national cemetery program, and so I wanted to ask you what your plans are for this important program.

As I understand it, it takes 5 to 7 years to plan and build a cemetery, and I just want to make sure that we're taking the necessary steps to deal with this now.

As I understand it, in about 7 years, veterans' deaths are going to almost double to 620,000. I just wondered if you could comment on that, the steps that we're taking.

Secretary PRINCIPI. Certainly, sir.

I agree. I'm pleased that we are moving forward aggressively to establish a new cemetery in Florida north of Miami.

I know that is a long distance from northern Florida, but we have $15 million in the budget to do that, and hopefully, we're going to go through the environmental impact, environmental assessment, and get a new cemetery opened in Florida in the very near future.

We have needs all over the country, you're absolutely right, and it's a long time from budgeting, planning, environmental impact, and getting a cemetery opened.

I've asked our Acting Under Secretary to look at establishing more columbariums. We are seeing a much greater increase in the number of cremated remains, and we could build columbariums a lot quicker than we can find and open a 500, 700-acre cemetery, so I think that's one of the initiatives that we can undertake.

We're opening one at Fort Rosencranz, I believe, in California, in San Diego, Mr. Filner's area.

I think we also need to look at our relationship with the States, and State veterans' cemeteries. That's a cost-effective way of our doing so.

I agree that the cemeteries should look like national shrines, and I'm afraid to report to you that a number of them do not. Even driving past Arlington Cemetery, I see a lot of the stones are beginning to look somewhat black, and they need to be cleaned.

Although that's not a VA cemetery, I think that's true throughout our cemeteries, as well. We have about a $40 million backlog in maintenance and repair of our national cemeteries, and we're making the first installment with this budget, to begin the process.

We also have a consultant, a study underway to determine which cemeteries, put together a priority list.

So quite a bit is being done, sir. I'm not sure we'll get there as aggressively as I would like, but I do believe the Department has moved forward pretty well. We have six cemeteries in the pipeline now, to be opened over the next several years, by 2006.

Mr. RAPP. Let me offer some, I think, better news about the State of the national cemeteries in Florida.

The cemetery, the large cemetery in Florida, a national cemetery, we have a $6 million project there to develop a columbarium for that cemetery.

That's our third most active cemetery in the system, and recently, the State of Florida has transferred land to us to expand that cemetery, so our big cemetery there will have land for many, many years to come.

At Pensacola, we have a cemetery there at the Naval Air Station. We're working with the Navy to get land transfered there, so contrary to the rumor that we're closing, we're going to keep that cemetery open to serve the panhandle.

South Florida, the Secretary has summarized. We have money in the budget to buy the land, and we're working on an environmental assessment there.

At Bay Pines, the medical center there has transferred land to us, and we have a cremation-only cemetery there, because of the high water table, we can still do cremations there and we're doing a columbarium there also.

I think that best answer for Jacksonville, and I see more receptivity within the State now that we're making progress with our national cemeteries, is to consider our State Cemetery Grants Program, which I think would be an ideal option for the Jacksonville area.

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

The CHAIRMAN. Thank you very much. The Chair recognizes the vice chairman of the full Veterans' Affairs Committee, Mr. Bilirakis from Florida.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I have an opening statement that I ask unanimous consent that it might be made a part of the record, Mr. Chairman.

The CHAIRMAN. Without objection, so ordered.

[The prepared statement of Congressman Bilirakis appears on p. 73.]

Mr. BILIRAKIS. Tony, congratulations again, and welcome.

Secretary PRINCIPI. Thank you.

Mr. BILIRAKIS. You've been before this committee many times in the past, and I trust you'll be here many times in the future.

Very quickly, regarding research, Dr. Snyder got into that point. Would you support a change in the law that would provide for a check-off on a tax return where a person has a refund coming, and they can choose a certain amount of that to go to VA research?

Secretary PRINCIPI. I would have to run it through the concurrence process at my end of Pennsylvania Avenue, so it would be premature for me to—but I think it's certainly something——

Mr. BILIRAKIS. It makes you wonder why anybody would even oppose it or even consider opposing it, wouldn't it?

Secretary PRINCIPI. So if it's a voluntary checkoff?

Mr. BILIRAKIS. That's what it is.

Secretary PRINCIPI. I think it's something that we should look at.

Mr. BILIRAKIS. We're in the process of doing something like that, anyhow.

Medical cost recovery. This is my 19th year on this committee, and it took us many years to finally get around to a third-party collections system, as you know.

We've done it. The performance metrics appear to be very poor, however.

For example, as I understand it, 92 percent of VA's account receivables were over 90 days old. In the private sector, that figure averages around 28 percent.

The accounts receivable from date of discharge are 60 days in the private sector. They are, as I understand it, 244 days in the VA.

The VA takes an average of 83 days to bill the patient—I suppose it would be the third party—and it takes 9 days in the private sector.

Collection cost, again, as I understand it, 21 cents per dollar collected VA; 7 cents per dollar collected the private sector.

Now, is it true that all of the collections come from insurance companies, private third-party insurers? That's really what we're talking about, isn't it?

Dr. GARTHWAITE. A significant portion comes from veterans themselves, the co-pays, but the remainder comes from insurance companies.

Mr. BILIRAKIS. The projected, the projected cost recovery, I think, at the time that all this was taking place, was approximately $1 billion, as I understand it.

About how much of that was anticipated to come from the third-party insurers, if you will?

Secretary PRINCIPI. Well, in 2001, we're estimating $472 million from the third party, from the insurers, and $203 million in co-payments, prescription fees.

Mr. BILIRAKIS. So that totals out to about $500 million?

Secretary PRINCIPI. About $600, almost $675 million?

Mr. BILIRAKIS. Were we off, then, when we projected $1 billion?

Dr. GARTHWAITE. I would say we've made significant progress.

One of the things that has helped us is improving our compliance. That is, assuring that the medical documentation justifies the bill so the insurers will pay.

The second improvement in implementation of what's called reasonable charges. We used to bill a fixed rate, so you get the same rate for a hypertension check that you get for an MRI scan. Now, we bill less for the hypertension check and more for the MRI scan, and that's helped us.

Mr. BILIRAKIS. But, Doctor, no, the point here isn't the co-pay. I mean, that comes out of the veterans' pockets, and I'm not sure that when we talked about third-party collection system we contemplated co-pays from the veterans. We're talking about an insurer.

And if it is an insurer, and the insurer does a heck of a lot better job in the private sector in terms of repaying, why are they being more difficult, or are they being more difficult when it comes to recovery by the VA?

Secretary PRINCIPI. Well, I'm just not sure we're doing a very good job in itemizing the bills that go to the insurers. I think we just simply need to take a good, hard look at——

Mr. BILIRAKIS. Tony, yes. I mean, that is——

Secretary PRINCIPI. Let me give you an example, Mr. Bilirakis. You know, it's anecdotal, and you just can't build a case on anecdotes.

But as Dr. Garthwaite and I were talking the other day, a veteran told me how his insurance company was billed $50 for an outpatient visit, but there was no itemization of what was included in that outpatient visit.

It turns out there was an MRI and other tests that this veteran underwent, as part of that visit, but the insurance company was only billed $50, and was probably very reluctant to even pay the $50.

Mr. BILIRAKIS. But it's been some time since we put this into effect. You mean we're no more efficient than that, after all these years?

Secretary PRINCIPI. I believe we are much better at providing a reasonable charge.

I haven't had a chance to look into this particular example, but we've set records the last 4 months for collections across the country, and we're projected to collect an additional $100 million this year and maybe even more next year; so I think we have significantly improved.

Another complexity is that many of our veterans don't have full insurance. They have Medicare supplemental insurance.

We have to submit a bill and go through the Medicare software to generate a form so that the private insurers will honor the supplemental portion of the bill that basically determines what they're on the hook for.

So that's an extra complexity in terms of our collecting from Medicare supplemental insurance, which is a significant portion of our veterans, because many are over 65.

Mr. BILIRAKIS. Well, Mr. Chairman, it just seems to me that we're discussing budgets, and if we have a second go-around, I'm going to get into OMB with you.

But we're discussing budgets such as the Independent Budget, when, in fact, there's money out there that the insurance companies are benefitting from, because their insurer is going to the VA. The insurance company is benefitting by virtue of veterans are going to the VA and then the insurance company is not being billed for it. I mean, it's ridiculous.

It's free money, so to speak, if you will, out there. It took so long to get to that point, and we're not taking advantage of it.

Secretary PRINCIPI. Right. There's absolutely no disagreement, Mr. Bilirakis, and Dr. Garthwaite and I do agree.

I assure you, over the next several months, I intend to make this a very important issue, and I will report back to the committee on what my findings are, and preliminary assessments as to where we should go with regard to medical care cost recovery.

I could not agree with you more that we need to do a better job because leaving money on the table is dollars that are not going to veterans' care.

Mr. BILIRAKIS. That's right. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Bilirakis. Mr. Hill.

OPENING STATEMENT OF HON. BARON P. HILL

Mr. HILL. Thank you, Mr. Chairman. Mr. Secretary, thank you for coming here, and also to the veterans' service organizations that are present here today.

I want to reinforce some of the concerns that have been expressed about the $1 billion increase. Last year, we increased the VA budget by $1.4 billion, the year before that, $1.7 billion, the Independent Budget is recommending 3.5; so there are some big differences that I hope that you will take a close look at.

The other thing that I want to do is to promote an issue that I have introduced as a resolution House Resolution 23. The reason why I bring it up, because it relates to a special group of veterans, our military retirees.

As you know, the Military Retirement Trust Fund is a fund that has a lot of money in it, and is being calculated into the budgetary process called surpluses these days.

We in the House, at least, have built a firewall around Social Security, and I think we need to build a firewall around the Military Retirement Trust Fund, as well.

I have only one question, and it's not really a question, it's a comment more than anything, and you may or may not want to comment on it. I understand.

Under contracting in A–76, in certain cities around the United States who contract out Governmental services, they allow the local employee representation to also bid on these contracts.

As a matter of fact, in some of the cities, like Indianapolis, the local representation are more times than not the most competitive bid that is being proposed.

So I'd like to get your thoughts, if you have any thoughts at all, if you'd like to have more time to think about it; but they also ought to be allowed to bid, in my view.

Secretary PRINCIPI. I believe, and certainly agree, that as part of the A–76 process, the local Government employees, in our case VA employees, should have an absolute right to bid on that contract.

I think what it does serve is to make the Government more efficient, if you will, to come up with the best bid, to reorganize, if necessary, to improve their processes. So I would hope it's a win-win.

But if I understand your question correctly, sir, should employees have the right to bid on the contract? I think they should, and I believe they do.

Mr. THOMPSON. Congressman Hill, we're actually in the middle of an A–76 study right now. Part of that process will be, after the proposals come in, that we create our own internal, most efficient organization, and that's what the outside organizations are competing against.

So in effect, the VA is bidding an efficient organization against the outside proposals. They not only have to better the existing performance, they have to better what we say would be our most efficient operation.

We work with our union partners, for example, on setting up these contract procedures, but I think they are very much a part of this process.

Mr. HILL. I guess my question is are they directly bidding? I mean, are they offering a written bid on these projects?

Mr. THOMPSON. No, I don't believe they have the option to do that. I'm not 100 percent sure that that can happen, but the VA, in essence, is bidding on their behalf.

Mr. HILL. Yes. I think it improves the efficiencies if they have the opportunity to actually propose a written bid.

In the city of Indianapolis—I'm from Indiana, as you can tell, I'm not from Indianapolis, though, I'm from a rural area—they actually have the opportunity to submit written bids, and it seems to me that that would be an idea at least worth exploring.

Secretary PRINCIPI. Sure. Sure. I wasn't aware of that, sir. I'll look into that.

Mr. HILL. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. Mr. Simmons.

Mr. SIMMONS. Thank you, Mr. Chairman. Welcome, Mr. Secretary. Like you, I also served in the Mekong Delta, and we'll have to swap some lies about that sometime.

Secretary PRINCIPI. I'd like to do that.

Mr. SIMMONS. A couple of questions. I was interested in your statement with regard to improving access to health care for eligible veterans and the fact that the President supports a health care task force.

I'm looking over the membership of the task force. It includes Executive Branch agencies and veterans' organizations, but no congressional representation.

Is there any particular reason why the Congress would be left out of that process?

Secretary PRINCIPI. No, and I'm not sure they should be left out of that process. As I indicated in my opening statement, I believe the Congress has to play an integral role in helping us to succeed, and without the Congress as part of that, buying into the solution, we'll never succeed.

That came up during my meeting with the leadership of the committee, I guess it was late last week. We talked about that and the purview of the veterans' benefits task force, in trying to reduce the backlog: should we get someone from the Congress, one of the staff, senior staff to join with us?

I think that's a good idea, and certainly we need to explore that, and I would venture to say for the health care side, as well.

I think it's important for the Department of Defense and VA to work closely together. I think we can respect the missions of each department, and the unique needs of the beneficiary populations.

When the Congress enacted jointness in the military, with the Goldwater-Nichols Act, when I was a young staffer on the Armed Services Committee, all the uniformed military were cynical of the idea. Today I think everybody in the military would embrace the idea of jointness and I think that the VA and DOD should work closely together.

You know, we have a lot of overlapping eligibility and duplication across the board, in research and in treatment, and I'm not sure it benefits the beneficiaries very well. I think we need to work a lot closer together.

I've talked with Secretary Rumsfeld several times now, and I know the President has talked to Secretary Rumsfeld about this issue.

That's the whole genesis of a task force to see where we can really partner, really share, and again, expand the reach of health care to our respective beneficiaries.

Mr. SIMMONS. I thank you for that response, and I welcome that response.

I'm a new member of the committee, obviously, but there are some people on this committee and in the Senate side with huge experience. There are staff people as well as members who have terrific experience and background and motivation, dedication.

So I would think that this is a natural for the Congress to play some role, as well.

My second question goes to the CARES program. It's my understanding that some people feel that this study, the study of the re-

configuration of our physical plant, is delaying approved projects and delaying investment, and that the longer this investment is delayed, the more deterioration occurs, and that in fact, by studying this problem, while not making investments for dollars already allocated, we're really creating a monster that affects the veterans and affects the overall program.

What's your comment on that?;

Secretary PRINCIPI. I agree. I fully agree. I'm concerned about the infrastructure needs out there.

You know, certainly in seismic deficiency areas, we just had this tragedy in the State of Washington that impacted one of our facilities up there, American Lake. We've got other seismic deficiencies around the system.

You know, it's interesting. The Surgeon General testified not too long ago about the deteriorating condition of the DOD health care system, not only in terms of the physical plant, but equipment which has outlived its usefulness; and I don't want to see the VA get to that point. I'm concerned about it.

We have a large infrastructure out there, and I think it can be done. I think we can maintain it, invest dollars in our infrastructure consistent with this CARES project, to see how we should realign our system. I don't think they're mutually exclusive.

I'm concerned about waiting until the CARES process is fully completed before we start addressing some of these deficiencies.

I look to work with the committee very carefully. I know there's legislation pending that would address this issue, and I think we need to work through some of these issues.

Mr. SIMMONS. Very good. I welcome that response as well.

Final question, on the issue of geographic problems and getting veterans to facilities where they can get patient care.

There is one VA hospital in Connecticut, there is one in Rhode Island, and since I represent eastern Connecticut, the Rhode Island hospital is actually an option of choice for many of our veterans.

In years past, we would reimburse veterans for their transportation to these facilities. That no longer is the case, so I guess we're looking at other alternatives, which is sharing agreements and contracting with other health care providers.

Some veterans feel that that's a mechanism for dumping them out of the system, and that they would prefer to get that transportation reimbursement, and then they would get to the hospital on their own, they would assume that burden if there was some reimbursement.

Could you comment on that issue?

Secretary PRINCIPI. Yes, Mr. Simmons.

It's my understanding we still reimburse veterans for the cost of travel. I don't think we've increased that line item, but I'm not aware of any problem on the part of veterans, and I'll ask the expert.

Dr. GARTHWAITE. No, we still do have travel pay. There is a mileage limit, and maybe it's close enough there on the East Coast that they're not far enough away or travel enough miles.

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

The CHAIRMAN. Thank you very much. Mr. Brown.

OPENING STATEMENT OF HON. HENRY BROWN

Mr. BROWN. Thank you, Mr. Chairman.

Mr. Secretary, I'm from Charleston, SC. We have a goodly number of veterans down in our area, and we have a veterans' nursing home that—I mean, a hospital, really—it has 87 beds utilized. We have 119 available.

I'm just wondering, is part of your program that you would maybe look into upgrading that hospital back to its capacity? We have plenty of space, we just don't have the personnel.

(See post-hearing question on p. 175.)

I have another question I'd like to ask, too. Would you adopt a special criteria to evaluate patients that have post-war syndrome disease, which acts like dementia or Alzheimer's?

I know we have some veterans in my district that won't qualify for war-related injuries because they say that this is—you know, this can't be proven, and I just wonder if we could—if you would take a look at that criteria that makes that determination, and also if you would look into allowing the veterans who stay at home for their care, and to provide some kind of maybe incentive or benefit for the health care provider that would be at home with them.

Secretary PRINCIPI. Certainly, with regard to the last question, I certainly think we need to look more to non-institutional forms of health care.

I believe the vast majority of people, if it's possible, would prefer to stay in their own home, rather than to be institutionalized. I think there comes a point in time where there's no alternative but to be placed in a nursing home or an assisted living center.

I think the VA needs to move a little bit more aggressively. My hope is we could move more aggressively into assisted living. I think that's the trend in America in extended care.

We have lots of facilities out there, large campuses that could be used to convert, perhaps, some of the unused building into an assisted living center, residential type, where it's again public-private sector, perhaps.

We provide the health care, 24/7 health care at that assisted living complex, and the veteran perhaps would participate in the residential, contributing to the residential component of it. I think are a lot of different models that we need to explore.

So yes, I support trying to keep the veteran home and having programs in place, adult day health care, hospital-based home care, and things of that nature.

We certainly will look into the Charleston situation on nursing home beds to see why we're not up to capacity, and we'll get back to you on that.

(See post-hearing questions on p. 175.)

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

The Charleston VA Medical Center continues to experience growth in new veterans enrolling for care, especially as additional community based outpatient clinics are activated. It is the VA medical center's intent to continue improving access to care employing the community based model. The VA medical center is also committed to maintaining the high quality of care by assuring that staffing levels are appropriate to meet the needs of a growing population seeking care at the VA.

As is true for many medical centers across the Nation, the availability of qualified nursing staff has been a real concern. In response, the VAMC has expanded the use

of recruitment bonuses, implemented retention bonuses, and taken other actions to improve recruitment and retention of its RN staff. These efforts are beginning to yield results. For example, during the last four months, nursing vacancy rates have declined from 21 to 11 percent.

Mr. BROWN. How about the post-war syndrome question? Do you have a thought on that?

Secretary PRINCIPI. I'm not familiar with that issue. Perhaps Dr. Garthwaite, or Mr. Thompson can address that issue.

Mr. THOMPSON. We constantly reevaluate how we assess, in this case, post-traumatic stress disorder, which I believe is the condition.

We can give you move details on how we go through those reviews, that's always an evolving decision. We rely, in this case, on the doctors who work for Dr. Garthwaite to give us an evaluation as to what the condition is. We make the rating based on that.

But you're right. If it can be related back to the person's military service, obviously, the rights and benefits they have are very different than if we can't do that.

The CHAIRMAN. Thank you very much. Dr. Simpson was next, but was called out of the room. Mr. Filner.

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman, and welcome, Mr. Secretary.

Secretary PRINCIPI. Thank you, Mr. Filner.

Mr. FILNER. It's good to have you back, both at the Department and in our room, nice to have somebody from the San Diego area in that chair.

I'm sorry you revealed the secret that you were putting the columbarium in at Fort RoseNcranz. The committee might vote to make me the first resident, this year. (Laughter.)

I want to make a couple of, I guess, comments in reaction to your testimony, if I may. We know of your commitment and concern for veterans.

There has been a tradition, by the way, just in the operation of our committee structure and testimony that the VA professionals testify first and then they pack up and leave, and then the VSOs and the public come.

I would hope that you could start a new tradition where you, or if your schedule can't allow it, your deputies stay and listen to what the veterans are saying directly. I know you've heard it, but to hear it in the public setting and how we respond, I think is important for the VA to do, and I hope you start that tradition.

Secretary PRINCIPI. Well, I have, sir. I have, and I announced it at the beginning.

Mr. FILNER. Great. I was not here. I'm sorry. I apologize.

Secretary PRINCIPI. Oh, that's quite all right, sir. That's no problem. I understand the demands on everyone's time.

But I want you to know that I know that that's been an issue in the past, and certainly when I was deputy secretary it was an issue, so I asked our senior level officials to please remain and listen to the testimony, because you're absolutely right. We need to learn from them.

Mr. FILNER. Thank you very much.

As I was listening to your answers to some of the previous questions on areas that obviously cry out for more support, and you know that as well as anybody, and when you talked about Category 7s, or the Hepatitis C demands, certainly the Persian Gulf War illness, research and treatment, long-term care, which I will, if I have time, get back to later, you wrote the bible on the need for the Montgomery GI Bill increases, you talked about, you know, trying to find a balance.

We know, you know, you're the Secretary in a Cabinet which has to operate within a certain framework.

However, I think we have to become spokespersons for the fact that over the last decade or so, I mean, we have asked the veterans to participate in bringing down the deficit, and they were willing to make that sacrifice along with all Americans, and we have been successful.

We now have a balanced budget. We have surpluses. This committee, under the leadership of Mr. Stump, significantly raised the amount of money to the VA in the last two rounds of budgets, but we're still behind, because we basically kept them, if not on a straight line on a reducing budget.

Just for comparison's sake, which the figures you know—the administration is recommending approximately a $1 billion increase in discretionary programs.

I'm a little disappointed we don't have any details in there. The Independent Budget was able to get it together. I know you're relatively new on the job, but I hope we can get that very shortly.

Secretary PRINCIPI. Yes, sir.

Mr. FILNER. This committee, when it discussed its recommendations tomorrow, as I understand it, will be recommending in the neighborhood of a $2.2 billion increase in discretionary programs, which I thank the leadership of Mr. Smith for. I think that's appropriate, that the Independent Budget asks for 2.8 billion in discretionary increase.

So your 1 billion, our 2.2 contrast to the 2.8, shows that, I think, we're still far behind, because we have come, and I hope you will too, Mr. Secretary, to value this Independent Budget very much. It is put together in a very professional way.

It just doesn't say, "Give us more money." It outlines, in very specific detail—and we'll have testimony in the panel that follows, that your chief deputies will hear—where they would like to see increase and on what grounds, and a really professional sort of statement on the criteria.

So I think we, as a Nation, with these surpluses, have to address this backlog of needs to the people whom we owe our freedom, the veterans of the United States.

I mean this is why, this week, you know, many of us in the House will make the argument that the President's tax proposals ought to follow the budget and not precede the budget, because we have these needs in the budget, which you know very well, and your staff knows very well, but we are not meeting them.

We all wasn't to meet them, and we all know the responsibilities of budget, but it seems to me we have the money to do it if we put the veterans back to a first priority. Instead of having them pay

the price for our deficiencies, let's now give them the rewards of the surplus.

Secretary PRINCIPI. I couldn't agree with you more. They should be the highest priority. I believe we've made a good-faith effort in this first year, this very short transition year, in building a budget that will help us to move forward.

Certainly, I applaud the previous administration, the Congress, and what they did the past 2 years. I think the VA would be in deep trouble, had those submission and enactments not materialized.

But you're right. Over the past 8 years, there have been a lot of flat-line budgets and I think that's hurt the VA.

I know the budget process takes a lot of twists and turns, and I have fought as hard as I could for the $1 billion increase. I will continue to fight for the resources I believe my department needs. I will not stop fighting.

When I get the enactment, at that level, I will work with the senior leadership team to make it go as far as possible to reduce this enormous backlog, which is a chokehold around us. I believe it's impeding our abilities and the efforts that Mr. Thompson has made to improve the process over the long term.

It's put a chokehold in the short term, that we need to address, so that we can get on with improving the quality and customer satisfaction, and to increase the high-quality health care.

I think there are things we are doing internally, in the CARES, to realign our system, open outpatient clinics, and to transition from a hospital-based system to a more contemporary veterans-focused health care system.

But you have to start with a realistic budget, I agree with you.

Mr. FILNER. With your permission, just 10 more seconds, Mr. Chairman.

We on the committee know your commitment and know you will be fighting, and we look forward to joining that fight. We hope, when we try to up that even more, we take that not as any, you know, criticism, but understanding the budget process, and we have our own independent judgments to make. We want to give you as much as possible to work with to keep the contract with our veterans.

Secretary PRINCIPI. I agree. I welcome that process.

Mr. FILNER. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Baker.

OPENING STATEMENT OF HON. RICHARD BAKER

Mr. BAKER. Thank you, Mr. Chairman.

Mr. Secretary, given your prior service here in Washington and your service in free enterprise, your commitment to the veterans, I am especially pleased that you have taken on this new mission.

Secretary PRINCIPI. Thank you, sir.

Mr. BAKER. To that end, I would preface my remarks by noting that my concerns are not a reflection on the agency today, nor your leadership.

But I have a specific, very narrow concern that comes from my personal experience with a list of agencies, one of which is that of veterans, in calling for my dad, to understand how the system func-

tions, and frankly, not using my name as Congressman Baker, but just calling as Mr. Baker, for my 78-year-old World War II Navy pilot, trying to find out what services may be available.

I'm not going to go through the litany. I will be happy to provide them to staff at an appropriate time, as to all of the calls I've made over several weeks.

In one case, I started with one agency, was given another number to which I was referred, was put on hold, being told after a few minutes, "You need to call this number," finally given a new number by that person, wound up at the fourth location, at which I got a recorded message saying I needed to call back next week.

I find that, frankly, an affront to veterans. When they got the order to go up the hill, there wasn't music on hold, there wasn't a 1–800 number, there wasn't a committee, there was a person in charge, and they did it.

I would think that, given the vast redundancy of telephone systems, receptionists, service points, locations, it just dawned on me, 1–800–veteran works. That's a telephone number.

I will do anything and everything to help you, because I don't know that it requires a congressional Act nor significant new expenditure, but to commit ourselves to having a number that any veteran anywhere can call on any subject and, one, get a human being; two, somebody that's nice; and a list of numbers where we can direct this person to get a clear, concise answer.

The one thing I've learned in my years of constituent service in Congress is that a nice, considered "No" is much better than a long delay, and being ignored.

I think veterans, of all, expect to be told yes or no, and they can live with those realities.

I don't believe we can promise everybody everything, and solve problems by spending every nickel in the world, but I do believe that we are all in the constituent service business, and a prompt answer to telephone calls is expected.

If I ran my constituent service operation in my congressional office the way I perceive veterans' services are run today, not Veterans' Department, SBA, you go across the board, wherever they're located, I would have been, at best, a one-term Congressman, if not a candidate for the columbarium.

I'm just telling you that we need to make a change. It's something that doesn't require extensive appropriations. It's a very simple thing to do, and I think it will do more to honor our veterans than almost any other thing we can do in the short term.

I would request, Mr. Chairman, that whatever this committee can do to facilitate this kind of change for the Secretary, I'll be right there, no matter what it takes to help you get it done.

Thank you, sir.

[Applause.]

The CHAIRMAN. Thank you very much, Mr. Baker. Mr. Stearns, the gentleman from Florida.

OPENING STATEMENT OF HON. CLIFF STEARNS

Mr. STEARNS. Thank you, Mr. Chairman.

Mr. Secretary, Let me congratulate you and just tell you how exciting it is for all of us to have you here, particularly in light of

your past experience in veterans' affairs, and also say, Mr. Secretary, that we now have the White House and we have the majority here in Congress, so we have a sort of a responsibility to veterans, because lots of times, we haven't had this opportunity that we have today, so that we can take the lead for veterans; and I'm sure you will do it, so I'm excited that you're at the helm.

I have three areas that I sort of want to briefly talk to you about.

I was the author, together with Chairman Stump, of the Millennium Health Care bill, and we almost did not get this through Congress, but we are finally successful.

As you know, this expanded long-term care, respite care, hospital care, adult day care, and assisted living, doing a pilot program. It also guaranteed nursing care to veterans 70 percent or more disabled from service-connected disability.

But the sad fact of the matter is that this bill is not being fully funded, and so we can pass all the legislation we want here, but if we can't get this fully funded, then the legislation is not important, it's not helpful to veterans.

So I urge you, when you look at your budget and make adjustments, perhaps that you'll look at the Millennium Health Care bill and do everything possible to provide the necessary funding.

The second point I wanted to make, which is a little more controversial in the sense that we also tried to pass, out of this committee and the House, we proposed a pilot bill on coordinated benefits in private hospitals.

Now, I warn you that the American Legion and VFW are in support of this, but a lot of the organizations are not in favor of this.

But in rural parts of this country, where veterans do not have access to hospitals and they do not have access to outpatient clinics, if these veterans could go to a private hospital and then be reimbursed by the veterans, it would be helpful.

We had such a program in Congressman Dave Weldon's district, which is in central Florida, and it worked superbly, and all the veterans were given comment sheets and almost 95 percent of them said it was an excellent program, they are very satisfied.

So instead of the veteran having to go sometimes as much as an hour-and-a-half, and if he has to, he or she has to stay in a hospital, then they have to bring their family and all the support services, it turns out to be not only cost savings but also, I think, beneficial in terms of the emotional stability of the veteran who goes in a rural area to the private hospitals.

We had 50 co-sponsors from both sides of the aisle—it was a bipartisan bill—but our bill, unfortunately, did not emerge at the end. The American Legion and the VFW supported this bill last year.

I hope you will take a look at it. You're starting your tenure now, but it's something that, for those veterans in rural areas, it's very helpful.

The third point I want to make, Health & Human Services is about 400 billion. That's the first, most expensive program. Then, of course, we come to the Department of Defense, which is roughly 300 billion. Then you come to the Veterans Affairs, which is $51 billion. That is a lot of money.

Now, you have been a CEO, and you know that if you went into a corporation that was $51 billion a year, you certainly could find duplication, you certainly could find, perhaps, waste, and you perhaps could find a lot of ways to save money for veterans.

When I asked the head of HCFA what he thought waste, fraud, and abuse was in HCFA, he said it was 20 percent. If you have a $400 billion budget and you have 20 percent, you're talking huge numbers.

Now, he said, well, it could be as high as 20. It's 15 to 20 percent. Even so, if you were CEO of a corporation that had something that big, I know, from your private industry experience, you would root that out, extirpate it, and find out ways to give that savings back to the corporation or the stockholders.

So I'm asking you also, and this perhaps has not been mentioned today, and I'd like you to think about it, but the veterans deserve, with a $51 billion budget, that you actually go in and have a program to eliminate duplication, any waste, fraud, and abuse.

Heaven knows, Terry Everett, who was chairman of the Oversight Committee, can give you lots of stories that will help you out.

Rarely do we hear a Secretary talk about this, but I think that if you could come with a program where you would save money for these veterans, it would probably dwarf the increase that you're asking for, which is very small, we both agree.

Secretary PRINCIPI. I need to comment on that, because I don't think I could survive in business, having been a CEO of a company, if I had the redundancy in every sector of my corporation.

In all my different business lines, I had various administrative functions, and I think that we need to do that in Government.

I respect that we don't need to centralize everything, but at the same time, I think we need to be more cognizant of that.

I always had to pay attention to the bottom line. I always had to know what my operating expenses were, because I knew the higher my operating expenses, and if they exceeded a certain percentage, I knew it was coming out of the bottom line, and the board of directors would have me fired in an instant, because we couldn't sustain the company.

I think the same has to be true of Government. We need to look at how we're doing business. We need to start breaking down some of the barriers that exist, not only within our department, but across departments.

There is so much overlap, and so much redundancy, that again, beneficiaries are not well served.

You know, we all get a little protective about turf. You do it in the private sector and you do it in the public sector.

I think one of the hallmarks of a good leader is to build consensus for change where change is warranted, and I think clearly the VA has its share of areas where we, principally the people at this table, need to come together and say how can we do things smarter, more efficiently and effectively. It requires some tough decisions, but I think we need to do it.

I also agree with Mr. Baker, if I might say, you know, we need to build a world-class organization.

I don't understand how my son, who is a captain in the Air Force in Insulat, Turkey, can call a certain insurance company, which I

won't name, 24 hours a day, 7 days a week, and get somebody at the other end of the line if he has a question about his insurance for himself or his car, or whatever, stationed overseas. You know, I think we should be able to do the same thing.

It's resource-driven, it's culture-driven, and those are the kinds of changes we need to make.

Mr. STEARNS. Mr. Chairman, I just think that, in the next 4 years, if the Secretary could come back with a cost savings for veterans, that would be another way we could increase the budget for veterans and provide better services.

The CHAIRMAN. Thank you, Mr. Stearns.

The Chair recognizes our new Chairman of the Health Committee, the former Majority Leader of the Kansas State Senate, Mr. Moran.

OPENING STATEMENT OF HON. JERRY MORAN

Mr. MORAN. Mr. Chairman, thank you, and Secretary, thank you for being here today. I appreciate the opportunity I had to meet with you and Dr. Garthwaite last Thursday, and look forward to a good working relationship on behalf of America's veterans.

I have kind of one general question. There's lots of good questions and lots of issues that I would enjoy discussing with you. Five minutes is a very difficult time frame in which to have those answered.

Let me first tell you that as I talk to veterans and then I talk to those who administer your facilities in my State, there is a continual plea for more resources, more financial resources, and yet I know that, since I came to Congress in 1997, that we have increased the budget for veterans' affairs, and particularly in the health care area, every year.

My question is, are my concerns unfounded that the resources that Congress appropriates to the Department are not appropriately forwarded to those institutions and employees who provide the actual service to veterans? Is there a bottleneck in which the dollars get caught in the system, rather than being utilized in ways that provide direct care for our Nation's veterans?

[The prepared statement of Congressman Moran appears on p. 74.]

Secretary PRINCIPI. I'm sure there's some bottleneck, but I don't think to a significant degree. If I may ask Dr. Garthwaite, perhaps having been closer to it for the past several years, if he can comment on it.

I think it's something that we continually need to look at to ensure that the dollars are indeed getting to the medical center directors who are providing the care and not being held back in some trust fund, so to speak, at the network level, or at some other place, and that they're getting out there.

Dr. GARTHWAITE. Virtually every dollar we spend ends up being spent at the local level.

I mean, we have some infrastructure in Washington and a little bit in the networks, but there's really no other place for us to spend it, except in the facilities, so the vast majority of money gets spent out in the facilities.

I think there's a perception that we used to hold a fair amount of money in Washington and then earmark how it was spent to protect certain programs.

We ended up decentralizing, putting out about $1 billion 5 years ago, that used to be in central programs. A lot of people liked the central control, because it did protect those programs; but it all gets spent at the facility level eventually.

I think the real challenge in some networks has been that, because of a congressional mandate to put funding where veterans were, in terms of reflecting a shift in migration of veterans over the years, we have moved a significant amount of money from largely Northern States to Southern States, to reflect migration of the veteran population. In some areas that's required adjustments, and at the local level it feels like the money is being taken away, but it is going somewhere else with greater needs.

Mr. MORAN. That's certainly the indication that one gets from visiting with administrators, as well as the veterans, who are told by the administrators, "We would love to do this, but Congress just simply refuses to give us any money," which is very frustrating to us, who believe we fought long and hard to increase the budget for health care for a number of years, now, in a row.

So I look forward to working with you to make sure that those dollars are spent in ways that benefit veterans, and look at the system-wide issues, the network.

A couple of Kansas-specific questions that perhaps are examples of problems elsewhere. I live in a very rural district, long distances between us, my constituents and VA hospitals, and the community-based outpatient clinics have been beneficial, and I appreciate the effort that particularly the Wichita VA Hospital has made in that regard.

We have an application pending for one in north central Kansas. I would appreciate your attention to that issue, and would hope that we can address kind of the waiting period, the backlog, as we look to put those resources where they can be best addressed.

Another issue related to nursing home care. In Kansas, we have Winfield, which has recently been utilized to—a former State hospital, now being utilized for nursing home care, a veterans' home, and it opened May 1 of the year 2000.

I just have learned from Kansans administering the home that although the home has been open for 9 months, we have yet to receive any of the VA dollars associated with operating that facility.

Although the VA and the Kansas Department of Health and Environment have found the facility to be in 100 percent compliance, their indication is that the VA now owes 409,000 in per diem, and we're still waiting.

So if you would take a look at that issue, as well, those are scarce resources that States as well as veterans need attention to that issue, if you would.

I look forward to working with you, and my time has expired.

Secretary PRINCIPI. Thank you very much, Mr. Moran.

Mr. MORAN. Thank you, Mr. Secretary.

The CHAIRMAN. Chairman Moran, thank you very much.

Mr. Secretary, I do have a number of questions I'd like to submit for the record, but I do have a few ones that I'd like to put forward today.

First, if you would comment briefly on the Veterans' Equitable Resource Allocation, the VERA formula, which many of us have come to believe to be very inequitable, particularly in our VISN.

At the core of it is that we seem to be serving an undue, vis-a-vis other VISNs, number of Category 7 veterans, and the threshold definition of poverty uniformly applied across the Nation disproportionately and adversely affects certain regions, like I said, especially our New Jersey-New York area, and others probably are hurt by it.

I would ask you, if you would, to very strongly visit that question so that a veteran is a veteran is a veteran, everybody is treated equitably, and those who happen to live in an area where the cost of living is unconscionably high, like in my area, are not adversely affected.

Also, you mentioned, in follow-up to Mr. Simmons' questions and earlier comments I had made, about the issue of major construction.

As you know, we do have legislation, H.R. 811, the Veterans' Hospital Emergency Repair Act, which would provide $550 million over 2 years to really try to make the difference on those repairs that are absolutely compelling and necessary.

I learned a lesson last year. I chaired the International Operations and Human Rights Committee, and we oversaw and wrote the budget authorizations for the State Department.

After the horrific explosions in Africa, which took out two of our embassies, caused unbelievable damage to the physical plant, as well as the loss of life, there was this big push to beef up our operations overseas to protect them from terrorists, from bin Laden to whoever else might be on the scene, and there was a recommendation made by a commission calling for $1.4 billion every year for 10 years to build up more diplomatic security people, and so on and so forth.

I authored the Embassy Security Act, which provided 5.9 billion over 5 years, along with a lot of other disparate measures in that bill, but we had an unbelievably hard time getting the administration at that point to support it. Because what happened in the first year, everybody wanted to build up our embassies and protect them. The second year, and the OMB was the culprit here, OMB said no money for fiscal year 2001. They were going to leapfrog it and look at the out years.

I'll never forget, we had Ambassador Crowe, who headed up the commission, former Chairman of the Joint Chiefs of Staff and our ambassador to England, testify and do so very persuasively as to the need to make sure this money flows now, not sometime in the distant future, which may never materialize. We were told Secretary Albright was overridden by OMB.

I look at the Price Waterhouse recommendation from 1998, which similarly says that we need between $700 million to $1.4 billion annually—that reminds me, it's deja vu, $1.4 billion again, now it's domestic—to continue the infrastructure, to make the necessary updates to our infrastructure. It's a $35 billion infrastructure. You

let it go to pot, it won't be there. We won't have it, and it will cost that much more in the future to rehabilitate.

I would ask you, please, and you made some very nice comments with regards to Mr. Simmons' question, to get behind this legislation.

I'm concerned that the CARES process will lead to, as was pointed out by Mr. Juarbe, a de facto moratorium he says on funding already approved, and any funding going forward could be held in abeyance and never happen, or the money won't be there. There will be other priorities, and meanwhile, as we see, a deterioration of our veterans' physical plant.

Finally, on the issue of adjudicating our claims, my understanding is we have about 459,000 claims waiting to be processed.

We will be recommending $49.8 million for an additional 830 FTE compensation and pension claims adjudication of personnel to try to make the difference.

We know you've made it a top priority to get rid of that backlog and to responsibly deal with the veterans who just want to know yes or no, and want to be treated fairly. It seems to me that personnel do make the difference with regards to this.

So I would throw out those three things—VERA, construction, and claims. And of course, I have many others like Medicare subvention, but we'll have to get that in, too.

Secretary PRINCIPI. Our goal is the same to treat the greatest number of veterans with the highest priority of care.

I think Dr. Garthwaite would be the first to say that he knows it's not a perfect model, but the best one we have. I think we can make it work. I think there are some fine-tuning adjustments that need to be made.

Certainly with regard to construction, I couldn't agree with you more. If the VA is to remain a national resource, we need to have a quality infrastructure, and it's going to take construction dollars to do that.

I forgot the last, but I'll follow up with more specific answers.

The CHAIRMAN. Thank you very much. Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman. Just one question, Mr. Secretary.

How does the VA plan to continue partnerships with union representatives in light of the recent executive order rescinding that partnership requirement?

Secretary PRINCIPI. I intend to address the labor union, I believe it is next week, and tell them of my commitment to work with them. I want to have a partnership with the labor union, and I intend to proceed in that manner and to work closely with them.

The CHAIRMAN. Thank you very much. Mr. Stump. Mr. Peterson. He has left. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman. Just very quickly, Mr. Chairman.

The Chairman touched on OMB, you have mentioned OMB. What a powerful non-elected group. I don't know whether you can tell us, and I don't mean to put you in a bad position, Mr. Secretary.

Of course, I consider you an advocate for veterans. Your job is for the veterans, but obviously, you've also been hired by the President.

You know, I would be very interested in knowing, if it's public—I mean, if it's some that could be made public—what your experience with OMB has been regarding this particular budget.

In other words, you made sort of a comment about you had to fight for the $1 billion. My God, are we then saying that OMB suggested it should be half a billion dollars or something of that nature, or were you higher than $1 billion, closer maybe to the 2.2 or whatever the case may be, and you had to basically come down?

I don't know whether this is something you would care to maybe talk about here. I don't know that we should take the time here.

Secretary PRINCIPI. Sure.

Mr. BILIRAKIS. But certainly I'd like to get something, maybe, whether it would be in writing from you or whatever, in our meeting, whenever it is that I know we've been trying to schedule, or whatever the case.

OMB just seems to me to be a little too damn powerful here.

Secretary PRINCIPI. Very critical. They play a very important role. Generally speaking, I have enormous respect for the difficult role that Mr. Daniels, the director, plays, and the people at OMB. I have enormous respect for them.

I must tell you that I thought I would have the shortest tenure in history when I received that first passback from OMB. I was really concerned.

Fortunately, I was able to work with Mitch Daniels. I spoke with the Vice President, spoke with the President, and, we were successful in getting it up to $1 billion. Of course, I wish it could be more.

But, yeah, it's a difficult process, and now the decisions with regard to how the $1 billion will be used is going to be—you know, I don't think it's going to be a tough process. I know how we're going to spend the $1 billion, and it's going to be tough for them to overrule me.

Mr. BILIRAKIS. Yeah, but I would suggest, before this comes out in the wash, it's going to be a heck of a lot more than $1 billion. I mean, if we do our job in this committee, it's going to be more, and the Appropriations Committee, Mr. Stump, and others.

Secretary PRINCIPI. But I have a good relationship with Mitch Daniels, and we both grew up somewhat, so to speak, on the Senate side of the Hill. We were both staffers there.

I think we both understand the process and respect each other, and I have an open door to him and we're in almost daily contact about these issues, and I will continue to work with Mitch Daniels, and I'm confident that we'll do okay.

Mr. BILIRAKIS. I understand that he's a University of Pittsburgh graduate, and that's my undergraduate degree. If he is, maybe we'll have an in there.

But, you know, who does he take his orders from?

Secretary PRINCIPI. The President, directly.

Mr. BILIRAKIS. I just would like, you know, I would just like to get the people at OMB out to see what we do.

Secretary PRINCIPI. Yeah, that's just it.

Mr. BILIRAKIS. I think if I could be successful in getting them into a VA hospital and talking to veterans——

Secretary PRINCIPI. That's just it, yeah.

Mr. BILIRAKIS (continuing). And getting into a regional office and seeing what we do, and the research we do, to try to open their eyes to some of the wonderful, wonderful things that the VA does day in and day out for a very deserving group of people.

Have we ever had them testifying before this committee? I don't ever remember them testifying before this committee.

You know, we're all accountable to someone.

All right. Thanks, Mr. Chairman.

The CHAIRMAN. Thank you very much, Mr. Bilirakis. Dr. Snyder.

Dr. SNYDER. Just a comment, since we're talking about OMB a little bit.

Our experience 2 years ago was we really went through an ordeal, but there was a lot of good-faith attitude at OMB. They thought that the number was an adequate number.

I know Mr. Evans had arranged to have a group of Democratic member sit down with him. I know the same with Republican colleagues, I know the VSOs. They actually believed that there were not waiting problems. You know, it was an educational experience, but I think there was a lot of work that went into that.

The only question I would ask, Mr. Secretary, is if I'm hearing you correctly, and I want to be sure I'm hearing you correctly, you are telling us today you would like more money than is in that budget number?

(Laughter.)

Dr. SNYDER. I can't read facial expressions.

Secretary PRINCIPI. I know. No, I support the President's budget, Mr. Snyder.

Dr. SNYDER. Thank you, Mr. Secretary.

The CHAIRMAN. I read it differently. Okay. Mr. Moran? Chairman Moran?

Mr. MORAN. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Reyes?

Mr. REYES. Thank you, Mr. Chairman. I have a number of questions for the record.

The CHAIRMAN. Surely. Without objection, they will be tendered to the VA, as will mine and Mr. Evans' and others.

(See p. 202.)

Mr. REYES. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Reyes. Mr. Filner.

Mr. FILNER. Thank you, Mr. Chairman.

Just briefly, I do want, for the record, to thank Mr. Baker for his moving comments, and I hope something will emerge from that, and I hope you do embark on your outreach program to OMB.

As Dr. Snyder said, we had a really heart-to-heart talk with the OMB under the Democratic administration, and they were using statistics for waiting times, for example, that looked like—they actually showed me, or showed us that from the—they were using a waiting time from the time, I don't know, somebody walked into the clinic and the time they got seen by the doctor, as opposed to the appointment waiting time.

There were some really strange statistics they were using. They didn't understand it. They just need some information and some education.

I'm not sure who responded to Mr. Crenshaw on the cemetery, the recommendation on the State Cemetery Grants Program. Mr. Rapp, I think, was it?

Mr. Rapp has given us in California some very good advice on the State Cemetery Grants Program, and we send out our local veterans to find the land, and that brought them into the process.

I think we have located with, you know, Mr. Rapp's advice and knowledge of the process, and I think we'll be able to, working with the State, working with VA, add some cemetery space under that program, which probably is under-utilized and allows the veterans to get in on the process, as it were, because I sent them out to look for the land, and they came up with some.

As I looked at the Independent Budget versus the recommendations, both of this committee and your bottom line, it seemed to me that the biggest difference was in the long-term care proposals, and so I would like you to, you know, look carefully at those. It looked like the biggest dollar figure difference, and that's something we wasn't to look at.

One last point, if I may—and I hope you're not in the position when we do get your specific figures that that report of yours that we keep referring to of the Transition Commission, which recommended such large increases for the Montgomery GI Bill, I hope as Secretary you're not forced to not do as much as you would like to do.

Lastly, I would just, as a committee—and Mr. Stearns, I think, referred to it earlier—I think the thing that gets us into the worst working relationship with the Department is when our legislation intent is just not met by the Department.

It seems to me that you have to give the legislation priority as opposed to some interpretation, especially when the intent is clear.

This is a minor issue I just want to just bring to your attention. Well, strike that "minor issue." It might not be viewed by many as minor.

We wrote some legislation requiring chiropractic services to be added to the VA's protocols, and there's just been tremendous resistance by the bureaucracy, based on prejudice against that. Well, I understand that prejudice, but we said otherwise.

We passed legislation years ago, several years ago, that has not been put into effect. I think it's wasting money. I mean, it's cost effective for you all, it gives veterans who want this kind of care a sense that they are being cared for, and besides, it's the law.

I can detail you, if you want, some other time, you know, some of the discussions we've had and some of the efforts we've had to try to get that law actually carried out by your department.

There's nothing that makes it worse for relationships when that occurs, so I hope you will look at that, also.

Secretary PRINCIPI. I certainly will. I think that's a very important point, and you have every right to expect that if a law is passed, that we're going to implement it in accordance with the law.

I certainly will work with the committee to keep you abreast of our progress in implementation.

Mr. FILNER. Thank you, sir.

The CHAIRMAN. Will the gentleman yield? I thank my friend for yielding.

Again, I want to impress upon you and your very distinguished staff, I agree with my good friend from California. We are concerned about laws that go unfollowed.

I mean, the long-term care capacity maintenance requirement imposed by the Millennium Act, in my view and many others, hopefully will be met sooner rather than later.

I mean, it's been 16 months since that legislation was enacted. You've only been on the job 5 weeks. We can't expect miracles, but we do encourage you to do whatever you can with regards to that.

Secretary PRINCIPI. Will do, sir.

The CHAIRMAN. Thank you.

I'd like to thank our very distinguished Secretary of Veterans Affairs, Tony Principi, for your testimony, and also your very distinguished staff.

We appreciate you being here and we'll look forward to working with you in continuing partnership on behalf of veterans. Again, thank you for your graciousness in this time commitment.

You've been here 2 hours. That's longer than most Secretaries that I have known, so we do thank you.

Secretary PRINCIPI. Thank you, Mr. Chairman, and members of the committee, and Mr. Evans. Thank you so much.

The CHAIRMAN. Thank you. I would like to invite to the witness table our second panel, which consists of four veterans' service organizations who have prepared the Independent Budget:

Harley Thomas from the Paralyzed Veterans of America; David Gorman from Disabled American Veterans, DAV; Howie DeWolf from AMVETS; and Fred Juarbe from Veterans of Foreign Wars.

Gentleman, let me just say that without objection, your full statements will be made a part of the record, but I do ask that you proceed as you would prefer.

I want members to know that the authors of the Independent Budget have demonstrated, in my view, how to put together a solid VA budget without even having specific proposals or numbers from the administration.

I have read and re-read the Independent Budget, and it has dozens of very, very good and viable suggestions. We will take many of them into account in preparing our views and estimates. Indeed, we have already done so. Our thanks to each of you for your part in preparing this very, very valuable document.

As has been the custom, our witnesses will be recognized for 5 minutes, in order to each present one part of this comprehensive budget proposal. We will start with Mr. Gorman, the chair of the Independent Budget, and he will introduce them, and move from there.

Mr. GORMAN. Thank you very much, Mr. Chairman. Good afternoon.

First, let me say that we appreciate your willingness to allow this panel to testify in the manner that we are, by sections of our responsibilities.

Before I introduce the panel, Mr. Chairman, if I may, I appreciate very much your comments regarding the Independent Budget.

I remember about 3 years ago when the Independent Budget decided to do town meetings. We did the very first one up in New Jersey, in your district.

You showed up before the Independent Budget meeting started with about probably 800 veterans up there. You stayed and listened to all of us make our presentations for the call for action for these veterans to respond in a like manner.

You also talked to them, and you stayed afterwards, and believe me, it was impressive then and it's impressive today. We welcome you to the Chair of the Veterans' Affairs Committee, and we look forward to working with you and your staff.

Mr. Stump, it's good to see you, that you, as the chairman of the last session of Congress returned to the committee and are lending your expertise and your guidance and your counsel to a committee who we enjoy very much working with, so we thank you for that.

If I may, Mr. Chairman, as you indicated, turn the hearing over first to Mr. Harley Thomas of Paralyzed Veterans of America, for the health care section, who will be followed by Mr. Juarbe to present the construction issues of the Independent Budget, followed by Mr. Howie DeWolf of AMVETS for the national cemetery system, and myself to wind it up with the benefits section.

STATEMENTS OF HARLEY THOMAS, HEALTH POLICY ANALYST, PARALYZED VETERANS OF AMERICA; FREDERICO JUARBE, JR., DIRECTOR, NATIONAL VETERANS SERVICES, VETERANS OF FOREIGN WARS; HOWIE DeWOLF, NATIONAL SERVICE DIRECTOR, AMVETS; AND DAVID W. GORMAN, EXECUTIVE DIRECTOR, DISABLED AMERICAN VETERANS

STATEMENT OF HARLEY THOMAS

Mr. THOMAS. Mr. Chairman, Mr. Smith, it's a pleasure to be here before you today, and members of the committee.

On behalf of the Paralyzed Veterans of America and the Independent Budget, it is our distinct pleasure to present the health care portion of the VA budget for fiscal year 2002.

The VA medical system is a national asset. After years of chronic underfunding and fiscal neglect, the VA has seen budget increases for the past 2 fiscal years. It is essential that the health care increases realized over the last 2 years be continued in fiscal year 2002.

There must be continued and sustained investment in the VA health care system, investment in protecting and strengthening specialized services, and improving access and ensuring that the infrastructure exists to provide first-rate health care as sought by our members and promised by the President.

To accomplish these goals for fiscal 2002, the IB recommends a $2.7 billion increase for VA medical care above the 2001 appropriation.

Every year, the VA requires additional funding in order to maintain the status quo. This additional funding is required because of mandatory salary increases and the effects of inflation. For fiscal

2002, the IB estimates that these "uncontrollables" will require an increase of $1.3 billion.

In addition, the IB has identified a necessary increase of $884 million to cover the startup costs of institutional and non-institutional long-term care initiatives mandated by Public Law 106–117, which was enacted by Congress.

The remainder of the recommended increase, $523 million, is slated to fund the vitally needed initiatives, including spinal cord injury/dysfunction capacity, meeting the challenge of rising pharmaceutical costs, and maintain VA capacity for mental health services.

Over the past 5 years, the capacity of the VA to protect SCI care has been seriously degraded by substantial staff reductions, despite the mandate instituted by the 1996 Congress to maintain system capacity.

Local hospital officials reduced SCI staff to a point they could only operate 65 percent of the SCI/D beds reported as operational in 1996.

Last year, the VA issued a directive establishing the minimally acceptable level of staffing and staffed beds at each SCI Center, and issued a memorandum regarding the need for local managers to identify and provide additional resources required to restore the mandatory staffing levels. The IB has requested $25 million additional funding to begin the restoration work.

We have all read the news stories concerning the increased cost of pharmaceuticals faced by our citizens. This was a primary issue during the recent campaign.

Because of the increased patient load projected by the VA, the IB has estimated that these increased costs will total $65 million.

The IB recommends a $100 million increase for mental health programs, a first step in a 3-year recommendation to add a total of $300 million to these vital programs.

The IB has recommended medical administration and miscellaneous operating expenses, MAMOE, of $12 million, bringing this account up to $74 million. Funding shortfalls in the MAMOE account have left the VA unable to adequately implement quality assurance efforts or to provide adequate policy guidance within the 22 VISNs.

Another important asset of the VA is its Medical and Prosthetic Research Program. With the bipartisan push to double the National Institutes of Health funding over the course of the next 5 years, we must not allow the VA Medical and Prosthetic Research Program to be left behind.

The IB advocates a $45 million increase to bring this account up to $395 million.

On February 28, the President released his "Blueprint for New Beginnings." This Blueprints a discretionary spending increase for veterans of $1 billion. However, this $1 billion increase will not fully be realized by veterans' health care. Traditionally, only 90 percent of discretionary increases accrues to health care.

As I've stated before the VA requires at least a $1.3 billion increase just to keep pace with fiscal year 2001. This means that the President's Blueprint falls short of what is required to maintain the status quo of the VA health care system for the coming year.

The Blueprint assumes a transfer of health care liabilities.

The administration may argue that the increase for VA health care will be higher because of its assumption that $235 million in VA health care liabilities will be shifted to DOD. This will be implemented by proposed legislation that would mandate that veterans choose either DOD or VA to receive their health care.

The administration assumes that 27 percent will switch to the DOD. There seems to be no justification for this percentage.

We agree with you, Chairman Smith, that, "The proposed $1 billion increase is a significant step in the right direction," and we applaud you for your recommendation.

We are heartened, and we also desire to push for even more money in the final budget, to address other pressing needs, such as long-term care, chronic illnesses, and transitional housing for homeless vets.

We, too, believe that the administration's Blueprint is a step in the right direction, but there is much, much more needed and much more must be done.

We recognize that this committee does not appropriate dollars, but you do authorize them. The authorization process must recognize the real resource requirements of the VA.

We look to you and your expertise in veterans' issues to help us carry this message forward, to your colleagues and to the public, I believe that was pointed out most eloquently in the past panel.

I thank you for this opportunity to testify concerning the resource requirements for the VA health care for fiscal year 2002, and I'll be happy to answer any questions.

[The prepared statement of Mr. Thomas appears on p. 78.]

STATEMENT OF FREDERICO JUARBE, JR.

Mr. JUARBE. Thank you, Mr. Chairman. On behalf of the Veterans of Foreign Wars and the Independent Budget, I have submitted a formal statement, which I would request be entered into the record.

The CHAIRMAN. Without objection, so ordered.

Mr. JUARBE. Thank you. Mr. Chairman, members of the committee, I would like to, if I may have your indulgence, to put a human face on the Independent Budget's request and that portion that I am presenting.

Mr. Chairman, on Saturday, March 3, 2001, I buried a friend. His name was Elton Campbell, but his family and friends knew him as Jack. The following summary of this man's life may seem all too brief, but what an awesome legacy it represents.

Jack was part of the generation that saved the world. As a corporal in the U.S. Marine Corps, he fought in the Asiatic Pacific theater during his service from July 28, 1944 to April 5, 1946.

Born on July 5, 1922 and raised during the Great Depression, he served his country, raised a family, and passed away on February 27, 2001. Jack is survived by his beloved wife of over 50 years, Evelyn, and his three daughters and one son.

A man of very modest means, Jack and his wife served faithfully in our church and in their community. He, as an usher until his advancing age and illness prevented his continued service, several years ago. And Evelyn, as a volunteer, faithfully and reverently prepares the communion sacraments in our church.

The relevance of Jack's existence and his death to the purpose of this hearing on the VA budget may escape some, but I am certain that all of us here know beyond a shadow of a doubt that it is because of and for Jack Campbell that we are here.

Not having asked this country for much when young, Jack was nonetheless able to buy a modest home under the GI bill, that he would have otherwise perhaps not been able to afford. As his widow, Evelyn, recounts gratefully, had it not been for the provision of medical care and critically needed medications by VA to sustain his health and quality of life during his protracted illness, they would have paid a heavy toll.

Much of what they owned and treasured, according to Evelyn, would have been lost, had they been required to pay for Jack's medical care all those years. For that, Evelyn thanks you from the bottom of her heart.

Jack's burial last Saturday was marked by an event that moved all to tears, or at least to quivering lips, and which no one there will ever forget.

You see, Mr. Chairman, Jack was honored by 15 of America's finest, a U.S. Marine Corps burial honor guard. These young Marines, six pallbearers, carried Jack, who was not a small man, with ease and sharpness. They folded his flag with precision, and reverently gave it to Evelyn.

Their captain brought the seven-man rifle squad to attention, and they fired a 21-gun salute. The 15th member of their detail, the Marine bugler, then played Taps.

Had this special ceremony not taken place, I would suspect that many, if not most, present at the burial would not have missed it, but I knew that it happened because Congress made it possible, just as Congress made possible the care that Jack received during his waning years.

Congress, expressing the will of a still grateful nation, funded the medical care Jack received from the VA. Congress also mandated that the military provide burial honors for veterans. Quite simply, Mr. Chairman, Congress did the right thing.

I come before you encouraged that you already are doing the right thing with your proposal to safeguard and improve the VA's capacity to provide medical care to veterans for the foreseeable future, with your proposed Veterans' Hospitals Emergency Repair Act, H.R. 811.

This proposal speaks to the heart of the concerns expressed by the Independent Budget veterans' service organizations regarding the construction needs of the VA.

My testimony and the Independent Budget legislative proposals in support of construction funding are a matter of record.

With all the improvements that have taken place in the provision of health care for veterans, we remain concerned that those very improvements are somewhat analogous to retrofitting a C–119 with space shuttle avionics.

Please do the right thing to build a physical infrastructure that can deliver the world-class medicine VA is capable of providing, and that America's veterans so rightfully deserve.

Thank you, Mr. Chairman.

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

The CHAIRMAN. Thank you, Mr. Juarbe, for your very moving statement. And you are correct. We have already taken the Independent Budget, in a bipartisan way, fully into consideration in devising our views and estimates, which will be submitted tomorrow when we hold a meeting to mark up the resolution. Mr. DeWolfe.

STATEMENT OF HOWIE DeWOLF

Mr. DEWOLF. Mr. Chairman, Ranking Member Evans, and members of the committee:

I am Howie DeWolf, the National Service Director of AMVETS. AMVETS is honored to join our fellow veterans' service organizations in providing you our best estimate of the resources necessary to carry out a responsible budget for fiscal year 2002 programs of the Department of Veterans Affairs.

Mr. Chairman, I have submitted a written testimony for record, and request it be accepted with your approval.

The CHAIRMAN. Without objection, it will be made a part of the record.

Mr. DEWOLF. Thank you, sir.

Due to the length of time available to us, I will briefly summarize our recommendations as they pertain to the National Cemetery Administration.

The Independent Budget veterans' service organizations acknowledge the dedication of the National Cemetery Administration staff, who provide the highest level of service to veterans and their families.

To provide this service, they oversee an infrastructure that includes 19 national cemeteries in 39 States, the District of Columbia, and Puerto Rico, 2.3 million gravesites in over 13,000 acres and more than 77,000 interments annually.

With this level of effort, the addition of new cemeteries and the anticipated increased interment rate of the aging veteran population, the Independent Budget veterans' service organizations recommend the following:

First, that the National Cemetery Administration operating budget should be funded at $119 million for fiscal year 2002, a $10 million increase over fiscal year 2001. This ensures our Nation's veterans are honored with a final resting place and a lasting memorial to commemorate their service to our Nation.

Secondly, we recommend the State Cemetery Grants Program be funded at $30 million. Long-term operational costs have deterred many States from participating.

The grants program provides funds to assist States in establishing, expanding, and improving State-owned cemeteries. Lack of participation is in part due to the low plot allowance of $150. We recommend it be increased to $600.

Additionally, we recommend that the eligibility be expanded to all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

Finally, we recognize that the National Cemetery Administration revised its strategic plan to address the 5-year period of 1998 to 2003. However, it is unclear to us how the system proposes to address the period of greatest demand, 2003 to 2008.

We recommend that the National Cemetery Administration establish a strategic plan for 2003 to 2008, and Congress make funds available for planning and fast-track construction of needed national cemeteries.

A great many Americans are aware that on the 18th of February, Dale Earnhart died in the last lap of the Daytona 500.

He was a 49-year-old veteran race car driver who was at the pinnacle of his career and who had earned the respect of the entire race car community. The media continually reminds us of his loss.

Certainly, nothing should be taken away from this man. He was a professional, and the best at his profession.

On the other hand, just a few weeks ago, six U.S. Army soldiers died in a training accident when two UH–60 Black Hawk helicopters collided during night maneuvers in Hawaii. Their children were mostly toddlers who will lose all memory of their daddies as they grow up. They died defending our freedom.

I take nothing away from the accomplishments of Dale Earnhart, but I ask you to perform a simple test.

Ask your fellow members or constituents who was the NASCAR driver who died on the 18th of February. Then ask them if they name one of the six soldiers who died in Hawaii 3 weeks ago.

Dale Earnhart died driving for fame and glory in the Daytona 500. the Nation mourns. Six soldiers die training to protect our freedom. Few can remember their names.

On Sunday, February 25, 10 years ago, the largest loss of American life in a military conflict in the last 10 years took place during Desert Storm. Twenty-eight young Americans were killed and 99 others were seriously injured.

You and your fellow Members recently honored those soldiers by passing House Concurrent Resolution 39. We thank you for remembering their service to our country.

In a similar manner, we ask you to remember the service of all our Nation's veterans who have guaranteed our freedoms during times of both peace and war by honoring them with a final resting place and lasting memorials. Your support of proper funding of the National Cemetery Administration will help accomplish this goal.

Mr. Chairman, this concludes my remarks. I thank you for the privilege to present my views and would be pleased to answer any questions you or the members of the committee may have.

[The prepared statement of Mr. DeWolf appears on p. 90.]

The CHAIRMAN. Mr. DeWolf, thank you very much for your comprehensive testimony. Mr. Gorman.

STATEMENT OF DAVID W. GORMAN

Mr. GORMAN. Thank you, Mr. Chairman.

I think Mr. Juarbe and Mr. DeWolf, in their testimonies, have, as Mr. Juarbe said, put a real human face to the issues that we face today, and that's really the reason that the four organizations that sit before you have put together the Independent Budget; it's the reason why you sit on this committee and try to do the right thing, sometimes in the face of great odds from other Members of Congress who don't as fully understand the importance of the work that you do and that we try to do.

I would say, Mr. Chairman, that this is the 15th year that the Independent Budget has been put together. We started as a very small, ragtag group back in 1985, 1986. Really, this was the birthchild of Dr. Don Custis, who was the former Chief Medical Director of, then, the Veterans' Administration. It was his idea and his persistence that brought the veterans' service organizations together to really bring us to where we are today.

I hope where we are today is a group of four very daring organizations who expend a tremendous amount of human and other resources to put together a document intended only to do one thing—and you stated it very well in your opening statement—to serve as another benchmark for where we think the real needs of veterans' benefits programs exist, to help you in your deliberations and your discussions with other members of the Budget and the Appropriations committees, and other Members of Congress to try to what is needed for veterans.

I would be remiss if I sat up here and said it's only an effort of the veterans' service organizations. We have to thank the Department of Veterans Affairs and their personnel who we count on to give us information, discuss issues, policies and procedures with. They've been very helpful in that endeavor.

As I said, Mr. Chairman, my remarks today will focus on the budget and policy issues for the benefit programs, which is the Disabled American Veterans' primary area of responsibility in the Independent Budget.

Also, because the President's budget does not offer details for us to address, I will highlight the IB recommendations for legislation and for resources.

Typically, Mr. Chairman, the administration's budget proposes a cost-of-living increase for compensation and dependency and indemnity compensation.

The IB also recommends an increase to keep compensation in line with the increase in the cost of living. To stay even with the cost of living, compensation must be increased by the same percentage as the annual rise in the cost of goods and services, as measured by the CPI.

However, as temporary deficit reduction measures, and to offset other spending, COLAs have been rounded down to the nearest whole dollar for some time. Each and every year the VA's budget recommends legislation to make this rounding down a permanent requirement. Regrettably, this budget continues the same objectionable recommendation.

Mr. Chairman, we remain at a loss to find any legitimate reason for that recommendation. We all know that many disabled veterans barely survive on the modest compensation they receive.

To us, this continued annual proposal is not in keeping with the obligation this Nation has to care for those disabled in service to their country.

This could not be done, however, Mr. Chairman, without your concurrence, and we look to you to make a strong statement that you will not move legislation for this singular purpose. Indeed, we would urge the committee to repeal the temporary round-down provisions already enacted.

We also urge you to reject the administration's proposal to make permanent the user fees and other temporary deficit reduction measures imposed upon veterans.

If I may, I would turn and address briefly the delivery of benefits, Mr. Chairman.

For years, VA has struggled to overcome poor quality and large backlogs in its compensation and pension claims processing system.

The President's budget states a commitment to ensuring timely and accurate processing of veteran's claims. We hope the details of the budget requests for VA include a real and meaningful request for the budgetary resources necessary to bring about that stated goal, and I believe they will. Adequate resources are a central issue in this respect.

In the IB, we recommend an additional $60 million to cover the cost of 830 new full-time employees for VA's compensation and pension service.

VA desperately needs these additional employees to make up for unwarranted past reductions in staffing and to meet increased workload demands.

It also needs these employees to improve adjudicative proficiency and accountability, and I would again say accountability, which is a key to the system, and thus improve the efficiency of that system.

To do this, VA needs not only to increase the number of decision makers, it needs employees to train as adjudicators in the law and procedures and employees to perform quality control reviews and enforce quality standards.

These additional employees are absolutely essential to any hope of fixing the problems in VA's claims processing system.

As I have noted in my written statement, even with optimum quality, an irreducible number of errors are inevitable in a mass adjudications system as large and complex as VA's.

That's why, Mr. Chairman, meaning and effective judicial review is also essential to enforce the laws and maintain fairness and uniformity in claims decisions.

In the IB, we recommended changes to make our judicial review process a more effective enforcement mechanism for veterans. I won't cover those here, but I ask that you refer to the Independent Budget for those recommendations and for several other recommendations to improve the benefits and their delivery.

Again, Mr. Chairman, we want to thank you for your attention. Welcome to the chair of the committee. That concludes my statement.

[The prepared statement of Mr. Gorman appears on p. 92.]

The CHAIRMAN. Thank you very much, Mr. Gorman, for your testimony and for the good work you do on behalf of veterans. I do have just a few questions I would like to ask.

Again, having read extensively, and underlined and yellow-highlighted the Independent Budget, both the summary and then the fuller text, it is a very, very useful product and will help both of us, all of us on both sides of the aisle as we make our recommendations to the Budget Committee and as we act as advocates for veterans in the appropriations process when we get there as well for as our legislation.

You give us a backdrop. As I said in my opening statement, every year it seems the Independent Budget gets better. It can bear the scrutiny that it must undergo. I met with the OMB director, others perhaps have done so as well—there usually is a learning curve when it comes to veterans' issues.

There's too much assuming that goes on as to what is required and the assumptions usually are in the negative in terms of monies that need to be married up with programs and projects.

In looking at—and I do have a number of questions, but I'll just narrow it—mental health programs for disabled veterans, as you know, over the last 5 years, the Department has conducted a managed shift of resources and programs away from institutional mental health.

It's been estimated by the VA advisory committee on seriously mentally ill veterans that the diversion of funds may be as high as $600 million. The VA, as we know, dramatically expanded its primary care clinics, which we all know as community-based outpatient clinics.

While we have supported that, we're very concerned about the loss of resources for the mentally ill, and I wonder if you might want to comment on that, as well as the issue of specialized care, which you've done so well on, for spinal cord injury veterans, and the like.

We've looked at your recommendation of $23 million and think that it's very justifiable, and hopefully we can persuade our friends on the Budget Committee and others in Congress as to its utility.

Mr. THOMAS. We truly believe that the figures that we have produced in the Independent Budget and put forth to this committee are very factual.

The data that we analyze is done on a very tight schedule, scrutiny basis. We have some high-level individuals that manipulate the data; and again, we appreciate the information that we get from the Veterans' Administration itself.

We believe these figures are correct. We don't believe we can do any less and provide the services that are necessary in both of those areas.

The CHAIRMAN. If I could, on the mental health side, have you seen a diminution of services being provided to our mentally hurting, mentally ill veterans?

Mr. THOMAS. I can't give you any specific figures on that, Mr. Chairman, but I have been told that those areas are on the down side.

Mr. GORMAN. There may be an indication, Mr. Chairman, that there are areas in the mental health field that are being diminished, and I would speak specifically probably to substance abuse and drug treatment programs.

What was once an inpatient program has now been relegated to an outpatient program, I don't think necessarily all the time to the betterment of the veteran patients.

Another area that may help to alleviate some of this issue, not only with mental health but other specialties, is while we all agree upon the concept of CBOCs, or the community based outpatient clinics, I would be concerned that the VA staff those in a manner that the staff can take care of the patients that are coming in, and

not simply be a referral center back to VA medical centers. That doesn't necessarily provide the needed assistance, and it defeats the purpose for which CBOCs were intended.

The CHAIRMAN. Would I be right to assume that you fully support the enactment of the legislation Mr. Evans and I have introduced on medical construction, hospital construction?

Mr. GORMAN. I'll be honest with you, without having read the legislation itself, certainly the concept is there, and I think Mr. Juarbe spoke to that in his testimony and the Independent Budget certainly speaks to it.

The CHAIRMAN. We would invite from all of you any recommendations for improvement, but also as to whether or not you would support it.

Let me just ask, Mr. Gorman, the DAV was a very strong advocate for restoring the VA's duty to assist veterans who file claims.

How is this affecting your service representatives who represent so many veterans, and do you think the VA budget is adequate to implement this law?

Mr. GORMAN. It certainly is creating an additional workload on us, as well as, I'm sure, all the other organizations, and in fact the VA.

It's a process where we're told the VA now is reviewing some 98,000 claims or 98,000 individual decisions that were made under the duty to assist.

It does have an impact, but it's the right thing to do. It's regrettable that the whole issue moved forward the way it did from VA.

I think they really, for the sake of maybe trying to make the system easier to deal with, they abandoned their long-standing tradition of helping, and I think that's what the VA is all about, is helping and providing the benefits they have to provide.

The CHAIRMAN. Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman.

Your Independent Budget proposal seeks to restore $23 million in shortfalls in the spinal cord injury program. Can you tell us how this figure was arrived at?

Mr. THOMAS. I can't give you the specifics on that, Mr. Evans.

Our statistician was the one that came up with the figures, and this is based upon workload studies, the number of veterans that have spinal cord injury, the increased number, and the reduced staffing levels that we've experienced over the past couple of years in the SCI centers.

Mr. EVANS. The Independent Budget estimate said $848 million should be added to the VA medical care budget to implement the long-term care provisions of the Millennium Bill.

Will you tell us briefly how you estimated the need for institutional and non-institutional care and the cost of these services in fiscal year 2002?

Mr. THOMAS. I will have to defer and give you a written answer on that one, sir, because I do not have the statistics on how that figure came about.

Mr. EVANS. If you could, for both questions, submit whatever information you would like to give us, I would appreciate it.

Mr. EVANS. Thank you, Mr. Chairman.

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

Mr. STUMP. Thank you, Mr. Chairman.

Gentleman, thank you not only for your testimony here today, or for the work you do on the Independent Budget, but for the work you and your respective organizations do day after day, year after year, for our veterans. Thank you very much.

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

Mr. FILNER. Thank you, Mr. Chairman. I want to, as I say many times during the year, thank you for the Independent Budget. It gives us a point of reference. We know it's very professionally produced.

I have traditionally offered the Independent Budget as the framework for the committee to make its recommendations to the Budget Committee, and I think it's a good reference point for us all.

I did note, I think, in my earlier statement, when the Secretary was here, that it looked to me that the biggest difference between the budget that either the committee or the Secretary was talking about was in long-term care, and I just wondered if you would want to take this opportunity to fill in what that might mean for our veterans.

You were very good about using specific people today. I wonder if you might just take some time to tell us how long-term care, the $850 million or so that you recommended, might help specific—how it would help—what it would mean to the lives of our veterans.

Mr. GORMAN. Well, I think it's clear that long-term care, especially with the aging veteran population, is an extremely important part of their continuum of care.

The VA does extremely well on both an outpatient and an inpatient basis, as far as taking care of acute and chronic diseases. There comes a point in time, however, where long-term nursing home care is an inevitability.

It's a qualify of life issue, in many instances. It's a— as Mr. Juarbe pointed out in his testimony, it has a tremendous impact, not only on the veteran patient, but on the family. It's a needed piece of medical care.

The other part of that is the alternatives to institutionalization, and those are the adult day health cares, the respite cares, etc.

We would like to see the VA move at a much quicker pace than they already have, only because, again, that really represents, at least in DAV's perspective, a real quality of life issue.

The longer you can keep somebody out of an institution, obviously, the quality of life is going to be improved.

So we're looking forward. It's discouraging that it hasn't moved forward, the regulations, as of yet. We're looking forward to the Secretary's commitment to move those as quickly as possible.

There is one glitch to—this has recently been brought, at least to my attention. When legislation was passed, it dealt with long-term care and nursing home care being offered to a veteran for a service-connected disability or for veterans who were 70 percent or greater service-connected.

It's now my understanding, and we believe incorrectly, that the VA has narrowed that definition of 70 percent to veterans who have a single disability at 70 percent, rather than for veterans who

may have multiple service-connected disabilities with a combined rating of 70 percent.

We're going to be taking a look at that, and we would hope that if we're correct, if that is, in fact, the intent of Congress, that you would be willing to work with us on that.

Mr. JUARBE. Mr. Filner, if I may add, having had the opportunity to serve on the Federal Advisory Committee on the Future of Long-Term Care with the VA, we addressed the future concerns.

One thing that was very clear to me, notwithstanding the increased reliance and very beneficial approach providing non-institutional care close to the home, in the community, or in the home itself, that there will be an increasing number of veterans that will need institutionalization.

My concern is with the improper placement of many of these veterans just for the sake of reducing costs.

There's always the tendency and the temptation to do that, to place somebody improperly in a community or in a home-based care program who should otherwise be institutionalized.

I would also offer the more recent studies, investigative reports that were written in *The Washington Post*, I believe it was just last week, that had to do with the use of assisted living and the improper use of assisted living in the private sector.

While the VA is a leader in long-term care, it is something of a novice in the area of assisted care living, and we've encouraged it to go in that direction, but we would also be concerned that it approach it very cautiously, very carefully, and that it not rely on assisted living as a substitute for other levels of care, higher levels of care that would be required in providing long-term care.

Mr. FILNER. Thank you. Mr. Chairman, I would hope that the committee, your counsel, might make the inquiry to the VA about the specific question on 70 percent total versus for one, as I understand, it, if we may just do that officially.

And again, as we proceed under your tenure, Mr. Chairman, I hope you will take—we will look at long-term care. It just seems to me the one piece that it missing from your good recommendations that we will consider tomorrow.

The CHAIRMAN. Thank you very much, Mr. Filner. Dr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman.

The CHAIRMAN. If I could, before you do, just to respond, we do make a recommendation in our budget for implementation of the Millennium Health Care Act of some $68 million, and admonish the administration, as I tried to in my comments to our distinguished Secretary, to faithfully implement that legislation.

It has been my—sorry, Dr. Snyder, I will go right to you—it has been my experience over the last 21 years as a Member of Congress that you have to follow up on legislation with several of the bills that I've had enacted into law over the years, I've gone back a year later and said: "What happened? Did it get lost on a shelf somewhere?"

So we will be doing our level best, because oversight and investigations, oversight is a very, very crucial part. So thank you for your comment. Dr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman. You're a hard-working chairman, Mr. Chairman, and you can take all the time you want, anytime.

Let's see, Mr. Thomas. I wanted to talk a little bit more about this research dollars.

As I read your written statement, you've got a fairly brief comment there about research in the prosthetics area, but it sounds like you share my concern that we see an augmentation—I think the President, in fact, talked about it in the speech last week—of increasing the research dollars for the National Institutes of Health.

But I'm getting increasingly concerned that, in other line items in the budget, it may not reflect that kind of increase.

Am I putting words in your mouth or is that what you're saying?

Mr. THOMAS. No, sir. That's exactly what our position is.

If you'll recall, the National Institutes of Health budget was supposed to be increased, doubled over the course of 5 years, several years back. It started off good for one year and then it kind of fell by the wayside.

The new President has indicated he wants to increase, double the budget over the course of the next 5 years.

We believe that the prosthetic research in the VA is very, very important. There are many innovative things that come out of that that not only help veterans, but help the general public, and——

Dr. SNYDER. Right. I think that's a good example where—excuse me for interrupting.

I think that's a good example, where the work that the VA does on research, while it may not be direct patient care, it benefits veterans.

I mean, we've had so many, unfortunately, so many of our veterans, through the decades of the 20th century, lose limbs.

Mr. THOMAS. Absolutely.

Dr. SNYDER. And not only from trauma, but also from diabetes and other conditions.

I think—is it Mr. Juarbe?

Mr. JUARBE. Juarbe.

Dr. SNYDER. Juarbe. You also make a comment, and I—yeah. I guess you were the construction guy in this operation. Your statement focused on the construction.

You specifically mention the need for additional funding for research facility upgrades. My guess is that's one of the real—the areas where we're most neglectful.

Do you have any comment on that?

Mr. JUARBE. Well, obviously, to carry out the research that is necessary, they need the proper facilities, and the facilities have not been upgraded as times have changed.

With the same deterioration we see in the physical plant providing health care, that same level of deterioration is occurring in many of the research facilities, and that's what we're hoping would be addressed.

Dr. SNYDER. We had an experience a couple—I believe it was a couple—years ago at the Little Rock VA, where they were at risk of losing funding for a VA research project because not all of it was

on the VA hospital, it was at the adjoining medical school, but they just didn't have the space.

I mean, they were actually proud of the arrangement they had made, but they desperately needed additional space.

I'm from Arkansas, but you, in your statement, I'd be interested—your comments about what occurred in Boston with regard to if there were additional infrastructure dollars there that would, in fact, save the money—save the VA money.

Would you talk about that a minute?

Mr. JUARBE. Mr. Filner, I don't—I'm sorry. Mr. Snyder, I don't have the specifics of that readily at hand, but I am aware that there were a number of proposals that have been made for consolidation of certain services in the Boston area, and the failure to carry out that project has resulted in the loss of $50 million per year projected savings that they have not been able to bring about.

Dr. SNYDER. Penny-wise and pound foolish?

Mr. JUARBE. Exactly. The cost of the project, as I understood, as we have it, was around $30 million. Had that amount been invested initially, it could potentially have saved by now $100 million.

Dr. SNYDER. I appreciate y'all's advocacy on behalf of research.

As you may know, I'm a family doctor that's trained in a couple different VAs, one in Oregon and one in Little Rock, 20 years ago.

And it is really important. I have this fear that—and we should focus on the National Institutes of Health, and I appreciate the President's commitment to it.

But if what's going on in the VA budget is reflective of what's going on in other budgets with regard to not just medical research, but research in general, I think we could have a real problem down the line in terms of our technology.

I mean, there's a lot of medical research dollars that comes out of the ag. budget. There's a lot of medical research dollars in the defense budget. You can go across the line items in different budgets.

It's going to be an area that I hope we focus on—what is the overall commitment to research, not just for NIH, although I support the increase in NIH.

Thank you for focusing on those needs.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Doctor.

I want to thank our very distinguished panel for your testimony, and again advise you that we are taking very seriously each an every one of your recommendations. I look forward to seeing you in the not-too-distant future.

I'd like to invite our third panel to the witness table, if they would. We'll start with James Fischl, then hear from Richard Weidman.

James is from the American Legion and will be testifying on behalf of the American Legion. Richard Weidman is from the Vietnam Veterans of America.

If you could proceed. Your full statement will be made a part of the record, but I invite you to proceed however you would like.

STATEMENTS OF JAMES R. FISCHL, DIRECTOR, VETERANS' AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; AND RICHARD WEIDMAN, DIRECTOR, GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA

STATEMENT OF JAMES R. FISCHL

Mr. FISCHL. Mr. Chairman, before I summarize my written statement, I would like to submit for the record the American Legion's view on the President's "Blueprint for New Beginnings" for the Department of Veterans Affairs, if I may.

The CHAIRMAN. Without objection, that submission will be made a part of the record.

(See p. 110.)

Mr. FISCHL. Thank you, Mr. Chairman and members of the committee.

The American Legion appreciates the opportunity to appear before you this afternoon. Our submitted statement outlines what we believe are VA's real funding needs for fiscal year 2002. Our budget recommendations are unchanged from those initially presented to this committee in September by National Commander Ray Smith.

In the fiscal year 2002 outline for the Department of Veterans Affairs, the President calls for a $1 billion increase for the entire VA. Simply put, the American Legion believes the administration's fiscal year 2002 discretionary budget for the Department of Veterans Affairs is not good enough.

It's not good enough to continue to provide quality health care for eligible veterans. It's not good enough to offset fixed cost increases in medical inflation and to address long-term care mandates contained in the Millennium Act.

It's not good enough to support a strong medical and prosthetic research program. It's also not good enough to hire and train enough veterans' claims representatives to expedite the delivery of earned benefits for veterans and their dependents.

The American Legion recommends a minimum $1.3 billion increase in health care appropriations for fiscal year 2002.

Maintaining current health care services alone requires nearly a $900 million increase. The Veterans Health Administration has made significant progress over the past 2 fiscal years in correcting years of funding neglect. Now is not the time to take a step backward from recent gains.

The American Legion supports Medicare subvention and generating new revenue sources for the Veterans Health Administration.

We believe that the GI Bill of Health is a large part of the solution to VHA's annual budgetary dilemma. It is up to this Congress to provide VHA with the tools it needs to help improve its own financial situation.

Mr. Chairman, veterans have a right to expect VA to provide accurate and timely claims processing. Too often, it takes many months, sometimes years, to get a claim correctly processed.

Unfortunately, the President's fiscal year 2002 budget outline does not contain adequate funds to strengthen VBA's ability to meet its responsibility to provide accurate and timely decisions.

The American Legion recommends a general operating expense budget of $1.2 billion for VBA for fiscal year 2002.

VBA must hire and properly train additional personnel to improve the benefits claims process.

The American Legion, over the past few years, supported a number of initiatives within VHA and VBA to improve the efficiency and effectiveness of service. The American Legion will continue to support reforms that clearly enhance service to veterans.

An example of this goal is the current CARES initiative, VBA's effort to incorporate new technologies into its benefits delivery system.

Achieving these goals will require a significant investment. The American Legion believes the President's proposed $1 billion increase for all VA programs does not provide for essential current services, let alone fund any new initiatives.

Mr. Chairman, you very recently and even today pointed out that private consultants have been warning that dozens of VA patient buildings are at the highest level of risk for earthquake damage or even collapse.

On February 28, 2001, a 6.8 magnitude earthquake damaged two of the buildings at the American Lake VA Medical Center near Seattle. These buildings had been cited as being at risk for earthquake damage. Because of a lack of funding, repairs were not made. The buildings now, of course, will have to be repaired.

What about the consultants and VA's own reports of an at-risk infrastructure? Are we prepared to gamble with the safety of our veterans?

Are we willing to again wait and make major repairs after the fact, when a lesser up-front expenditure for corrective maintenance would be more prudent and cost-effective?

Over half of the $250 million requested by the American Legion for VA is for major construction for fiscal year 2002. It's designated for seismic correction projects. It is time that Congress hears this message and provides sufficient funding to correct these dangerous deficiencies.

Mr. Chairman, the administration's fiscal year 2002 discretionary budget increase for VA is not good enough. The American Legion looks forward to working with this committee to seek out long-term solutions to VA's recurrent problems.

In the meantime, we respectfully ask the committee to join with us in recommending an adequate increase in VA's discretionary budget for fiscal year 2002.

Mr. Chairman, that concludes my remarks, and I'll be happy to answer any questions that the committee may have.

[The prepared statement of Mr. Fischl, with attachment, appears on p. 97.]

The CHAIRMAN. Thank you very much for your testimony, and we will get to questions momentarily, but we would like to hear from Mr. Weidman.

STATEMENT OF RICHARD WEIDMAN

Mr. WEIDMAN. Thank you, Mr. Chairman, Mr. Evans, Mr. Stump.

We appreciate all of the extraordinary work of you, Mr. Chairman—that you will be undertaking in the future as the new Chair, and I send you congratulations on behalf of all of us at VVA—and

of this committee, which has really been our champion and ever more so, in difficult times.

The Vietnam Veterans of America enthusiastically endorses the Independent Budget of the veterans' service organizations and is grateful to our colleagues at AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars, for all of their work.

While we enthusiastically endorse that, we would like to point out that merely to keep up with inflation, the Veterans Health Administration will require at least—at least—$1.7 billion.

That does not even begin even begin to meet all of the requirements of the Millennium bill, such as emergent care, et cetera, but merely to stay right where we are right now. That's figuring medical inflation, which runs in this country between 8 and 12 percent, at only an 8 percent level.

We believe, in addition, that the specialized services have, in fact, diminished, beginning with seriously and chronically mentally ill, but also spinal cord injury and others.

We need at least $600 million or an average of $1 billion over a 3-year period beginning with $600 million for fiscal year 2002, then $1 billion, and then $1.6 billion, or excuse me, $1.4 billion the third year to ramp up to restore that organizational capacity lost during those years from 1996 until 1999 when, with the help of this committee, we finally got an increase.

For VBA and the cemetery authority, we believe that—and MAMOE, et cetera—we believe we need roughly another $200 million or a total of a minimum of $2.5 billion, and that's a minimum, Mr. Chairman. For the capital—and that's in the discretionary fund.

Insofar as the capital fund, we're grateful to you, Mr. Chairman, for your introduction of H.R. 811, and we enthusiastically support that and other upgrading of facilities.

We were somewhat bemused at VVA about OMB constantly saying that we should close VA facilities because they're outmoded. The question that we had is: "How in the world did they get outmoded? How did you so mess up your stewardship?"

One of the most sacred principles we have in this country, whether you come from an urban area or a rural area, is you leave things better than you found them.

The hospitals do not belong to any current administration or anyone else, and certainly not to OMB. They belong to the veterans, present and future, in this country, and it's an obligation on our part to leave it in better shape than we received it.

In regard to Mr. Principi, we are delighted with Secretary Principi taking over VA. We know him well. While we don't always agree with him, we have tremendous respect at Vietnam Veterans of America for his honesty and for his caring.

We can't always say that about Office of Management and Budget, and there needs to be some significant education there.

One of the first rules that they teach in managerial accounting and in accounts receivable is, ask for your money. While that's true in medical cost recovery—third-party payments, if you will—that's also true in the Office of Management and Budget.

Part of the problem in keeping and in implementing the Millennium bill fully and in maintaining capacity at the legal level of fiscal year 1996 and adequately serving our veterans has to do with the fact that Office of Management and Budget has ignored that basic principle within a capitalistic democracy, which is, ask for the money.

Vietnam Veterans of America is totally committed to a holistic health care model, and more accountability at all sections of the VA. We are equally as concerned with how the money is used as we are with the amount of money itself.

Yes, there have to be adequate resources to keep pace with inflation and to restore organizational capability, but the principles of the Government Performance and Results Act need to be assiduously implemented in all VA activities.

That would begin with holding the managers accountable. No matter how much money, more money, we put in VBA, until they change the way in which they hold both the adjudicators and the supervisors and the managers accountable, the system will not get any better, because right now, it's throughput.

We would offer the analogy of Ford Motor Company. It wasn't until—it wasn't until they improved the quality of the product that they improved the quantity of the product that it could go on the market and be received by the consumers and therefore restore the confidence of the public.

Similarly with VBA, it's the accuracy with which the claim is adjudicated that's going to cut down on too many appeals and clogging of the system and delay after delay after delay.

With regard to holding managers accountable, we believe that at VHA there has to be a much better management information system in real-time developed for the VISN directors and for the under secretary's office to know exactly what is going on at any given time.

And until such time as the VISN directors, or Veterans Integrated Service Network directors, there is that kind of managerial system and they re held truly accountable for the quality, as well as the quantity of care of the full range of services set by the policy that was set by the Congress, then some things, such as specialized services and other instances such as Hepatitis C, we believe will have to be restored to centralized funding.

Nothing else worked when it came to prosthetics. The prosthetics program, with recentralized control, is now working very well.

When VHA can demonstrate that the VISN directors are in fact responding to the will of the Congress and to the will of the—working with the President and the Secretary, then restore that power and end centralized funding. Until that time, we need to make sure there's no more diminishment of capacity.

We do strongly comment the Veterans Health Administration for the veterans' health initiative and the move to make it a veterans' health care system, to move toward that, in the direction of taking a full, complete military history and using that in the diagnosis and the treatment.

There has to be a lot more effort in that regard, however, at VHA, and support by the Congress for that.

In regard to research, yes, there needs to be more money in research, but we would urge the Congress to make sure that the majority of the research monies that are allocated to VA go to address the wounds of war.

It is not a generalized health care system that happens to be for veterans, it is a veterans' health care system, and more working with your colleagues in regard to the National Institutes of Health—National Institutes of Health, theoretically, can address veterans' problems. In fact, they never do. In fact, they never do any studies solely of veterans of any generation.

So there needs to be more money and more cooperative relationships worked out that will instigate studies of veterans at NIH working closely with VA.

Two last things—three last things, if I may, Mr. Chairman.

One is that Secretary Principi, who has a terrific management team at the under secretary level, we believe, and hope that they continue, have a heck of a problem in front of them in terms of changing the corporate culture all the way through, as was noted by Mr. Baker and others.

Mr. Baker's suggestion, incidentally, about having a national 800 number that then switches off by computer point to each VISN but is monitored, I would suggest that you need to tell them what they've won, Johnny, as they say on the television show, and list—in New York State a couple of years ago, working with the Governor, we issued a New York State Veterans' Bill of Rights for Employment Services.

Other States, such as New Jersey, have emulated that, and around the country, where you said what you were entitled to, and if you don't get it, call this 800 number, and somebody will respond immediately.

And that worked. It made essentially every veteran in the State of New York, when it came to employment services, an omsbudperson.

I would suggest that the same thing would be true at VA if you follow through on Mr. Baker's suggestion, and help in changing that corporate culture.

Last, but by no means least, we would urge you strongly on this issue of accountability to hold oversight hearings on both VBA and VHA, as well as the cemetery authority, on what they said they were going to do in fiscal year 1999 and fiscal year 2000.

Since the Congress gave them significantly more money than they said they needed to accomplish those goals, we would urge you to have a series of oversight hearings that drills into some of the issues of greatest concern to the veterans' community.

Mr. Chairman, I thank you very much for your patience and for all of the efforts of this committee to make sure that we have the resources and the accountability that we need in order to deliver the best quality care to America's veterans.

[The prepared statement of Mr. Weidman appears on p. 117.]

The CHAIRMAN. Mr. Weidman, thank you very much, and I think your point is very well taken about the issue of accountability.

As you might recall, I began this hearing talking and focusing on accountability and the fact that we do not have the kind of measure as to how well or poorly our money is being spent, and account-

ability, it seems to me, sharpens the mind, and we do plan to have a series of hearings in the oversight committee, as well as full committee, with a focus on that very, very important issue.

It's not just the money, as you pointed out, it's how well it's being utilized. So thank you for that. And of course, we'll learn how to better utilize it going forward, and hopefully, we'll learn it together with the VA.

Mr. Fischl, in looking at your testimony, and this really hasn't been discussed in today's hearing, but regarding the issue of the Persian Gulf War veterans, you point out that September's Institute of Medicine, the IOM, because of lack of sufficient information or science, was not able to really come to any concrete conclusions.

They recommended additional research for long-term health benefits, or health effects, as you would say, and then you and the American Legion made the recommendation that appropriate action should be taken to extend the presumptive period for VA undiagnosed illness compensation claims which is set to expire on January 1, 2002.

Would you please elaborate on that?

Mr. FISCHL. Yes. We believe that this should be extended, and we believe that the Secretary can do that without legislation, that he has the authority to do that, and we would ask the Secretary to consider that, because we believe that undiagnosed illness is real and we believe that it cannot always be identified.

Doctors have a tendency to put a label on something and give it a name, and if you give it a name, it's no longer undiagnosed, but we believe undiagnosed illness is a legitimate concern, and there are many veterans suffering from undiagnosed illnesses related to their service in the Persian Gulf, and we believe the VA should extend that entitlement.

The CHAIRMAN. Mr. Weidman, I take to heart your comments about research being dedicated to the wounds of war, and I couldn't agree more, but I think there are some exceptions with the practical implementation of a program to help especially those suffering from dementia.

The VA estimates that 600,000 veterans are suffering from brain diseases. Many of them are Alzheimer's.

I noted earlier the committee's deep concern, and frankly, our happiness, over the fact of what is being done at some of our GRECCs, particularly the one in Bedford, MA, and we hope that additional dollars would be spent to help those who are suffering from Alzheimer's, many of whom are the World War II veterans.

So I just note that while generally, I would agree, I think there are some exceptions where the practical and the research dollar might go hand-in-glove. We are looking to plus-up research as well as long-term care in our recommendation to the Budget Committee.

$88 million more, I think, I said $68 million earlier, I meant $88 million, for long-term care, and we are looking to plus-up again the research dollars, as well.

Mr. WEIDMAN. If I may, Mr. Chairman.

The CHAIRMAN. Please.

Mr. WEIDMAN. The corporate culture and the focus here is really important. Let us take dementia.

Dementia, there are studies now, or looking at, mostly not at VA, but at individuals who had head wounds as young people having a greater incidence of dementia at an older age, similarly, potentially those who had been through traumatic events of any sort.

So relating it back to the wounds of war on that general research, whether it be Alzheimer's or anything else, is important. Let me give you just one example, if I may.

In VISN 3, I sit on the advisory, outside advisory committee to the MIRAC, which looks at research on mental illness, and Tom Harvey and I made this suggestion, who also sits on there as a layperson, who many of y'all know is a fine veterans' advocate, and they made the change. They were talking about schizophrenia research.

Our point was, are you taking down whether or not—a combat exposure scale for these people, and seeing if there's any difference in the course of the disease of schizophrenia if, in fact, these people have been exposed to either gross physical wounds or combat exposure in great degree, so they might have post-traumatic stress disorder, which dramatically changes the course of the disease?

They hadn't, and they have changed the research protocols within VISN 3 at this time.

That's all I'm suggesting, is that the mindset shifts. You still can do the basic research. Just add some other factors into it, and then it becomes more immediately applicable to the men and women who have been injured by virtue of service to country.

The CHAIRMAN. I thank you for that elaboration. My good friend from Illinois.

Mr. EVANS. Thank you, Mr. Chairman.

The Legion is continuing its support of Medicare Subvention. Do you believe that the VA will be able to bring in additional revenues that could be used to provide additional care to veterans, given the fact that the Secretary spoke so strongly about that possibility?

I believe it's debatable, but do you see that as a realistic source of dollars that could be used by the VA to treat other veterans?

Mr. FISCHL. We believe it would, because the Category 7 veterans are entitled to Medicare, and if they are treated at the VA hospital, they have to pay for their care. If they go to a private hospital, Medicare will then cover it.

But if they come into the VA, the dollars, with Medicare subvention, would follow them to the VA hospital. It would bring in significant amounts of money.

Also, then, we believe dependents would then be treated at the VA hospital, and we support this, because that would also bring in more money and that would significantly help the VA.

Mr. EVANS. All right. Rick, the VVA has asked the committee to disregard the proposal by the administration to transfer $235 million from the VA to the DOD.

Will you further explain why you believe this would be inappropriate?

Mr. WEIDMAN. Well, there are really several reasons.

First of all, if, in the State of Michigan, or anyplace else, United Auto Workers negotiates a new contract with the Ford Motor Company, they don't turn around to State Medicaid in New Jersey or in California or in Illinois and say, "Hey, since you were paying for

under Medicaid before, therefore, you reimburse us X amount of money back to our insurance plan." It doesn't work that way, and it's a foolish thing, from that point of view.

Longevity retirement, and the TriCare, or as we believe, full access to Federal employee health benefits, the same as folks who retired from the civilian sector, ought to be available to every man and woman who retires by virtue of longevity from the military service.

If it's good enough for their civilian counterparts, it ought to be good enough for the folks who made the military a career, and DOD should pay for it. They should not be trying to foist it off onto an agency that has unfortunately been underfunded.

Can one argue that DOD needs to be funded in certain areas, such as pay increases, et cetera? One certainly can make that legitimate argument.

However, it's on the defense side of the budget, and it's easier to find dollars on that side than it is on domestic discretionary spending; therefore, for the committee to work with Chairman Stump and Armed Services Committee in a recommendation to the Appropriations Committee to make sure that $235 million and a full funding of TriCare gets there, but it gets there from the defense side of the ledger.

We believe in the expenditure. We just don't believe it is proper to take it from the VA.

Mr. EVANS. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Mr. Stump.

Mr. STUMP. I believe that's going to happen, I really do, starting October 1.

Gentlemen, thank you for your patience and thank you for your statements. Thank you.

The CHAIRMAN. Mr. Filner.

Mr. FILNER. Thank you, Mr. Chairman, and I thank the panel.

I just, for the record, want to thank the members of the VA staff who have been here for the whole hearing. I understand the chief of staff for the Secretary is here. So we thank you for that.

Mr. Weidman, you know I have long been an admirer of what the Vietnam Vets do for our veterans, especially their sponsorship of the standdowns, which started in San Diego and have been there for, I think, almost every one since the 1987-or-so star.

But what often struck me about the standdowns is that you took—you were able to offer, in a voluntary way, in bringing the resources of the community and with the cooperation of the VA, the most hardest to reach veterans, and really helped solve their problems, by bringing together all the resources into one place, whether it was legal advice or dental care or haircuts, and on and on.

It just seemed to me—I always sort of give this speech—that I'm tired of having this, because what we have shown on the standdowns, we've shown that if you bring the resources together with the proper enthusiasm and organization, you can solve the problems.

I'm not sure. I think the VA ought to study what the standdowns do in those few days, just because it shows that we can do it, as a Nation.

We have the resources to deal with the hardest issues that veterans have, whether it be homelessness, whether it would be drug and alcohol abuse, whether it would be job skills, whether it be—and, you know, it just strikes me that you have shown that we can do this, and I wish the VA could become one big, enthusiastic sort of operation that could produce those results for so many people.

Mr. WEIDMAN. If I may comment back, sir?

Mr. FILNER. Sure.

Mr. WEIDMAN. The concept of the one-stop center or dealing with the veteran in a holistic way is not a new idea in our generation.

The majority of U.S. cities, by the end of 1946, in a model that actually started in Connecticut, had expanded across the country, and the majority of cities had veterans' one-stop centers with VA, Department of Labor, and they were all run, labor unions, everybody, by a local committee that coordinated everything from employment to psychiatric help to medical help, et cetera, in one center, funded by the city, so that you could have that holistic help.

The standdowns really were a reinvention, if you will, because we couldn't get government to do it. When the vet centers were first conceived, they were suppose to be one-stop centers.

The other half of the equation, having to do with the psychosocial things, et cetera, and dealing with housing issues, never got created in 1979 and 1980, which was part of the original design of the readjustment counseling services.

The problem with that is that helped exacerbate and lead to many homeless vets, because there was no one place where you could go in and get that holistic help treatment that included medical treatment at the VA medical center, with someone case-managing you to make sure that you got better.

It's the whole veteran, how well you're functioning at the end, and that's why that holistic approach, that includes diagnosis, testing and diagnosis for what happened to you in the military, based on when and where you served and branch of service, we believe is so important, and will actually save us money so we stop churning people back and forth through the acute medical care system, but they never get well and back to work, when they're of working age and potentially able to do so.

Mr. FILNER. Thank you. I hope we have that as a vision, sort of, what do we want to do.

I know, you know, bureaucracy is sometimes necessary and sometimes it gets in the way of really dealing with the problem, and I would hope that your eloquent statement stays with all of us as we look at this.

I have just a strange question, Mr. Fischl. You have a very good set of recommendations from the American Legion. I think you're the biggest VSO in the Nation. Mr. Weidman's group enthusiastically endorsed the Independent Budget.

Wouldn't the veterans' community be stronger and wouldn't we have a—wouldn't you have even a stronger voice if you were all in—if you all supported the Independent Budget? I mean, why does the American Legion not get into that act?

Mr. FISCHL. The American Legion is independent, and so our budget, in a way, is an Independent——

Mr. FILNER. You're ready for Congress. You're ready. (Laughter.)

Mr. FISCHL. But we believe our budget to be realistic. We looked at this very hard.

Obviously, we wouldn't refuse more money, and we wouldn't be upset if my colleague wins and we lose. I mean, we would welcome the additional funds.

But our budget is realistic. We think this absolutely can be done, and it's the bare minimum.

So we're not asking for the top, we're asking for the bare minimum. If veterans are to survive, this is how much we need. We welcome more, but we want at least that much.

Mr. FILNER. You should be sitting here. You didn't answer the question—but very effectively, very eloquently.

Mr. FISCHL. But I didn't answer it well.

Mr. FILNER. Right, exactly.

Mr. FISCHL. I learned from the Secretary. I was watching the Secretary.

Mr. FILNER. He was very good.

I just, you know, I don't—you know, I can't tell you what to do with your own organization.

I just think, you know, adding your voice to the exact budget and recommendations, as a coalition, would make all of us, I think, be able to fight better for that budget.

But I thank you for all the work that you all have done. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Mr. Filner.

I have one final question, Mr. Weidman, to you.

You've long expressed a concern about the way the VA deals with the Hepatitis C issue, and we know that the VA has advanced an initiative with regards to this.

What is the VA doing right, and what would be your recommendations to the VA to improve its Hepatitis C work?

Mr. WEIDMAN. Adopt everything that's in Mr. Frelinghuysen's bill, would be our first step, I think.

But seriously, the national guidelines and the national protocol policies that have been put forth within VA are very good. The problem is the implementation at the service delivery level.

Even as close to the flagpole as Washington, DC VA Medical Center, we discovered recently, through our local chapter here in the Washington area that they were following a different protocol than was on the web.

So we went to the hospital director and the chief of staff and said, "Excuse us, what do y'all think you're doing?"

So then they since have corrected that, and they're now starting to distribute in every primary care clinic the risk factors and that people can be tested, even if—and to push people to get tested.

The problem is the quality assurance, and the holding people accountable. This is true throughout the system, on many different kinds of diseases.

As an example, as you know, we have tremendous respect, and I certainly do personally, and affection for Secretary Principi, but he's mistaken, and is not being given the straight scoop, when he says that we've maintained capacity.

There are at least five VISNs, or networks. that have no inpatient or residential post-traumatic stress disorder treatment—non, zip.

It is wrong to suggest that you can do that all outpatient.

In fact, in a number of VISNs, I've talked to the person in charge of the mental health line, as they call it these days—and I can't get used to "product line," by the way. These aren't product lines.

I thought we were dealing with sick veterans who had served their country well. It's not a product line, dammit. It is how do you look and help make this person who pledged their life and limb in defense of the Constitution well again, for all of these things, and stop thinking of it in terms of products.

We aren't widgets. We're human beings who took the step forward in defense of the Constitution.

So anyway, my only point is, I've talked with them and they said, "Well, it's more effective to do it outpatient."

I said, "Would you show me the data?"

And they said, "Well, we're working on developing the data."

I said: "Excuse me. You eliminate a whole section of treatment that is important to the veterans' community, to veterans of every generation, and now you say you're developing data to show that it's effective?" Which, first of all, smacks of Justificatory theory.

And secondly, as Secretary Principi said at his confirmation hearing, Mr. Smith, it's—in VBA, they're doing a lot of things, but that's not the bottom line. The bottom line is what they do in terms of results to the veteran.

I would suggest to you, when it comes to Hepatitis, the same is true. We've only scratched the surface.

A number of places where they're assiduously trying to test, I would add, the positives are coming in between 17 and 21 percent of all the veterans who they are testing.

This is in comparison to 1.8 percent Hepatitis C in the general population and 4 percent among males of the cohort group of Vietnam, which is a cohort group which are two-thirds of those who are testing positive at VA.

There's a huge problem in getting it better. We either get a grip on this problem now, or we're going to have hell to pay in 10 years, 15 years, because there won't be livers to do transplants, we won't have the money, and we'll have very sick veterans in the system that we're not going to be able to help, because the livers aren't available, and the money is not available.

And what are we doing to do then if we don't do the job of preventive public health now, properly, on Hepatitis C?

That's what we think.

It's that sense of urgency, if you will, Mr. Chairman, as well as the specifics of holding, making sure that what happens in Lyons or San Diego or Arizona or Illinois at Heinz is exactly the same, that they're actually testing and that they're treating people in a holistic way for Hepatitis C.

The CHAIRMAN. Thank you very much.

You know, getting back to that issue of accountability, we have raised the concern that we don't know how poorly or well the money is being spent on Hepatitis C, and we have not gotten the full accounting ourselves.

Thankfully, this is the beginning of new era, and just for the record, you mentioned the mental health programs—tomorrow our budget recommendation will ask for an additional $141 million over the administration's request, and in our budget submission, we very clearly delineate how we hope that money will be used.

Just for the record, I think, unless any of my colleagues have anything further they would like to add, I would just point out that, in keeping with what the Secretary had suggested, VA did stay here.

Staying on for this hearing, to hear the VSOs provide their testimony to the committee, in the room, we have Dr. Garthwaite, the Under Secretary for Health; Nora Egan, the Chief of Staff; Jack Thompson, the Acting General Counsel; Mark Catlett, the Acting Assistant Secretary for Management; Dennis Duffy, the Acting Assistant Secretary for Policy and Planning; and Roger Rapp, the Acting Under Secretary for Memorial Affairs, and I might have missed someone.

I think that does set a good precedent, although one should be set. Again, I've been here a number of years, and very seldom have I seen anyone from the VA, or in my previous chairmanship, from the State Department.

Usually when the State Department witness, whether it be the assistant secretary or the under secretary or the Secretary of State himself or herself, as the case was during the Clinton administration, soon as they left, everybody else in the room practically got up and left with them, except for perhaps a notetaker.

So I think it's hopefully the beginning, or the harbinger of the kind of two-way street that is being established today.

I thank them for staying on, and look forward to building on that kind of two-way street.

Thank you for your testimony, and without further ado, this hearing is adjourned.

[Whereupon, at 4:30 p.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CHAIRMAN SMITH

The hearing will come to order. Good afternoon. We want to welcome all of our witnesses today.

The hearing on the budget is one of our committee's most important functions. We have usually worked in a bipartisan manner to address budget needs for veterans programs. When there were deficits as far as the eye could see, we worked together to present the best advice we could on what was needed, and I am confident that we will do no less today.

This year's budget hearing is reminiscent of the hearings we had in 1993 and 1989, both Presidential transition years. Despite the absence of the usual specific information about how the proposed budget for the Department of Veterans Affairs would affect ongoing programs, we are required by the Rules of the House and the congressional budget process to present our committee views no later than March 12, which is next Monday.

Fortunately, we know what issues must be addressed in this hearing:

- Aging and seriously ill veterans require health care services.
- The hundreds of thousands of pending disability compensation claims must be addressed.
- And we must continue to honor those who have died so that future generations may learn of their faithful service.

Mr. Secretary, your appointment begins a new chapter. However, you will be asked to address some of the problems which your predecessors did not solve. The most serious problem is one of *accountability*. The Congress has been careful to assure that veterans programs are adequately funded. Even when the funds were not included in the President's request, Congress has often stepped in and provided what was needed. In accepting these resources, administrators throughout the Department have found reasons not to apply them to the purposes for which they were provided. I am talking specifically about funds to provide long-term care, care for veterans with Hepatitis C, chronic mental illness, or spinal cord injuries. This is a very serious breach of their obligation to carry out the laws which Congress enacts.

Over the next few months, I expect that we will have additional hearings which may make some of these administrators uncomfortable, particularly those who have closed nursing home beds or spinal cord injury (SCI) beds in defiance ofthe law requiring the Department to maintain a minimum number of these beds.

Mr. Secretary, the World War II generation is popularly known as "the greatest generation". Yet this committee has evidence that health care administrators are closing nursing home care beds and otherwise curtailing access to the long-term care services these veterans desperately need. One of the reasons cited for these actions is that there isn't enough money to maintain these services. This is simply not true. I appeal to you to adopt a firm policy on this issue, to honor their sacrifice, and to comply with the law that requires the Secretary to ensure that these services do not fall below the 1998 level.

As I said at the outset, the President's budget has few details, but it is easy to discern that is a very tight budget, perhaps a little too tight in some areas. I think of it as a work in progress. Choosing the programs deserving an increase is a difficult task, and it is made complicated if a program has been ignored or its funding slashed for several years in a row. That is why Mr. Evans and I introduced H.R. 81 1, the Veterans' Hospital Emergency Repair Act, and H.R. 801, the Veterans' Opportunities Act of 2001, last week.

The VA has a long list of buildings that it knows are seismically unsafe, including several that suffered damage last week in the Seattle area. Yet OMB has squelched funding for repairs and strengthening. The Emergency Repair Act would authorize

funds to be used at the Secretary's discretion for these types of vital and overdue projects.

Similarly, the benefits for families of veterans who died of a service-connected cause have not been raised in many years. The Veterans Opportunities Act sends the message that we care about these veterans and their families.

Later this week, I will be asking all of my colleagues to join me in introducing a bill which will substantially increase payments to veterans attending school under the Montgomery GI Bill. By their faithful service, these veterans earned a decent chance to improve their prospects in life.

We need to find the funds to make these three proposals a reality, and I ask all of my colleagues, and you Mr. Secretary, to join me in this effort. Together, we can make this work in progress something that we can all be proud of.

Let me also note that there has been tremendous change in the VA in the last few years, particularly in its health care system, and we need Members to understand that this change has been mostly for the better.

The Veterans Health Administration is often depicted as inefficient and inaccessible to all but a few veterans. In the past few years, VA has opened more than 300 community-based outpatient clinics, and veterans recently responded to this effort by rating VA 10 points higher than private sector hospitals in an independent customer satisfaction survey.

Veterans are seeking VA health care in record numbers, with more than 3.6 million receiving care last year, a 15 percent increase over the number in 1997. At the same time, VA has reduced the average cost per patient by 16 percent compared to two years ago.

While the media always reports incidents in which VA failed to treat patients as it should, VA is using technology and changed procedures to lead the Nation in efforts to prevent medical errors. Examples include a bar code system for medications and electronic entry of prescriptions to overcome illegible handwriting. The VA has also substantially exceeded national standards for disease prevention and early intervention so that hundreds of thousands of veterans diagnosed with diabetes, heart disease, or mental health problems are receiving better care than they could receive from most private health care providers.

Few recognize that VA is the Nation's largest single provider of care for patients who are infected by the human immunodeficiency virus. Almost 50,000 veterans and their families know how well VA delivers this care. VA has also recently established two centers of excellence to deal with the increased incidence of veterans infected by the Hepatitis C virus.

It sometimes took hours to complete a phone call to the Veterans Benefits Administration, but a focus on this problem has reduced the rate at which callers get a busy signal from 52 percent to 3 percent in less than three years, while the number of veterans who hang up before reaching a VA representative has been cut in half.

VA has also established 31 out-based claims processing centers at military discharge centers, resulting in rapid decisions on disability claims for tens of thousands of new veterans.

We've seen a gradual expansion of the VA National Cemetery system, and we're looking for the opening of six new cemeteries in the next several years. Annual interments have increased by 41 percent over the last ten years (projected 88,000 interments this fiscal year), while the number of employees has only grown by about 17 percent (1,450 employees (FTEE) in 2001). VA has also provided funds so that eleven new State veterans cemeteries will open by the end of this year.

Improved management of the VA's home loan and insurance operations has led to the same or better service with almost 20 percent fewer staff. Although there is still much to be done, the VA is increasingly using electronic means to gather and process benefit applications to speed up decisions that have taken longer than they should.

Probably the least appreciated improvement over the last several years has been the increased attention on measuring how veterans perceive the services VA provides and what effect these benefits have on their lives. While it may be several more years before there is a real "outcome-driven" budget, the backbone of the VA management structure is incorporating performance measures at a rate that is perhaps unsurpassed in the rest of the federal government.

Mr. Secretary, you know as well as I do about the compassion and devotion which defines so many of VA's employees, and we want to recognize their spirit of service and zeal for improvement. People make the difference in so much of what VA does, and we'll do whatever needs to be done to ensure that VA can continue to attract talented and dedicated employees to serve our Nation's veterans.

I now recognize Mr. Evans.

(When recognizing the Secretary:)

Let me briefly introduce the fourth Secretary of Veterans Affairs. He is accompanied by his staff who have appeared before this committee on numerous occasions, but this is Anthony J. Principi's first appearance as the Secretary of Veterans Affairs. Prior to becoming Secretary, Mr. Principi undertook the task of chairing a distinguished group looking at the future of benefits for servicemembers leaving service. It was a diverse and experienced group which comprised the Commission on Servicemembers' and Veterans' Transition Assistance, but Mr. Principi was able to put together a number of meaningful recommendations for change which were adopted unanimously be the Commission.

Mr. Principi is a U.S. Navy veteran who served as an officer in Vietnam. He has served as the Staff Director of the Senate Committee on Veterans' Affairs, and as the Deputy Secretary and Acting Secretary of Veterans Affairs in President Bush's Administration (that's the current President's father's Administration). He has private business experience as well as Capitol Hill experience, and has demonstrated a life-long commitment to honoring the service of America's veterans and their families. Mr. Secretary, welcome.

(Recognize Members for questions and after Members are done:)

Thank you, Mr. Secretary. The committee will submit questions for the record.

PREPARED STATEMENT OF CONGRESSMAN BILIRAKIS

Mr. Chairman, I want to commend you for scheduling this timely hearing on the Administration's Fiscal Year 2002 budget request for the Department of Veterans Affairs. I would also like to welcome Secretary Principi and our other witnesses to the committee this afternoon.

I am anxious to hear Secretary Principi's testimony regarding the Administration's overall budget recommendations for the upcoming fiscal year. As the representative of a district with a large veterans population, I strongly believe that we must do everything we can to repay the great debt that we owe the men and women who answered the call to duty.

There a number of serious challenges facing the VA. First, there is already a tremendous backlog of pending claims, and the average processing time for a VA claim is 202 days. Left unchecked, the situation will only get worse because of the expected influx of claims for diabetes, Hepatitis C, additional radiation-related diseases, and requests for readjudication under the Veterans' Claims Assistance Act of 2000.

In his written statement, Secretary Principi reiterated the President's promise for a top-to-bottom review of the VA's claims processing system to restore confidence in the VA's ability to adjudicate claims in a fair and prompt manner. I am anxious to learn how the Department's budget request will assist the VA in this much needed effort.

Florida has the second largest veterans population in the country. We also have one of the oldest and sickest veterans populations. Consequently, veterans' access to high quality care continues to be one of my top concerns. I firmly believe that the VA provides quality care to our Nation's veterans, but the quality of the care is irrelevant if veterans cannot access the VA health care system in a timely fashion.

The Administration's request includes a $1 billion increase for discretionary veterans spending—most of which is directed towards the Veterans Health Administration. While I think this is a good starting point, I am concerned that this increase will basically cover just the cost of inflation.

I am also concerned about the VA's ability to maintain its specialized services such as spinal cord injury and blind rehabilitation. Veterans depend on these vital services and we must ensure that the VA continues to support them appropriately. I look forward to discussing these issues with Secretary Principi.

I am also anxious to hear the recommendations of the authors of the Independent Budget as well as those of other witnesses. The veterans service organizations often provide us with valuable insight into the day-to-day operations of the VA and its needs and I look forward to their suggestions.

As always, Mr. Chairman. I look forward to working with you and the other members of our committee to ensure that our veterans receive the benefits they earned through their service to our country.

PREPARED STATEMENT OF CONGRESSMAN STEARNS

I am pleased to be here this morning. I would like thank you Chairman Smith for holding this hearing today. I would also like to welcome our new Secretary An-

thony Principi as well as the other distinguished members scheduled to testify and thank them for being here today. I am sure I speak for everyone when I say that we look forward to hearing their insightful testimony.

While I applaud the fact, Mr. Secretary, that you have requested a 1.2 billion dollar increase in funding for medical care, that figure includes 200 million dollars in collections from third-party payers. I have long believed that these third party payer collections should be a supplement to and not instead of guaranteed health care dollars. I think we can find the money to guarantee that medical care is adequately funded—I believe we need to find a way to increase medical care above the President's request for 2002. I pledge to work with our new Chairman to do this.

One of the most pressing issues of concern is that the veterans population continues to increase in a number of States and many of these same States have seasonal increases in the number of veterans seeking care. This causes long waiting periods and puts a strain on not only the facility but also the personnel in attendance. We must provide some type of relief for these overburdened facilities. Why should residents that live in these regions be subjected to such delays before receiving treatment?

In my home State of Florida we hear from veterans who tell us that they must wait for many months before getting an appointment at the VA. It is unconscionable that veterans must wait so long to be assigned to a primary care physician. This should be top priority for us all.

I also want to applaud the President for setting up a health task force to address such problems and to find solutions for improving access to health care for our veterans.

Last fall the President stated that he wanted to form an advisory commission to aid in implementing the Veterans Millennium Health Care Act of 1999. Since this legislation enjoys great support from veterans, I believe that this common goal can be accomplished.

I am very proud of the Millennium Health Care bill that we developed to address the long-term health care needs our of nation's veterans. As you know, long-term care for veterans was the centerpiece of the Millennium Health Care Act and I plan to work vigorously to make certain that it is fully implemented an fully funded.

In conclusion, I am sure I speak for every committee member present when I say that I think we can work with the proposals that you have presented. We must strive to ensure that Veterans receive access to quality health care.

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

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

PREPARED STATEMENT OF CONGRESSMAN MORAN

Welcome, Mr. Secretary, and your colleagues, to the committee. Mr. Secretary, I think being here today, before the Committee on Veterans' Affairs for your first testimony before Congress as Veterans Secretary, represents a good beginning. This committee has a rich and vaunted history. We are proud to say, under our Chairman today and all his predecessors, that we serve America's veterans and help them bind their wounds, restore them to civilian life, assist them with housing, health care, education and employment, and do all that we can *in partial compensation* for what they did for us.

Mr. Secretary as Chairman of the *Congressional Commission on Servicemembers and Veterans Transition Assistance*, an activity that offered a thoughtful report to Congress two years ago, you are in a superb position—the best position—to know what the current challenges are, and to begin to put in place methods to meet these needs. I understand you've already started that process by consulting with Secretary Rumsfeld at Defense, and I look forward to working with you on these matters of mutual interest within the VA and between VA and DOD as we go through this Congress. I pledge to you my support as Chairman of the Health Subcommittee to help get this job done, in a responsible way, for America's veterans.

PREPARED STATEMENT OF CONGRESSMAN CRENSHAW

Mr. Chairman, as a member of both the Veterans' Affairs and Budget Committees, I truly appreciate your holding this hearing today. I would also like to thank you, Mr. Secretary, for your candid advice as a veteran and a representative of the Veterans' Administration.

As I noted at a Budget Committee hearing last week, the extraordinary surplus we enjoy today does not absolve us in Congress of the responsibility of making tough choices. The surplus is the people's money—it is borne of their hard work—and I fully support the President's proposal to return a substantial portion of that money to the taxpayers.

I also believe, Mr. Chairman, that the taxpayers want Congress to apply some of that surplus to continuing to reduce the public debt and to important funding priorities, including education and national defense. The President makes it clear in his budget blueprint that veterans' needs are an important spending priority by increasing discretionary spending for these programs by $1 billion.

Regrettably, as our veterans' population ages, its numbers dwindle and its health needs expand. These men and women sacrificed a lot for their nation and we owe them more than simple gratitude. Congress has made great strides in meeting the needs of our aging veterans, particularly with the wholesale reformation of the veterans' health system enacted with the Veterans Millennium Health Care and Benefits Act. I share the Secretary's goal of implementing these programs fully, promptly, and thoughtfully.

I also think that we must improve our ability to provide appropriate burial space for our veterans as they pass. More than 1,000 die each day now, and we simply do not have enough cemetery space in our national or State cemeteries to accommodate them all. In my home State of Florida, for instance, which has the second largest population of veterans and the largest population of veterans over 60, we have four national cemeteries; but only one can still take interments. Two have no room for even cremated remains.

A fifth national cemetery for Florida is in the earliest of planning stages, but it will be sited in South Florida, as much as 350 miles away from the part of Florida that I represent. Anyone who has ever driven to South Florida from the North border of the State knows how long and tedious that trip is. Imagine being an elderly widow who has to take that trip to visit her loved one in his final resting place.

Much effort has been expended for the establishment of a national monument to our World War II veterans here on the Mall, and I fully support that important project. But, there can be no better monument to our greatest generation than a burial with honor and a place of rest with dignity.

I understand that the Department of Veterans Affairs is currently working on a report that will identify additional needs for veterans cemeteries, and that it will specifically address our interest in having 90 percent of all veterans reside within 75 miles of a national or State cemetery. I very much look forward to the results of this report, and to working with the Secretary and my colleagues here to provide a reasonable and appropriate alternative to the veterans of North Florida and other areas of like need.

Again, thank you, Mr. Chairman, for holding this hearing, and thank you, Mr. Secretary, for sharing your thoughts with us today.

STATEMENT OF THE HONORABLE ANTHONY J. PRINCIPI

SECRETARY OF VETERANS AFFAIRS

FOR PRESENTATION BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS

MARCH 6, 2001

Mr. Chairman, and members of the Committee, good afternoon. Thank you for inviting me here today to discuss the President's FY 2002 budget proposal for the Department of Veterans Affairs. I am honored to present my first congressional statement as Secretary before this distinguished Committee.

As you know, the President released his budget blueprint last week. Additional information regarding specific funding levels for each of our programs will be provided early next month. I look forward to addressing the details of our request at that time. Until then, I am pleased to discuss the overall budget request for VA and my priorities for the next fiscal year.

We are requesting more than $51 billion for veterans' benefits and services: $28.1 billion for entitlement programs and $23.4 billion for discretionary programs, such as medical care, burial services, and the administration of veterans' benefits. Our budget increases VA's discretionary funding by $1 billion or 4.5 percent over the FY 2001 level. With an increase in medical care collections of approximately $200 million, this brings the total increase to $1.2 billion or 5.3 percent.

The budget ensures veterans will receive high-quality health care, that we will keep our commitment to maintain veterans' cemeteries as national shrines, and that we will have the resources to tackle the challenge of providing veterans more timely and accurate benefits claims determinations.

The President promised a top-to-bottom review of our benefits claims processing. He has designated this area as a key budget initiative and I have made it one of my top priorities. I know you share this Administration's commitment to restore the confidence of many veterans who have lost faith in VA's ability to fairly and promptly decide their benefits claims.

Mr. Chairman, as we all know, VA is not completing work on benefits claims in as timely a manner as our veterans deserve. I am proud to say this budget will rejuvenate VA's efforts to process compensation claims promptly and accurately.

This request fully implements new legislation that strengthens VA's "duty to assist" role in helping veterans prepare their claims. It also will enable us to carry out the new policy of adding diabetes to a list of presumptive conditions associated with exposure to herbicides. The 2002 budget provides additional staffing for these efforts. Additional resources will be coupled with a proactive approach to solving problems. I plan to establish a task force that will address claims processing and develop hands-on, practical solutions.

Our future approach to benefits delivery will incorporate a paperless technology. The Veterans Benefits Administration plans to consolidate its aging data centers into VA's core data center in Austin, Texas. This is an important step in realizing our vision for the future.

For veterans' health care, the budget request reaffirms our primary commitment to provide high-quality medical care to veterans with service-connected disabilities or low incomes. VA provides comprehensive specialty care that other health care providers do not offer, such as services related to spinal cord injury, Post Traumatic Stress Disorder, prosthetics and addiction programs. I am proud of our unique accomplishments and will insist on full funding to continue our leadership role in these areas.

We recognize the need to improve access to health care for eligible veterans. The budget supports the President's new health care task force, which will make recommendations for improvements. The task force will be comprised of representatives from VA and the Department of Defense (DoD), service organizations, and the health care industry.

The budget request also ensures that our National Cemeteries will be maintained as shrines, dedicated to preserving our Nation's history, nurturing patriotism, and honoring the service and sacrifice of our veterans. Funding will be used to renovate gravesites and to clean, raise and realign headstones and markers.

Mr. Chairman, our 2002 budget is not simply a petition for additional funding. It also reflects opportunities for cost savings and reform. VA will do its part to ensure the most efficient use of limited resources, while maintaining the highest standards of care and service delivery.

The National Defense Authorization Act for Fiscal Year 2001 established a new DoD benefit for military retirees over age 64 who have Medicare coverage. These retirees will be able to use their own private doctors for free care and receive a generous drug benefit. Currently, 240 thousand of these retirees are enrolled in VA's health care system. Our budget assumes that 27 percent of them will switch to the DoD benefit in 2002, which shifts $235 million in VA medical liabilities to DoD.

This recent legislative change underscores a critical need for better coordination between VA and DoD. The Administration will seek legislation to ensure DoD beneficiaries who are eligible for VA medical care enroll with only one of these agencies as their health care provider. We will work with DoD to avoid duplication of services and enhance the quality and continuity of care.

Restructuring efforts in our health care system will continue in 2002. VA has begun an infrastructure reform initiative that will enhance our ability to provide health care to eligible veterans living in underserved geographic areas. Savings from this effort will allow us to redirect funds from the maintenance of underused facilities to patient care. As we await the results of this assessment – referred to as "CARES" – we will continue to expand sharing agreements and contracting authorities with other health care providers.

The budget also includes legislation for several proposals that will yield mandatory savings totaling $2.5 billion over the next ten years. Most of these proposals will extend previously enacted mandatory savings authorities that would otherwise expire over the next several years.

Finally, we will continue to reform our information technology. New technology offers VA opportunities for innovation. It also offers a means to break down the bureaucratic barriers that impede service delivery to veterans, divide VA from other Federal government departments, and create inefficiencies within VA itself.

I have gone on record as stating that I will not initiate any new technology-related activities until an integrated strategy for addressing our information systems and telecommunications is developed. We will continue to improve coordination among our three administrations to implement a technology plan that serves veterans first. Reforms will include developing a common architecture, establishing common data definitions, and coordinating systems across VA.

Mr. Chairman, that concludes a general overview of VA's 2002 budget request. I thank you and the members of this Committee for your dedication to our Nation's veterans. I look forward to working with you. My staff and I would be pleased to answer any questions.

STATEMENT OF

HARLEY THOMAS, HEALTH POLICY ANALYST

PARALYZED VETERANS OF AMERICA

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

THE *INDEPENDENT BUDGET*

AND THE DEPARTMENT OF VETERANS AFFAIRS BUDGET

FOR FISCAL YEAR 2002

MARCH 6, 2001

Mr. Chairman, Ranking Democratic Member Evans, members of the Committee, the Paralyzed Veterans of America (PVA) is honored, on behalf of our members and the *Independent Budget*, to present our views on the Department of Veterans Affairs' (VA) budget for fiscal year (FY) 2002. We are proud to be one of the four co-authors, along with AMVETS, the Disabled American Veterans, and the Veterans of Foreign Wars, of the 15th *Independent Budget*, a comprehensive policy document created by veterans for veterans.

The *Independent Budget* is an annual budget and policy review for veterans programs and represents an unprecedented joint effort by the veterans' community to identify the major issues facing the veterans' community today while serving as an independent assessment

of the true resource and policy needs facing veterans. It is our distinct pleasure, once again, to be responsible for the health care recommendations and analysis, and I shall address these in my testimony today.

The VA medical system is a national asset. After years of chronic under-funding and fiscal neglect, the VA has seen budget increases for the past two fiscal years. It is essential that the health care increases realized over the last two years be continued in FY 2002. There must be continued and sustained investment in the national resource which is the VA health care system, investment in protecting and strengthening specialized services and in improving access and ensuring that the infrastructure exists to provide first-rate health care, as promised by the President and sought by our members.

To accomplish these goals, the *Independent Budget* recommends, for FY 2002, a $2.7 billion increase for VA medical care.

Every year, the VA requires additional funding in order to remain in the same place it was the previous year. This additional funding is required because of mandatory salary increases and the effects of inflation. For FY 2002, the *Independent Budget* estimates that these "uncontrollables" will require an increase of $1.3 billion.

In addition, the *Independent Budget* has identified a necessary increase of $848 million to cover the costs of institutional and non-institutional long-term care initiatives mandated by the Veterans Millenium Health Care and Benefits Act (P.L. 106-117) enacted last Congress.

This $848 million represents start up costs for the long-term care initiatives established in the Millennium Act two years ago that have yet to be implemented. The VA has a responsibility, and an historic duty, to meet the long-term care needs of an aging veteran population. It has the opportunity to do so in the most cost-effective and appropriate way by implementing the community and home-based care programs called for in the bill. It can also show that it can become a leader in the United States in providing long-term care

in a country that has no broad based long-term care programs for older Americans and all Americans with disabilities.

The remainder of the recommended increase, $523 million, is slated to fund vitally needed initiatives. These initiatives include restoring spinal cord injury/dysfunction capacity, meeting the challenge of rising pharmaceutical costs, and maintaining VA capacity for mental health services.

Over the past 5 years the capacity of the VA to provide SCI care has been seriously degraded by substantial staff reductions despite the mandate instituted in 1996 by Congress to maintain system capacity. Local hospital officials reduced SCI staff to a point that they could operate only 65 percent of SCI/D beds reported as operational in 1996. Last year, the VA issued a directive establishing the minimally acceptable level of staffing and staffed beds at each SCI Center, and issued a memorandum regarding the need for local managers to identify and provide additional resources required to restore the mandatory staffing levels. The *Independent Budget* has requested $25 million in additional funding to begin this restoration work.

We have all read the news stories concerning the increased costs of pharmaceuticals faced by our citizens. The *Independent Budget* has estimated that these increased costs will total $65 million because of the increased patient load projected by the VA.

The *Independent Budget* recommends a $100 million increase for mental health programs, a first step in a three-year recommendation to add a total of $300 million to these vital programs. We have witnessed an unprecedented erosion of the VA's capacity to provide specialized treatment within distinct dedicated programs for veterans with serious mental illness, substance-abuse problems, and post traumatic stress disorder. Extensive closures of specialized inpatient mental health programs, coupled with slashed budgets, have lead to the emergency situation faced by these vital programs. These programs must be protected and expanded in order to meet the needs of veterans.

The *Independent Budget* has recommended an increase for Medical Administration and Miscellaneous Operating Expenses (MAMOE) of $12 million, bringing this account up to $74 million. Funding shortfalls in the MAMOE account have left the VA unable to adequately implement quality assurance efforts or to provide adequate policy guidance within the 22 Veterans Integrated Service Networks (VISN). Veterans Health Administration headquarters staff play the essential role of providing leadership, policy guidance, and quality assurance monitoring under the decentralized VA health care system. It is important that these important roles be strengthened.

Another important asset of the VA is its Medical and Prosthetic Research Program. VA research plays a critical role in attracting first-rate clinicians to practice medicine and conduct research in VA health care facilities, keeping veterans' health care at the cutting-edge of modern medicine. Advancements in medical treatment and technology developed in VA hospitals and laboratories have revolutionized modern health care and pioneered advances that are sustaining the health and quality of life of veterans and all Americans. As has been stated, "today's research indeed creates tomorrow's health care."

With the bipartisan push to increase research funding for the National Institutes of Health, to double its funding over the course of five years, the VA Medical and Prosthetic Research program must not be left behind. The President is seeking a $2.8 billion increase to $23.1 billion. VA research is an important component of our national research effort. The *Independent Budget* advocates a $45 million increase to bring this account up to $395 million.

The President, on February 28, 2001, released his Administration's "Blueprint for New Beginnings." PVA has many questions concerning the Administration's plans for the VA. Although we were heartened by the fact that the Administration has proposed an increase in discretionary spending for the VA, this "Blueprint" raises more questions than it answers. We look forward to seeing the full scope, and the complete rationale, of the Administration's FY 2002 budget request for the VA in April.

The President's "Blueprint" trumpets a discretionary spending increase for veterans of $1 billion. This $1 billion increase, of course, will not be fully realized by veterans' health care. Traditionally, only approximately 90 percent of discretionary increases accrue to health care. As I stated before, the VA requires at least a $1.3 billion increase just to keep pace with FY 2001. This means that the President's budget "Blueprint" falls short of what is required to maintain the status quo of the health care system for this coming year.

In addition, any additional funding needed to address claims backlogs will come at the expense of VA health care because these additional funds would lay claim to the finite pot of discretionary spending. It is essential that the claims process be fixed – we have argued for years that a benefit delayed is a benefit denied – but this vital work must not come at the expense of sick and disabled veterans.

The "Blueprint" assumes a transfer of health care liabilities. The Administration may argue that the increase for VA health care will be higher because of its assumption that $235 million in VA health care "liabilities" will be shifted to the Department of Defense (DOD). This will be implemented by proposed legislation that would mandate that veterans choose either DOD or VA to receive their health care. The budget assumes that 27 percent will switch to the DOD. There seems to be no justification for this percentage, and we have questions concerning how the figure of 27 percent was settled upon.

The President's "Blueprint" assumes that the VA will realize "net mandatory savings totaling $2.5 billion over the next 10 years." The OBRA Extenders are slated to save $2.3 billion over ten years and the elimination of the VA's vendee home loan program is slated to save $228 million over the same time frame. None of these savings are available for FY 2002, and, in fact, eliminating the vendee home loan program is estimated to cost $19 million in FY 2002. Finally, these savings would not be available for discretionary programs unless budgetary legerdemaine is employed.

PVA awaits the final budget numbers to ascertain the role played by the Medical Care Collections Fund (MCCF) in any of these projections. As we have stated in the past, and firmly hold today, these funds should be used to augment, not replace, appropriated dollars to enhance the health care provided to veterans. The inflated collection estimates have never been reached in the past, and, in fact, have steadily declined each year since 1995 despite highly exaggerated yearly estimates of soaring receipts. Veterans should not be forced to pay the price for these failures to reach these rosy estimates.

The President's "Blueprint" states that the "VA has begun the assessment phase of an infrastructure reform initiative that will result in a health care system with enhanced capabilities to treat veterans with disabilities or lower incomes living in underserved geographic areas. Savings from the disposal of underused VA facilities will support these improvements." We await the details and we urge caution. It is not clear how, in a budget sense, these savings will be realized and directed to VA health care. We applaud the President's desire to protect and augment the VA's core missions, but we insist that the needs of veterans, not the needs of budgets, must come first.

We agree with Chairman Smith that "the proposed $1 billion increase in discretionary funding is a significant step in the right direction" and we are heartened that the Chairman also desires to push "for even more money in the final budget to address other pressing needs, such as long term care, chronic illnesses and transitional housing for homeless veterans." We too believe that the Administration's "Blueprint" is a step in the right direction, but much more is needed, and much more must be done.

We recognize that this Committee does not appropriate dollars, but you do authorize them. You serve as a resource, and as advocates, to the appropriators as they fashion budgetary policy. The authorization process must recognize the real resource requirements of the VA. We look to you, and your expertise in veterans' issues, to help us carry this message forward, to your colleagues and to the public.

We need your help, and we offer our assistance, to ensure that the VA receives the funding it needs to ensure that veterans receive the health care they have earned, and the health care they have been promised. Let us move forward from our accomplishments of the last couple of years and build a strong, and continuing base, for the national asset that is the VA.

On behalf of the co-authors of the *Independent Budget*, I thank you for this opportunity to testify concerning the resource requirements of VA health care for FY 2002. I will be happy to answer any questions you might have.

STATEMENT OF

FREDERICO JUARBE JR., DIRECTOR
NATIONAL VETERANS SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO
THE DEPARTMENT OF VETERANS AFFAIRS' CONSTRUCTION BUDGET
REQUEST FOR FISCAL YEAR 2002

WASHINGTON, DC MARCH 6, 2001

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

This year, as in the past, Mr. Chairman, the Veterans of Foreign Wars of the United States is proud to be one of the co-authors of the *Independent Budget*. Our primary responsibility is for the Construction Programs and my remarks will be focused on that major area.

The capacity to provide timely access to quality care for service disabled and low income veterans, while further transforming the VA into the health care provider of choice for those veterans whose cost of care can be covered by third party payers, symbolizes an acknowledgement of the special debt of gratitude owed by our nation to those who faithfully served to ensure our freedom and security. That this unique system of delivering health care to America's veterans has undergone a major transformation is in itself a major understatement. The many milestones that have marked the VA health care system during the past decade have had the ironic effect of both helping in its transformation into a world-class medical system, while at the same time placing it in a dilemma that can potentially lead to the deterioration of the system and, eventually, to its inexorable collapse.

Succeeding Administrations and Congresses have promulgated numerous measures that have made possible the significant improvements of the system. These efforts, however, have been neither sufficiently consistent nor amply sustained to ensure

the Veterans Health Administration timely evolvement into a streamlined, cost-effective provider of health care that will stay ready to change with the times. The present condition of the substantial capital assets held by the VA, through which it is expected to deliver most of the services it's mandated to provide to veterans and their dependents and survivors, stands out as a glaring example of the deleterious consequences of an on-again-off-again approach to funding VA programs.

The improvements in VA health care, coupled with the advancing age of the entire veterans population, have resulted in a substantial increase of the number of veterans seeking services from the system. At the same time the level of investment in maintaining the physical infrastructure, through Major and Minor Construction projects, has plummeted dangerously since fiscal year 1993 to the current fiscal year, from $600 million to just over $200 million. Understandably, the focus of construction projects has had to change from one of building large centralized physical plants to a design of having more access points to state of the art facilities that can provide primary and specialty care, backed by centers of excellence ready to provide more complex care for acute and chronic or long-term ailments. But this strategy has been weakened by the lack of consistent funding. In addition to the lack of attention to the construction needs, this neglect has created an untenable backlog of non-recurring maintenance needs which have not been adequately funded under the medical care account.

VA must maintain and improve its existing facilities to support delivery of veterans' benefits and health care services, while protecting the nation's investment by assuring the continued viability of this infrastructure. The ongoing evaluation under the Capital Assets Realignment for Enhanced Services (CARES) to design a reconfiguration of the Department's physical plant that will free up – or generate new – resources to provide more timely access to quality care for more veterans, while a worthy effort, should not be an impediment to meeting ongoing construction and maintenance needs. Regrettably, the *defacto* moratorium on funding already approved construction projects since the start of the CARES studies has further exacerbated the manifest lack of stewardship of the system's facility assets.

As the Committee is well aware, an independent study by Price Waterhouse concluded that the VA should be investing an amount equal from 2 to 4 percent of the

value of its facilities to improve and update them. It recommended a similar amount annually for non-recurring maintenance. Not to do so would amount to a plan for the deterioration of the system that would lead to its closure. We are much encouraged, Mr. Chairman, by the legislative measure you – along with Messrs. Evans, Moran and Filner – have introduced to address this and the other construction concerns cited in the *Independent Budget*.

The construction needs of the VA are evident, and can only be missed -- or ignored -- by those who would like to see the Veterans Health Administration deteriorate out of existence. Men and women of good will, both in Congress and throughout the nation, want to see the right thing done. As daunting as the funding requirements to meet these needs may seem, a strategic approach would validate the need for a major investment today that would save much unnecessary waste in the future. The demonstrated need for a $30 million project in Veterans Integrated Service Network 1, which would facilitate the consolidation of certain services in the Boston area, resulting in an annual operating savings of $50 million, is a poignant example of how the current approach to approving and funding VA construction needs is seriously flawed. Failure to realize these improvements since they were first identified in 1998 will cost the VA over $100 million in extra operating costs. This is just not a good way to run a business. It is, particularly, not the way to care for the trust placed on the Administration and Congress by America's taxpayers.

As we are all well aware, the VA has an inventory of seismic improvement projects that continue to go unfunded. Just in the last budget cycle, Congress failed to fund a much-needed seismic project in the Palo Alto VA Medical Center at a cost of $26.6 million. The critical nature of this need was, ironically, poignantly underscored on the same day the President released his budget proposal, when the 6.8 magnitude earthquake in the state of Washington damaged two buildings at the American Lake VA Medical Center resulting in the temporary evacuation of many of the patients. These buildings were part of the VA inventory of seismic needs. While we are relieved that the damage wasn't extensive, and no one was injured, the timing would seem almost providential. We should all be thankful that, by Devine grace, the earthquake did not

occur hundred miles to the south at that other more seismically unstable area where the Palo Alto facility is located. But, this is a warning that should not go unheeded.

Continued neglect of all the VA construction needs constitutes a tragic mismanagement of what is the free world's most cost-effective system for delivering quality health care, education, research and pioneering in the delivery of medical care and rehabilitation. Moreover, not allowing the system to go beyond the threshold, at which it is presently poised, of fulfilling its potential for being all that it can be in serving America's veterans, would be tantamount to squandering what is a national health care treasure that indirectly benefits all citizens.

In order to prevent this tragic consequence, the *Independent Budget* recommends a total funding level for construction in Fiscal Year 2002 of $804 million as a down payment to complement the total transformation of the Veterans Health Administration into a more agile and cost effective deliverer of quality health care for today and tomorrow's veterans.

For Major Construction, we recommend an increase of $308 million, for a total funding level of $374 million. This increase is needed for a major portion of the seismic corrections needs of $250 million.

An increase of $265 million to the Minor Construction account is recommended, for a total funding level of $431 million. This increase will support inpatient and outpatient care delivery infrastructure improvements, research facility upgrades, and a historic preservation grant program that will protect the VA facilities which are part of the historical heritage of our nation. We also recommend that the current $4 million ceiling authority for Minor Construction projects be increased to $16 million. The current limitation results in a piecemeal approach to design and completion of projects that adds delays, facility disruptions and promotes poor fiscal management practices.

Other programs covered by the *Independent Budget* with recommended construction funding increases include grants for construction of state extended care facilities and state veterans cemeteries. In addition, we are recommending an increased funding in the medical care account for nonrecurring maintenance to the level of $391 million. This would be a modest step in the right direction towards addressing the

considerably higher funding needed to address the problems cited in the Price Waterhouse report.

Finally, Mr. Chairman, the *Independent Budget* calls for Congress to provide sustained support for Major and Minor Construction so that planning and design for future projects can continue without interruption.

Mr. Chairman, this concludes my statement. I will be happy to answer any question you or members of the Committee may have.

Prepared statement of AMVETS

Mr. Chairman, Ranking Member Evans, and members of the Committee:

I am Howie DeWolf, National Service Director for AMVETS. AMVETS is honored to join fellow veterans service organizations in providing you our best estimates on the resources necessary to carry out a responsible budget for the fiscal year 2002 programs of the Department of Veterans Affairs.

AMVETS testifies before you today as a co-author of *The Independent Budget*. For over 15 years AMVETS has worked with the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars to produce an Independent Budget. This document provides our spending recommendations on veterans' programs for the new fiscal year. Besides working collaboratively on the overall publication effort, AMVETS' primary responsibility has focused on developing the recommendations in the National Cemetery Administration section of *The Independent Budget*.

Neither AMVETS nor I have been the recipient of any federal money for grants or contracts. All of the AMVETS activities and services are accomplished completely free of any federal funding.

Before I address budget recommendations for the National Cemetery Administration, I would like to say that AMVETS fully appreciates the strong leadership and continuing support demonstrated by the House Veterans Affairs Committee. AMVETS is truly grateful to the members who serve on this important committee. Clearly, you have at heart the best interests of veterans and their families and have distinguished yourselves as willing to work in a bipartisan manner to address numerous issues of great importance to the Nation's veterans.

Since its establishment, the VA National Cemetery Administration (NCA) has provided the highest standards of service to veterans and eligible family members in the system's 119 national cemeteries in 39 states, the District of Columbia, and Puerto Rico. Recently opened NCA cemeteries in Chicago, IL; Albany, NY; Cleveland, OH; and Dallas, TX., continue this tradition of remarkable achievement and service. Additionally, the NCA expects to begin the second phase of construction on four new cemeteries in 2001 and the completion of the planning process on a fifth.

While the National Cemetery Administration maintains more than 2.3 million gravesites in over 13,000 acres of cemetery land, there remains a need to establish additional national cemeteries in some critically needed areas. AMVETS supports the Committee's active review of encouraging the Administration to add more cemeteries to meet the growing demand for space. Clearly, without the strong commitment of Congress and its

authorization, VA will likely fall short of burial space for millions of veterans and their eligible dependents.

The members of *The Independent Budget* recommend that Congress provide $119 million for the operational requirements of NCA in fiscal year 2002. Currently, the NCA averages more than 77,000 interments annually. The aging veteran population has created great demands on NCA operations. The NCA is a labor-intensive workplace. We believe that the continued high standard of service cannot be maintained without the provision of adequate resources of new staff and equipment improvements. $119 million for the NCA will provide the additional full-time employees and necessary supplies and equipment for grounds maintenance and program operations.

For funding the State Cemetery Grants Program, the members of *The Independent Budget* recommend $30 million for the new fiscal year. The State Cemetery Grants Program serves a critically important function working in complement with the National Cemetery Administration to encourage states to establish state veterans cemeteries. Through the State Grants Program, VA can provide up to 100 percent of the development cost for an approved cemetery project. This type of support can greatly assist in establishing gravesites for veterans in those areas where NCA cannot fully respond to burial needs.

To properly support veterans who desire burial in state facilities, members of *The Independent Budget* support increasing the plot allowance to $600 from the current, unreasonably low level of $150. In addition, we firmly believe the plot allowance should be extended to all veterans who are eligible for burial in a national cemetery not solely those who served in wartime.

Based on National Cemetery Administration statistics projecting a dramatic increase in the interment rate until 2010, members of *The Independent Budget* recommend that the National Cemetery Administration establish a strategic plan for the period 2003 to 2008. We must plan for a truly national system, and it must have congressional and administrative budgetary support. We call on Congress to make funds available for planning and fast-track construction of needed national cemeteries.

Mr. Chairman, this concludes my statement. I thank you again for the privilege to present our views, and I would be pleased to answer any questions you might have.

STATEMENT OF
DAVID W. GORMAN
EXECUTIVE DIRECTOR, WASHINGTON HEADQUARTERS
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 6, 2001

Mr. Chairman and Members of the Committee:

I am pleased to appear before you on behalf of the more than one million members of the Disabled American Veterans (DAV) and the members of its Women's Auxiliary to discuss the fiscal year (FY) 2002 budget for the Department of Veterans Affairs (VA) and to present the alternative recommendations of the *Independent Budget (IB)*.

This year marks the 15th year the DAV has joined with AMVETS, Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars of the United States (VFW) to assess the funding needs and make recommendations for veterans' programs. With the shared goal of ensuring that the needs of America's veterans are adequately addressed, we engage in this collaborative effort to present our collective views on policy questions, programmatic issues, and resource requirements for the effective and efficient delivery of benefits and services to veterans and their families.

The DAV has primary responsibility for the portions of the *IB* that deal with Benefit Programs, General Operating Expenses, and Judicial Review of Veterans Matters. My focus will therefore be on those areas of policy and the budget. The members of *IB* group appreciate the courtesy this Committee has extended by permitting us to present our views together in this format.

Because the President submitted only a broad budget outline without details, we are unable to compare in any depth his funding recommendations with our assessment of VA's resource needs. Unquestionably, his recommended $1 billion increase in discretionary budget authority will fall far short of what is necessary to maintain adequate delivery of benefits and services for veterans, however.

Similarly, the President's budget submission contains few details on the Administration's policy positions and legislative proposals for veterans' benefits. The narrative does indicate that the budget includes "several proposals" for legislation designed to "yield net mandatory savings totaling $2.5 billion over the next 10 years." According to the discussion, these several proposals comprise one to eliminate VA's vendee home loan program and other proposals to "extend permanently mandatory savings authorities that would otherwise expire over the next several years."

If it will result in savings, we have no objection to elimination of vendee loans. Vendee loans are those that VA provides to purchasers of properties VA has acquired by reason of default on guaranteed loans. We agree that such loans are outside VA's mission of providing benefits and services to veterans and their families.

However, we strongly oppose recommendations to permanently extend budget reconciliation measures that were enacted for a limited period to reduce budget deficits. Most of these measures adversely affected veterans. They reduced veterans' benefits or imposed upon them such things as user fees and co-payments. Especially repugnant is the one that requires rounding down compensation rates to the nearest whole dollar amount after adjustment for increase in the cost of living. Veterans have borne a substantial part of the burden of deficit reduction. No justification exists for permanently imposing these burdens upon veterans. We urge you, in the strongest possible terms, to reject these proposals as unfair, unwarranted, and unconscionable.

In the *IB*, we have presented several positive proposals to improve veterans' benefit programs to make them more effective and make them better meet veterans' special needs. For

benefits funded under the compensation and pension appropriation, we recommended changes in law to:

- Provide a cost-of-living adjustment (COLA) for compensation and dependency and indemnity compensation
- Permit career military veterans to receive disability compensation and military longevity pay without offset
- Remove the offset between military nondisability separation, severance, or readjustment pay and disability compensation
- Permit veterans to recover taxes withheld on disability severance pay or exempt retired pay beyond the current 3-year period
- Include certain radiogenic diseases in the list of disabilities that may be presumed service connected on the basis of radiation exposure
- Presume all Vietnam veterans were exposed to herbicides containing dioxin
- Authorize presumption of service connection for amyotrophic lateral sclerosis affecting Persian Gulf War veterans
- Repeal the prohibition on service connection for smoking-related disabilities
- Authorize presumption of service connection for hearing loss and tinnitus for combat veterans and veterans that had military duties typically involving high levels of noise exposure
- Authorize temporary increases in compensation to be effective on the date of hospitalization or medical care that resulted in temporary total disability
- Restore the reimbursement for a headstone or marker acquired privately in lieu of furnishing a Government headstone or marker
- Increase the amounts of the burial allowances
- Permit payment of fees under the Equal Access to Justice Act to nonattorneys who successfully represent eligible VA claimants before the Court of Appeals for Veterans Claims

For readjustment benefits, the *IB* proposes legislation to:

- Permit refund of Montgomery GI Bill (MGIB) contributions when the individual becomes ineligible for the benefits by reason of a "general" discharge or a discharge "under honorable conditions"
- Increase the amount of specially adapted housing grants, provide for automatic annual COLAs, and authorize a grant for adaptations to replacement homes
- Increase the allowances for specially equipped automobiles to 80% of the average cost of a new automobile and to provide for automatic annual COLAs
- Increase the maximum home loan guaranty amount to $63,175

For veterans life insurance programs, the *IB* recommends legislation to:

- Exempt the cash value, dividends, or proceeds from consideration in determining entitlement under other Federal programs

- Authorize VA to revise its premium schedule for Service-Disabled Veterans Insurance to reflect current mortality rates

The *IB* also recommends repeal of the 2-year limitation on the payment of accrued benefits to survivors and repeal of the estate limitation for mentally incompetent veterans.

Without specifics, the Administration's budget indicates that it will provide the means to "rejuvenate" the VA's "efforts to ensure the timely and accurate processing of veterans' disability compensation claims." The budget states that it will "fully fund the Veterans Benefits Administration's (VBA) additional workload" from last year's legislation that restored the VA's "duty to assist" and the additional workload from a presumption of service connection for diabetes related to herbicide exposure. We support these recommendations in concept.

Problems with claims processing, accurate decisions, and timely benefits delivery have plagued and challenged VA for years. VBA has a number of initiatives and reforms under way to correct these problems. While Congress must hold VA accountable for effective and efficient administration of benefit programs, Congress must support VA with resources adequate to overcome past inefficiencies and to meet increasing demands. Without the necessary resources, the existing major problems will only grow worse.

To bring about positive change, VA must train both its new and experienced adjudicators in the procedural and substantive aspects of veterans' law without losing additional ground to the claims backlogs while adjudicators' time is spent administering or undergoing training. VA must increase staffing levels to meet the workload demands; it must devote sufficient time to claims development and analysis in decisions to allow for complete records, thorough reviews of the law and evidence, and well-reasoned, well-explained decisions. VA must devote additional resources to quality assurance, an area where its vigilance has been lacking and a crucial aspect of proficiency, performance, and accountability. VA is already understaffed in its claims processing personnel, yet it also desperately needs an infusion of substantial numbers of new employees to offset the expected retirement of many of its experienced adjudicators in the near future. Thus, a sizable number of additional full-time employees (FTE) is essential to meet real needs and make up for past staffing reductions.

In the *IB*, we recommend that VA add 200 FTE to deliver training on a systematic and system-wide basis. We have recommend that VA add 170 new adjudicators to bring its staffing to the minimum level necessary to meet its workload demands. VA's appellate workload in field offices places great demands on its personnel. We recommend that VA add 200 new Decision Review Officers to address this appellate workload.

VA needs additional staff to perform quality reviews of the work of each of its claims adjudicators to assess performance, impose accountability, and remedy deficiencies on an individual employee level. Through its "Systematic Individual Performance Assessment" (SIPA) initiative, VA intends to review 100 decisions of each adjudicator per year. To accomplish this task, VA needs 260 additional new employees.

Accordingly, we have recommended that VA be authorized a total of 830 additional FTE for its Compensation and Pension Service in FY 2002.

Even with optimum quality, an irreducible number of errors are inevitable in a mass adjudication system as large and complex as VA's. With the necessarily and intrinsically complex statutes and regulations that govern disability and compensation issues, errors and legitimate differences of interpretation are unavoidable. In veterans' benefits, as it has often been acknowledged generally, law is not an exact science. The variables of human interactions and the corresponding nuances inherent in the factual bases on which legal rights rest require the intervention of human judgment. Such judgment is, of course, not infallible. Meaningful and effective judicial review is essential to maintain fairness and uniformity and to remedy the injustices that result from human error. To make judicial review a more effective enforcement mechanism for veterans, the *IB* recommends legislative changes in three areas.

First, we recommend a change in the legal standard under which the United States Court of Appeals for Veterans Claims reviews VA's findings of fact. In veterans' benefits law, the "benefit-of-the doubt" rule is a fundamental element of the process designed to favor veterans.

This rule mandates that VA decide a factual question in favor of the veteran unless the evidence against the veteran is stronger than that supporting him or her. However, under its "clearly erroneous" standard of review, the Court allows VA's decision to stand unless a factual finding is without a plausible basis. The Court's lack of enforcement of the benefit-of-the-doubt rule nullifies and renders it meaningless. We have therefore recommended a change in the Court's standard of review to require that it set aside any finding of fact adverse to a veteran when the finding is not reasonably supported by a preponderance of the evidence.

Second, we recommend that the jurisdiction of the Court of Appeals for the Federal Circuit be expanded to permit it to review questions of law. Under its jurisdiction now, the Federal Circuit can review disputes involving the interpretation of a statute or regulation, but it cannot review ordinary questions of law decided in the first instance by the Court of Appeals for Veterans Claims. These questions of law arise when the Court of Appeals for Veterans Claims imposes its own new rule of law to govern a matter of substance or procedure. This situation presents an anomaly inasmuch as it insulates decisions on such questions of law from any appellate review whatsoever.

Third, we recommend that the law be amended to authorize a direct challenge in the Federal Circuit of VA's changes to its schedule for disability rating. Currently, VA regulations are subject to such direct challenge, but regulations in the form of rating schedule changes are immune to such challenge. That means there is no remedy for changes to the rating schedule that are clearly unlawful or arbitrary and capricious. No unlawful or arbitrary and capricious regulation, especially one governing disability rating, should be immune to correction. As it should, this very narrow basis for challenge would leave protected VA's lawful exercise of discretion in establishing disability rating criteria.

We hope our analyses of these issues and VA's funding needs will be helpful to you. We appreciate the opportunity to present our views, and we thank this Committee for its continuing support of our Nation's veterans.

DISABLED AMERICAN VETERANS
Building Better Lives for America's Disabled Veterans

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Disabled American Veterans (DAV) does not currently receive any money from any federal grant or contract.

During fiscal year (FY) 1995, DAV received $55,252.56 from Court of Veterans Appeals appropriated funds provided to the Legal Service Corporation for services provided by DAV to the Veterans Consortium Pro Bono Program. In FY 1996, DAV received $8,448.12 for services provided to the Consortium. Since June 1996, DAV has provided its services to the Consortium at no cost to the Consortium.

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STATEMENT OF
JAMES R. FISCHL, DIRECTOR
VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
FISCAL YEAR 2002 APPROPRIATIONS FOR
THE DEPARTMENT OF VETERANS AFFAIRS

MARCH 6, 2001

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to appear before you today to express the views of The American Legion concerning the Fiscal Year (FY) 2002 Department of Veterans Affairs (VA) appropriations. Last September, The American Legion's National Commander Ray G. Smith offered many of these same recommendations during a joint session of the Veterans' Affairs Committees. The National Commander called for an overall increase in discretionary spending of approximately $1.75 billion in appropriations for VA in FY 2002. The purpose of the joint hearing was to paint a clear budgetary picture for the next administration and Congress. These recommendations were also provided to the major political parties, to all incumbents seeking re-election, and to those candidates who requested copies of the testimony.

The American Legion believes the formulation of the VA budget must be based on the needs of America's veterans, especially those with service-connected disabilities. This is especially important if the Department of Defense (DoD) plans to effectively resolve its recruitment and retention problems. America must honor those promises (implied or not) made to previous generations of veterans. The American Legion believes taking proper care of those who have already served is the linchpin to future veterans. Veterans and their families are DoD's very best recruiters. Young men and women considering military service will seek out active-duty personnel, veterans and their family members for advice. Their voices will carry more weight in the decision process than slogans, recruitment materials or glowing promises.

Honorable military service must provide a veteran with more than individual pride, personal dignity and self-respect. Broken promises, hollow pledges and meaningless gestures do not strengthen national resolve, build morale, or promote unselfish devotion to duty. The thanks of a grateful Nation must be much more than holidays and parades. Long after the guns are silenced, the parades are over and the dead are buried, medals and citations do not help feed, house, educate or heal a veteran.

Over the years, Congress has implemented an array of programs designed to meet the needs of the veterans' community. Many veterans have never turned to VA for any assistance until now. Many of them never thought that VA would become an important part of their lives, but due to external factors (time, money and health), VA has become their life support system!

In addition to the specific budgetary recommendations outlined below, The American Legion believes Congress needs to focus on other budgetary solutions that involve both mandatory and discretionary funding. Medicare subvention is one such issue. Why must a Medicare-eligible veteran have to pay for treatment from VA for a nonservice-connected medical condition out of his or her own pocket, especially if he or she has purchased Part B? Congress allows VA to bill, collect, and retain third-party reimbursements, except Medicare. Why? *Medicare-eligibility is not, and never has been, a priority or criteria for treatment in VA.* When VA treats a Medicare-eligible veteran for a nonservice-connected condition, the veteran is billed. If these Medicare-eligible veterans want to seek health care in VA facilities, why can't they use their Medicare dollars to cover the cost of care for nonservice-connected medical conditions?

TRICARE is another such issue. All military retirees are eligible to seek treatment in VA medical facilities. Should they receive treatment for nonservice-connected conditions, the veteran or TRICARE will be billed. If the military retiree receives a prescription from VA, he or she can get the prescription filled at no charge in a DoD pharmacy. If the prescription is filled in the VA pharmacy, he or she may or may not have to pay a copayment (depending on the status of the veteran). This does not make sense, since the Federal government buys the medications for both agencies! This is but one instance where greater cooperation and coordination between VA and DoD could provide better quality, more timely and accessible health care coverage for all veterans and their families.

The American Legion greatly appreciates the actions of all Members of Congress regarding the increases in VA health care funding for FY 2000 and FY 2001 of approximately $3 billion. The American Legion believes such an increase was long overdue and has allowed VA to better meet the needs of veterans seeking care for their many medical problems. The American Legion believes VA should continue to receive full funding in to order to continue providing world-class health care. However, in order to do so, the Veterans Health Administration (VHA) requires about a billion dollars in new funding each year just to maintain existing services. With a mediocre budget request from a new Administration, the veterans' community must, once again, turn to Congress to make sure "no veteran is left behind."

The American Legion is very appreciative that Congress has realized that the flat-line funding imposed on VA health care under the Balanced Budget Act of 1997 was a bad idea. Just like the Medicare and Medicaid programs, the VA health care budget requires an annual increase to maintain its existing service level and to fund new mandates. For years, VA managers were asked to do more with less. The recent funding increases now allow VHA to do more with more, and will repair some of the problems related to long patient waiting times and limitations on access to care. Congress must not allow the recent funding gains to regress back to the days of doing more with less.

The past eight years have witnessed a significant reorganization and realignment of VHA resources and programs. Many dramatic and bold changes were initiated to improve VA's ability to meet the health care needs of the veterans' community. Now over four million veterans are enrolled in the VA health care system and even more veterans would come, if additional resources were available to cover the cost of care. VA continues to provide outstanding quality care that is recognized and praised by health care critics internationally. VA's medical research is still, dollar-for-dollar, the Nation's best investment. Quality, efficiency and effectiveness are the hallmarks of today's VHA.

Congress must continue to support increased VHA funding to maintain a world-class health care system. There are precious little additional efficiency savings expected throughout the system. Yet, those veterans now enrolled and using the system will continue to rely on VHA for the foreseeable future. Therefore, The American Legion believes that Congress must examine how to balance the annual appropriations process with additional funding that will not be offset by the Office of Management and Budget (OMB). The American Legion believes that a strategic goal of VHA should be to seek opportunities to increase funding sources, both appropriated and nonappropriated.

The overall guiding principle for VA must be improved service to veterans, their dependents, and survivors. This requires improving access to and the timeliness of veterans' health care, increasing quality in the benefit claims process, and enhancing access to national and state cemeteries. Specific American Legion objectives yet to be met by Congress include:

- **Set the veterans' health care system on a sound financial footing for meaningful long-term strategic planning and program performance,**
- **Improve clinic appointment scheduling for access to medical treatment,**
- **Enact Medicare subvention legislation,**
- **Establish pilot programs to provide health care to certain dependents of eligible veterans,**

- **Improve cooperative arrangements between VA and DoD's TRICARE system,**
- **Reduce the benefits claims backlog and improve the quality of the claims process,**
- **Continued enhancement of the Montgomery GI Education Bill,**
- **Repeal of section 1103, title 38, U.S.C., removing the bar to concerning service-connection for tobacco-related illnesses,**
- **Increase the rate of beneficiary travel reimbursement, and**
- **All third-party reimbursements collected by VA should be used to supplement, rather than offset, the annual Federal discretionary appropriations.**

The American Legion offers the following budgetary recommendations for FY 2002:

BUDGET PROPOSALS FOR SELECTED VA PROGRAMS

	FY 2001 Appropriations	*The American Legion's Proposal*
Medical Care	$20.2 billion	***$21.6 billion***
Medical and Prosthetic Research	$350 million	***$375 million***
Construction		
• **Major**	$66 million	***$250 million***
• **Minor**	$166 million	***$175 million***
Grants for State Extended Care Facilities	$100 million	***$80 million***
National Cemetery Administration	$109 million	***$115 million***
State Cemetery Grants Program	$25 million	***$25 million***
VBA's General Operating Expenses	$1.08 billion	***$1.2 billion***

MEDICARE SUBVENTION

Public Law 105-33, the Balanced Budget Act of 1997, established VA's Medical Care Collection Fund (MCCF) and requires that amounts collected or recovered after June 30, 1997, be deposited in this account. Beginning October 1, 1997, amounts collected in the fund are available only for furnishing VA medical care and services during any fiscal year; and for VA expenses for identifying, billing, auditing, and collecting of amounts owed the Federal government fore such care. Public Law 105-33 also extended to September 30, 2002, the following Omnibus Budget Reconciliation Act (OBRA) provisions:

- Authority to recover co-payments for outpatient medications, nursing home and hospital care;
- Authority for certain income verification; and
- Authority to recover third-party insurance payments from service-connected veterans for nonservice-connected conditions.

The Health Service Improvement Fund was established to serve as a depository for amounts received or collected under the following areas as authorized by title 38, U.S.C., Section 1729B:

- Reimbursements from DoD for TRICARE-eligible military retirees;
- Enhanced-use lease proceeds; and
- Receipts attributable to increases in medication co-payments.

The Extended Care Revolving Fund was also established to receive per diems and co-pays from certain patients receiving extended care services authorized in title 38, U.S.C., Section 1710B. Amounts deposited in the fund are used to provide extended care services.

Congress is providing VA with the authority to bill, collect, retain, and use revenues from sources other than Federal appropriations. However, the country's largest health care insurer (Medicare) is exempt from billing; yet, its beneficiaries are welcomed and encouraged to receive treatment in VA medical facilities.

Currently, approximately 10.1 million veterans are Medicare-eligible solely based on their age. Criteria for Medicare-eligibility are different than eligibility for treatment in VA. In the VA health care network, certain veterans are eligible for treatment at no cost for medical conditions determined to be service-connected. Medicare-eligibility is ***not*** a priority or criteria for health care at no cost in the VA health care system. Other veterans are eligible for treatment at no cost, because they are economically indigent. All other veterans must pay for treatment received.

Medicare subvention would allow VA to seek reimbursement from the Health Care Financing Administration (HCFA) for treatment of nonservice-connected medical conditions of Medicare-eligible veterans. VA and HCFA should explore either the Fee-For-Service or Medicare+Choice options or both. Medicare-eligible veterans should not forfeit their Medicare health care dollars because they prefer VA health care to health care offered in the private sector.

More than 734,000 Medicare beneficiaries have lost HMO coverage over the past two years and another 934,000 seniors will be dropped by their HMO plans next year. Many VA-eligible beneficiaries are included in those dropped from coverage and will eventually come to VA for care. The argument that VHA is already reimbursed for its Medicare population and that Medicare subvention will result in double funding is mistaken. VHA is now mandated to provide care to all seven priority groups. As more Medicare-eligible veterans seek first time care in VHA, health care costs and subsequent waiting times will increase. It is imperative that Congress examine this issue and take the actions necessary to ensure that VHA receives all funding necessary to execute its health care mission with quality and in a timely manner.

Medicare subvention for VA ***must*** be included in any planned Medicare reform legislation passed in the 107th Congress. Access to VA health care is an ***earned benefit***. No Medicare-eligible veteran, treated for a nonservice-connected medical condition, should be ***deprived*** of his or her Federal health care insurance dollars to pay for the care received in a VA medical facility.

VETERANS HEALTH ADMINISTRATION (VHA)

The American Legion commends VHA for the evolutionary changes made over the past several years. Most, if not all, of these alterations were long overdue and necessary. This includes eligibility reform, enrollment, the reorganization of the 172 medical centers into 22 integrated service networks, the elimination of certain fiscal inefficiencies, and the expansion of community-based outpatient clinics. For many years, VHA's annual budget appropriation was the guiding principle behind its management decisions. To a degree this is still true. However, today there is growing evidence that VHA strategic planning will help guide future budget development.

The primary short-term objectives of VHA must be to improve patient access and health services delivery. The American Legion's VA Local User Evaluation (VALUE) guidebook cites patient access as the largest single source of continuing veteran complaints. In accordance with its strategic planning, VA annual inpatient admissions have decreased by 32 percent since 1994; ambulatory care visits have increased 35 percent. However, in some areas, like substance abuse, the number of veterans actually being able to access treatment has declined. This phenomenon, along with a large decrease in administrative and clinical staff, and a significant increase in patient enrollments over the past few years, has placed a huge strain on VHA's ability to meet its workload in a timely and consistent manner. As VHA becomes more proficient in attracting new patients, it must also provide consistent access to care across all 22 Veterans Integrated Service Networks (VISNs).

Currently, the national average waiting time for a routine, next-available appointment for Primary Care/Medicine is 64 days (with a range of 36-80 days). The next available appointments for specialty care:

Specialty Care	Average Days	Range
Eye Care (Ophthalmology & Optometry)	94	42-141
Audiology	50	22-91
Cardiology	53	19-78
Orthopedics	47	12-69
Urology	79	39-108

There are additional concerns about the average clinic appointment waiting times for dermatology and pulmonary clinics. However, these specialty clinics are not included in the VISN director's performance standards. Therefore, no national average waiting times were reported. These waiting times indicate that there are serious access differences between VA health care and private sector health care.

There are also reported concerns about long distances that veterans in rural areas have to travel for certain care. For example, veterans in eastern Montana must travel nearly 700 miles to Fort Harrison, MT for routine inpatient surgery. For complex surgical procedures, these same veterans are required to travel to Salt Lake City or Denver. This excessive travel places great strain on veterans and their families. Since 1994, the Miles City, MT VA Medical Center has reduced its payroll over $7 million per year by eliminating nearly 145 full time employee positions. The American Legion questions why contract services for required surgery have not been acquired to reduce excessive travel requirements?

In some cases, The American Legion believes VHA has gone too far, too fast in attempting to improve its fiscal efficiency. Veterans should not have to increase their travel time for the benefit of VA. Rather, VHA needs to improve its cooperation with other federal, state and private health care providers to improve the quality and timeliness of care for veterans.

VHA's short-term and long-term future must be clearly defined to be responsive to the needs of the veterans' community. All individuals who enter military service should be assured that there is a health care system dedicated to serving their needs upon leaving the military. That concept is especially important to disabled veterans and military retirees. The GI Bill of Health would ensure that all honorably discharged veterans would be eligible for VA health care on a permanent basis, as they would fall into one of the core entitlement categories. A unique feature of the GI Bill of Health is that it would also permit certain dependents of veterans to enroll in the VA health care system. The American Legion advocates that dependents of veterans be allowed to use the system and that VA retain any third-party reimbursements for treatment. An additional significant step will be to enact VA-Medicare subvention.

At the current workload level, VHA requires an annual appropriation increase of approximately $1 billion to maintain current services and meet its prosthetics and pharmacy costs. The amount of potential efficiency savings is decreasing yearly. The

projected $3 billion funding increase over FY 2000-2001 must compensate for the flat line budgets of FY 1997-99, and fully fund the provisions of the Millennium Act involving emergency and long-term care, Hepatitis C treatment. Consequently, there is a continuing need to adequately fund VHA's uncontrollable cost increases at an acceptable level in order to maintain capacity in the Special Emphasis Programs (Mental Health, SCI, Blind Rehab, etc).

Change within VHA, over the past several years, has been the result of a series of small steps. The American Legion acknowledges that the progress made within VHA has been extraordinary. However, this progress has to be sustained and reinforced. In order to accomplish this goal, Congress must unlock the creative potential of VHA to develop alternative revenue sources to complement the annual appropriations process, but these additional sources of revenue should not be used to offset the appropriated dollars from Congress.

At a recent VA planning meeting, VHA unveiled six strategic goals to be accomplished by 2006.

- Put quality first,
- Provide easy access to medical knowledge, expertise and care,
- Enhance, preserve and restore patient function,
- Exceed customers' expectations,
- Maximize resource use to benefit veterans, and
- Build healthy communities.

The American Legion believes these are important goals. *However, we believe VHA must explore all opportunities to develop alternative revenue sources to complement its annual appropriations.* To do less will continue to force VHA to solely rely on the annual budget process to establish patient treatment priorities. There is a distinct possibility that if future funding does not keep pace with the growing needs of veterans who seek treatment through VHA; the current open access to all seven-priority groups will close.

THE AMERICAN LEGION RECOMMENDS $21.6 BILLION FOR VHA.

TRICARE

The most significant recent change in military health care is the introduction of TRICARE (DoD's regional managed care program). TRICARE is facing many challenges to providing and maintaining a quality health care delivery system for active duty military personnel, military retirees, and dependents.

DoD continues to confront severe administrative problems with TRICARE. The American Legion is extremely concerned how DOD will fix these problems and if DoD can guarantee TRICARE's long-term success.

There are multiple reasons why TRICARE is failing to meet the expectations of its beneficiaries:

- Infrastructure and financial problems,
- Problems with provider networks – resulting in weak network links to subcontractors,
- The inability to attract and retain qualified health care contractors,
- No financial tracking system outside of the military treatment facilities,
- Difficulties in processing claims in a timely manner,
- TRICARE lacks portability between all 12 regions, and
- Military retirees and their dependents are required to pay an annual enrollment fee.

The American Legion believes that VHA can greatly assist DoD through expanded authority to provide care to TRICARE beneficiaries. With limited budgets,

both VA and DoD must discover innovative ways to provide care to active duty personnel, to all veterans and military retirees, and to eligible dependents.

Congress recognized the utility of having VHA play a greater role in the treatment of TRICARE beneficiaries when it passed the Veterans' Millennium Health Care and Benefits Act (PL 106-117). This legislation requires VA and DoD to enter into an agreement to reimburse VA for the cost of care provided to retired servicemembers who are eligible for TRICARE and who are enrolled as Priority 7 veterans. These veterans would not be required to pay VA inpatient and outpatient copayments. The program is to be phased in as DoD enters into TRICARE contracts after November 30, 1999.

Five years ago, it was impractical to suggest that VHA was capable of assisting DoD in resolving many of its patient treatment problems. Today, although not without concerns of its own, VA is in a much better position, both financially and organizationally, to assist with the delivery of health care to DoD beneficiaries. The American Legion believes that VA and DoD should better coordinate medical care and services to the extent possible, thereby eliminating duplication of effort and achieving greater cost efficiencies. With proactive planning, VHA can become the largest single provider of health care to America's veterans, military retirees and their dependents. DoD could then assume the responsibility of providing health care to active duty servicemembers, Reserve Component members and their dependents.

MEDICAL AND PROSTHETIC RESEARCH

The contributions of VA medical research include many landmark advances, such as the successful treatment for tuberculosis, the first successful liver and kidney transplants, the concept that led to development of the CAT scan, drugs for treatment of mental illness, and development of the cardiac pacemaker. The VA biomedical researchers of today continue this tradition of accomplishment. Among the latest notable advances are identification of genes linked to Alzheimer's disease and schizophrenia, new treatment targets and strategies for substance abuse and chronic pain, and potential genetic therapy for heart disease. Many more important potentially groundbreaking research initiatives are underway in spinal cord injury, aging research, brain tumor treatment, diabetes and insulin research, and heart disease, among others.

VA devotes 75 percent of its research funding to direct clinical investigations and 25 percent to bioscience. Patient-centered research comprises one of every two dollars spent on research within VA. In FY 2001, VA's appropriations funding for research is $350 million.

Gulf War Veterans' Illnesses

The American Legion continues to actively support Gulf War veterans and their families, as it has since August 1990. The American Legion created two programs specifically for Gulf War veterans, the Family Support Network in October 1990, and the Persian Gulf Task Force in October 1995. Today, The American Legion serves Gulf War veterans and their families at the community, state, and national levels through 15,000 local posts and an array of programs and services.

Thousands of Gulf War veterans, who suffer undiagnosed illnesses with a range of symptoms, know as "Gulf War veterans' illnesses," are not receiving adequate care or compensation from VA and DoD. As the number of sick Gulf War veterans has continued to increase, it is apparent that VA has narrowly interpreted and implemented the Persian Gulf War Veterans' Benefits Act (Public Law 103-446), effectively denying compensation to some of the veterans the law was designed to help. It is clear that the intent of Congress was not only to compensate Gulf War veterans with conditions that can not be diagnosed, but to also compensate sick veterans diagnosed with poorly defined conditions such as chronic fatigue syndrome and fibromyalgia. As a result of VA's narrow interpretation of PL 103-446, it has become quite clear that legislation is needed to amend Title 38 USC § 1117, Compensation for Disabilities Occurring in Persian Gulf War Veterans.

The American Legion makes the following recommendations in addition to the legislative course of action discussed above:

- VA and DoD should conduct their respective exams in a standard and uniform way as well as create a database that will merge the individual data from both exams so that patterns in health can be better analyzed,
- VA and DoD should aggressively move to educate its medical doctors about newly defined illnesses (Chronic Fatigue Syndrome, fibromyalgia, etc.) that are commonly misdiagnosed as psychological conditions. VA should also discourage its doctors from giving diagnoses for common symptoms unless diagnosed properly, so that the VA's Persian Gulf War Registry and DoD's Comprehensive Clinical Evaluation Program (CCEP) data will be accurate,
- VA and DoD should conduct extensive follow-up to Gulf War veterans who participate in the Registry and CCEP examinations to monitor health status.

Additionally, this past September the Institute of Medicine (IOM) released a much-anticipated report on the health effects of exposures during the Gulf War. Unfortunately, due to the lack of evidence and quality research on the long-term health effects of the various exposures these veterans faced during the Gulf War, IOM was unable to make any determinations regarding veterans' health due to exposures. IOM recommended additional research for long-term health effects. In light of the inconclusive findings and IOM's call for additional research, appropriate action should be taken to extend the presumptive period for VA undiagnosed illness compensation claims which is set to expire January 1, 2002.

Additional research on the long-term health effects of the various hazards veterans were potentially exposed to during the Gulf War, as called for by IOM, will require additional funding. Anticipated extension of priority health care for sick Gulf War veterans will also require additional funding. The American Legion urges Congress to continue aggressive oversight of the implementation of the landmark Gulf War legislation passed by the 105th Congress (PL 105-368).

THE AMERICAN LEGION RECOMMENDS THAT MEDICAL AND PROSTHETICS RESEARCH BE INCREASED TO $375 MILLION.

MEDICAL CONSTRUCTION AND INFRASTRUCTURE SUPPORT

Major Construction

The VA major construction program is not being funded in an adequate manner. The major construction appropriation over the past few years has allowed for only one or two projects per year. Meanwhile, the number of priority projects continues to accumulate. For FY 2001, 16 major ambulatory care or seismic correction projects were submitted to Office of Management and Budget. Of this number, only one major VHA project is recommended. For FY 2002, 28 major projects are to be submitted for funding. The American Legion does not believe that the FY 2001 funding level of $66 million is sufficient to meet this goal.

THE AMERICAN LEGION RECOMMENDS $250 MILLION FOR MAJOR CONSTRUCTION.

Minor Construction

Annually, VHA must meet the infrastructure requirements of a system with approximately 4,700 buildings, 600,000 admissions and over 35 million outpatient visits. To do so requires a substantial inventory investment. The FY 2001 appropriation of $166 million for minor construction needs additional funding to meet future physical improvement needs. It is *penny-wise* and *pound-foolish* to reduce this investment. VHA was forced to delay approximately one-third of its priority minor projects. The American Legion believes that Congress must be consistent from year to year in the amount invested in VHA's infrastructure.

THE AMERICAN LEGION RECOMMENDS $175 MILLION FOR MINOR CONSTRUCTION.

GRANTS FOR THE CONSTRUCTION OF STATE EXTENDED CARE FACILITIES

Currently, this nation is faced with the largest aging veterans' population in its history. VA estimated the number of veterans 65 years of age or older will peak at 9.3 million in the year 2000. By 2010, 42 percent of the entire veteran population, an estimated 8.5 million veterans, will be 65 or older, with half that number above 85 years of age. By 2030, most Vietnam Era veterans will be 80 years of age or older. The State Veterans' Home Program must therefore continue, and even expand its role as an extremely vital asset to VA. Additionally, state homes are in a unique position to help meet the long-term care requirements of the Veterans' Millennium Health Care and Benefits Act.

State veterans' homes provide over 24,000 beds with a 90 percent occupancy rate that will generate more than seven million days of patient care each year. The authorized bed capacity of these homes is 90 nursing care units in 40 states (17,844 beds); 46 domiciliaries in 32 states (5,841 beds); and 5 hospitals in 4 states (469 beds). For FY 2000, VA spent approximately $255 per day to care for each of their long term nursing care residents, while paying private-sector contract nursing homes an average per diem of $149 per contract veteran. The national average daily cost of caring for a state veterans' home nursing care resident during FY 2000 was $137. VA reimbursed state veterans' homes a per diem of only $40 per nursing care resident.

On the basis of the available funding in FY 2001, a total of 42 priority one state home construction grant projects with an estimated cost of $110 million remain unfunded. As many VA facilities reduce long-term care beds and VA has no plans to construct new nursing homes, state veterans' homes are relied upon to absorb a greater share of the needs of an aging veteran population. If VA intends to provide care and treatment to greater numbers of aging veterans, it is essential to develop a proactive and aggressive long-term care plan. VA should work with the National Association of State Veterans' Home Directors to convert some of its underutilized facilities on large multi-building campuses to increase the number of available long-term care beds.

THE AMERICAN LEGION RECOMMENDS $80 MILLION FOR THE STATE VETERANS' HOME EXTENDED CARE CONSTRUCTION GRANTS PROGRAM.

NATIONAL CEMETERY ADMINISTRATION (NCA)

Currently, NCA oversees 119 national cemeteries in 39 states and Puerto Rico. The Department of the Army or the Department of the Interior administers sixteen other national cemeteries. Sadly, there are 57 national cemeteries closed to first interments. Recently, new national cemeteries were opened in Chicago, IL; Albany, NY; Cleveland, OH; and Dallas, TX. Major construction projects are planned at other existing sites to extend the active life of the cemeteries for as long as possible.

The National Cemetery Administration has no national cemeteries in some critically needed areas. Among these are Atlanta, GA; south Florida; Pittsburgh, PA, Sacramento, CA; Detroit, MI; and Oklahoma City, OK. Additionally, some existing cemeteries will soon run out of available space without significant expansion.

The National Cemetery Administration statistics project over 80,000 burials during FY 2001. The number of veterans' deaths is projected to peak at 620,000 in 2008 and slowly return to the 1995 level of 500,000 by 2020. Notwithstanding the development of six new national cemeteries over the past 10 years, there is an urgent requirement to continue the recent expansion. Without a strong commitment from Congress to take on this effort, VA will not be able to improve access to burial in national cemeteries for millions of veterans and their eligible dependents.

The American Legion believes that Congress should remove the current restriction on eligibility to an appropriate government furnished marker for veterans that

have a marked grave. This outmoded statute affects over 20,000 families per year. This restriction should be removed so NCA can be of assistance to all families that seek appropriate recognition of a veteran's honorable military service.

THE AMERICAN LEGION RECOMMENDS $115 MILLION FOR NCA. ADDITIONALLY, CONGRESS SHOULD COMMIT TO BUILDING SIX NEW NATIONAL CEMETERIES BY 2008 AND PROVIDE APPROPRIATE FUNDING IN VA'S MAJOR CONSTRUCTION PROGRAM FOR THIS PURPOSE.

GRANTS FOR THE CONSTRUCTION OF STATE VETERANS' CEMETERIES

The State Cemetery Grants Program is an excellent complement to NCA. The enactment of PL 105-368 in November 1998 significantly improves the state grants program, but does not ensure that the states will commit to developing veterans' cemeteries in the areas of greatest need. Therefore, to strengthen the program, Congress must increase the burial plot allowance paid to the states and make the allowance applicable to all veterans. Additionally, to lessen the demand to invest millions of dollars in the construction and long-term maintenance of new national cemeteries, a significant increase in state grants applications funding must be provided.

THE AMERICAN LEGION RECOMMENDS $25 MILLION IN NEW STATE VETERANS' CEMETERY GRANTS.

VETERANS BENEFITS ADMINISTRATION

Mandatory spending for the payment of compensation, pension, and burial benefits by the Veterans Benefits Administration (VBA) for FY 2002 is expected to exceed $23 billion. This reflects the impact of recent new regulatory and legislative entitlements as well as higher average benefit payments, certain new proposed legislation, and a cost-of-living adjustment.

The proposed increase in discretionary funding for FY 2002 will do little, if anything, to improve VBA's claims adjudication process. The promised improvements in service cannot be achieved without a substantial staffing in the regional offices. This is clearly evident in the fact that the current backlog of pending claims, new appeals, and remanded cases from the Board of Veterans Appeals is continuing to grow rather than decrease. In addition, there will be a substantial increase in the regional offices' workload associated with new claims for diseases such as diabetes related to Agent Orange exposure, Hepatitis C, and radiation-related claims, as well as the readjudication of claims as a result of the Veterans' Claims Assistance Act of 2000. Additional funding is also needed to enable VBA to continue its efforts to reengineer their business processes, improve training, continue succession planning, and improve the overall quality and timeliness of the service provided to veterans and their families.

The American Legion is supportive of the broad performance and service improvement goals set forth in VBA's strategic management plan. Progress has been made in a number of areas under the current year budget. However, this is a long-term process and many significant challenges remain. Without adequate funding support at this critical period, VBA's implementation of a broad spectrum of operational, programmatic, technological, and administrative initiatives now underway or planned will be delayed and service will deteriorate. Disabled veterans must now wait months and sometimes years for their benefit claims to be decided. They are deeply frustrated and disappointed by a bureaucratic system that appears to be "not very user friendly", inefficient, and frequently unresponsive to their personal problems and needs. VBA's budget for FY 2002 must ensure that progress toward its stated service improvement goals will continue and that veterans and their survivors receive the benefits and services they are entitled to in a timely manner

BENEFIT PROGRAMS

In FY 2002, the estimated number of compensation, pension, education, and burial claims is expected to increase over the FY 2001 workload projections. While the number of pension claims will decline, due to the high mortality among World War II veterans, this will be substantially offset by the expected influx of claims for diabetes, Hepatitis C, additional radiation-related diseases, and requests for readjudication under the Veterans' Claims Assistance Act of 2000. It is apparent from the growing backlog of pending claims and appeals, which is now in excess of 500,000 cases, that present staffing levels are inadequate to meet the current workload and provide veterans and other claimants the level and quality of service they are entitled to and deserve.

One of the biggest challenges facing VBA over the next several years, in addition to the much needed modernization of its computer systems, is the prospect of the large scale turnover among its most experienced and senior personnel within the next three to five years. This issue was recognized as a major concern in the FY 1999 budget request and we were pleased that additional staff for VBA has been authorized in each of the past three-year budgets. However, currently, only 45 percent of authorized decisionmakers have three years or more of experience. The prevailing level of inexperience, the sheer number of claims and appeals to be processed, and the legal and medical complexities of all types of claims has contributed to an unacceptable error rate and a growing backlog of pending cases. VBA is continuing its efforts to recruit new personnel, improve the level, and the availability of training. It has also instituted several initiatives that will not only help identify errors in adjudication and improve the quality of decisions, but will make individuals and managers personally accountable for the quality of their work. It is essential that these initiatives continue and be fully funded.

Hepatitis C Claims

Hepatitis C has become a national public health challenge and The American Legion is deeply concerned by the prevalence of the Hepatitis C virus in the veteran population. According to government estimates, there are approximately 4 million Americans with this virus and many have serious health problems, such as cirrhosis of the liver and liver cancer. According to VA estimates, 400,000 veterans may be infected with this disease. The reason why veterans are more likely to have Hepatitis C than the non-veteran population is because of the presence of a variety of risk factors inherent in military life and the increased risk of exposure by those serving on active duty.

The American Legion has been generally pleased by VA's responsiveness to the Hepatitis C problem. In light of study data showing an increased incidence of this disease among the veteran population, The American Legion asked the VA Secretary to consider issuing regulations providing for presumptive service connection. Proposed regulations are now under development and will, hopefully, be available for public comment later this year. When finalized, these are expected to result in a substantial influx of claims for disability compensation and VA medical care. While these regulations will assist veterans in establishing entitlement to disability and medical care benefits, we believe that Congress should codify by statute the presumptions which will apply to Hepatitis C claims. This will ensure VA has the necessary resources to fully and fairly adjudicate this type of claim and provide the support needed for its outreach, information, and treatment programs.

THE AMERICAN LEGION RECOMMENDS $1.2 BILLION IN VBA-GOE.

BOARD OF VETERANS APPEALS

The American Legion believes the Board of Veterans Appeals (BVA) will require additional staffing resources for FY 2002, so that efforts to improve productivity and reduce their response time can continue. Staffing at the BVA is currently 520 FTEE. However, due to a number of internal and external factors, the BVA's workload is expected to remain high and their response time increase to over 220 days. In FY 2002, BVA expects to increase production slightly and reduce the number of pending appeals at the Board. However, these modest gains will be largely offset by the impact of directives

of the Court of Appeals for Veterans Claims that require additional time, effort and resources in deciding appeals and those cases remanded from the Court to the Board for readjudication. In addition, the Board's long-term workload continues to trend upward, despite VBA's many quality and service improvement initiatives, including the establishment of the Decision Review Officer program and greater cooperation between the regional offices and the BVA. The number of new appeals filed each year remains in excess of 60,000 and the number of substantive appeals filed is at least 32,000, most of which will eventually reach the BVA. In addition, there are thousands of cases remanded to the regional offices over the last several years and a majority of these will return to the BVA.

SUMMARY

Immediately after seeing the new Administration's budget request for FY 2002 and its recommendation of only a billion dollar increase in VA discretionary funding, National Commander Smith said, "The administration's suggested increase is simply not good enough."

The American Legion believes VA must receive at least $750 million more than the $1 billion in discretionary spending requested by President Bush and Secretary Principi. The American Legion specifically recommends the following minimal funding levels:

- **Medical Care** — **$21.6 billion**
- **Medical and Prosthetic Research** — **$375 million**
- **Construction**
  - **Major** — **$250 million**
  - **Minor** — **$175 million**
- **Grants for State Extended Care Facilities** — **$80 million**
- **National Cemetery Administration** — **$115 million**
- **State Cemetery Grants Program** — **$25 million**
- **VBA's General Operating Expenses** — **$1.2 billion**

If VA is to provide quality health care to America's veterans, more funding is absolutely necessary. A billion dollars will not begin to address Hepatitis C treatment or long-term care mandated by the recently enacted Veterans' Millennium Health Care and Benefits Act. A billion-dollar increase will fall short of covering the on-going costs associated with maintaining current health care services. There will be nothing left to address the claims adjudication crisis. VA must hire enough new claims adjudicators to expedite the delivery of benefits and replace the large number of retiring experienced adjudicators.

This budget request is insufficient to fulfill the campaign promises made by President Bush, Vice President Cheney, and Secretary Principi to America's veterans and their families:

- Improve health care delivery,
- Modernize the claims process,
- Closer cooperation with TRICARE, and
- Full utilization of health care facilities throughout the system.

Mr. Chairman and Members of the Committee, adequate health care for veterans is important because veterans are important. Their sacrifice is the human cost of failed foreign policy. Whenever the VA budget suffers, it hurts America's veterans, and adversely impacts on their families. Many of you know of classic examples of your constituents that waited months, and sometimes years, for a claim to be processed. You know of others that must wait weeks, and sometimes months, for a medical appointment. Yet, when this Nation called on them to fight, their response was immediate!

Sadly, many veterans do not live long enough to see their claims resolved. Years of suffering, frustration, and financial hardship all too often follow them to their grave.

The American Legion knows this is wrong and you know this is wrong. These problems cannot be properly resolved without adequate discretionary funding.

Thank you Mr. Chairman, this concludes my testimony.

The American Legion
For God and Country

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March 6, 2001

Honorable Christopher H. Smith, Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
335 Cannon House Office Building
Washington, DC 20515-6335

Dear Mr. Chairman:

The American Legion would like to submit the attached response to the President's **Blueprint for New Beginnings** for the Department of Veterans Affairs. Without a specific budget to review, The American Legion has addressed this budget summary in very general terms. The American Legion looks forward for the opportunity to discuss this budget request in greater detail in subsequent hearings held by this Committee and the Armed Services Committee.

Sincerely,

Steve Robertson, Director
National Legislative Commission

Blueprint for New Beginnings

Highlights of 2002 Funding for the Department of Veterans Affairs

- Provides more than $51 billion for veterans' benefits and services: $28.1 billion for mandatory entitlements and $23.4 billion in net discretionary budget authority to administer veterans' benefits and provide medical care and burial services.

At the present time, VA receives the bulk of its funding from Federal mandatory and discretionary appropriations. VA does generate non-appropriated dollars through third-party reimbursements from individuals or private health care insurers, but cannot receive any reimbursements from the Nation's largest single health care insurer, Health Care Financing Administration. The American Legion strongly believesVA should be allowed to bill, collect and retain third-party reimbursement from the treatment of nonservice-connected medical conditions of Medicare-eligible veterans and, possibly, dependents.

In addition, The American Legion believes that military retirees deserve to receive the same quality health care provided to service-connected disabled veterans. VA's full continuum of care is much broader than that available under TRICARE, especially the specialized care and long-term care. Many military retirees are service-connected veterans that are dependent on VA for quality care and treatment for their specific medical conditions; however, should these military retirees be treated for nonservice-connected conditions, they will be billed. The American Legion strongly encourages the close coordination of health care treatment and services between VA and TRICARE.

- Increases net discretionary budget authority by $1 billion, or 4.5 percent, over the 2001 level.

The American Legion strongly encourages Congress to increase this recommendation to at least $1.75 billion. The American Legion's recommendation is the minimum necessary to sustain current level of care and begin making necessary improvements. The Public Laws passed in the 106th Congress carry price tags into the 107th Congress. Federal pay raises, Cost-of-Living-Adjustments, the Veterans' Millennium Health Care Act's Long-Term Care and other mandates, Duty To Assist, and others far exceed the minimal increase proposed by President Bush.

- Ensures that the Nation's veterans receive high-quality health care, accurate and timely entitlement benefits, and a continued commitment to make veterans' cemeteries national shrines.

The American Legion applauds and fully supports these admirable goals, but good intentions don't pay the bills! The Budget Resolution must include enough discretionary funding to allow these goals to be effectively measured and achieved. Furthermore, all third-party reimbursements collected by VA should be considered a supplement rather than an offset since the health care is for nonservice-connected medical conditions.

- Implements a Presidential initiative to ensure the timely and accurate processing of veterans' disability claims, while strengthening the Department of Veterans Affairs' (VA's) "duty to assist" role.

Clearly, The American Legion fully supports this objective. The current claims processing maze is absolutely disgraceful. Sadly, it takes years for a claim to be processed while veterans must suffer and often die before a decision is rendered. Federal employees responsible for adjudicating claims are simply overwhelmed with an incredible workload. The American Legion believes two key issues that must be properly addressed: manpower and technology. Both of these areas of concern will need additional revenue earmarked to employ new personnel and state-of-the art technology.

- Focuses VA's health care system on its core mission of providing high-quality health care to veterans with disabilities or low incomes; and supports the President's new task force to study ways of improving health care access and quality.

Without adequate funding, all of the improvements made in VA health care over the last decade will be in peril. Over the years The American Legion has witnessed the adverse impact of budgetary shortfalls. Rationing of care and reduction in services are unacceptable consequences. Veterans served this country with honor; America must serve its veterans with honor.

- Assumes that $235 million of VA's current health care liability will shift to the Department of Defense due to generous new benefits available to military retirees over age 64.

The American Legion believes this is a faulty assumption for several reasons. VA health care is not based on longevity of military service, but rather honorable military service. Every veteran is eligible to have access to the VA health care system – this is an earned benefit.

VA provides specialized services, like blind-rehab, long-term care, drug and alcohol rehab, and others that I think are not readily available through TRICARE.

The American Legion believes the DoD health care system, the VA health care system and TRICARE clearly have different priorities. The top priority of the DoD health care system is to provide care for active-duty personnel, in peace and in war. The first priority of the VA health care system is to provide quality health care for veterans, especially service-connected disabled veterans. The first priority of TRICARE is to provide quality health care for a profit.

Initiatives

1. The President's budget will rejuvenate the Department of Veterans Affairs' (VA's) efforts to ensure the timely and accurate processing of veterans' disability compensation claims.

The American Legion fully supports this initiative and will work with Secretary Principi and his staff to achieve this goal, but where will the money come from?

2. It will fully implement new legislation that strengthens VA's "duty to assist" veterans in preparing their claims and a regulation that adds diabetes to the list of presumptive conditions that are associated with exposure to herbicides.

The American Legion worked very hard on the Duty To Assist Public Law. This decision will bring tens of thousands of cases back into the claims process for readjudication. This will be added on to the current backlog. Again we ask, where will the money come from?

3. The budget will fully fund the Veterans Benefits Administration's (VBA's) additional workload for this initiative and assumes that VBA will develop a vision for future benefit delivery that incorporates and harnesses paperless technology.

Another admirable goal fully supported by The American Legion. But where will the money come from?

4. Part of this effort to modernize will be for VBA to complete the consolidation of aging data centers into its state-of-the-art facility in Austin, TX.

Redirected Resources

I. The National Defense Authorization Act of 2001 authorized a new Department of Defense (DoD) benefit for military retirees over age 64 who have Medicare coverage. These retirees will be able to use their own private doctors for free care and receive a generous drug benefit. Currently, 240,000 of these retirees are enrolled with VA for care. The budget assumes that 27 percent of them will switch to the DoD benefit in this first year, shifting $235 million in VA liabilities to DoD.

The American Legion does not understand how the $235 million is considered liabilities. Military retirees with service-connected disabilities are entitled to treatment. Military retirees that are economically indigent are entitled treatment. Military retirees that are treated for nonservice-connected medical conditions are billed for the services received. Therefore, treatment of military retirees in the VA health care system is not a liability. VA offers many health care services unavailable through TRICARE (long-term care, blind rehabilitation, etc.).

II. The budget also includes legislation for several proposals that will yield net mandatory savings totaling $2.5 billion over the next 10 years. The first eliminates VA's vendee home loan program. It is unrelated to the VA's mission because it allows the general public to obtain a direct loan from VA to purchase a home that VA has acquired when a veteran defaults on a loan. The general public may obtain financing from various other public and private institutions for this purpose. Other proposals would extend permanently certain mandatory savings authorities that would otherwise expire over the next several years.

The American Legion remembers when veterans were asked to "do their fair share" to help reduce the Federal deficit. Veterans and their families lost earned benefits like plot allowances and headstone allowances to help reduce the deficit. Now that there are staggering surpluses,

why are these mandatory savings authorities are now going to be made permanent? Does this mean "pay go" requirements no longer apply?

Potential Reforms

A. Both the budget and the President's National Security Directive on Military Quality of Life reflect the Administration's commitment to improve VA health care for those veterans eligible for treatment in the system by enhancing access to timely, high-quality care.

The American Legion will be one of the President's strongest supporters of this potential reform as long as it does not restrict access to care or deny services to any honorably discharged veteran.

B. The President will convene a Veterans Health Care Task Force composed of officials and clinicians from VA and DoD, leaders of veterans and military service organizations, and leaders in health care quality to make recommendations for improvements.

The American Legion welcomes the opportunity to serve on the President's Veterans Health Care Task Force. The American Legion has a health care plan for the 21st Century, entitled the GI Bill of Health, for all veterans and their families. The GI Bill of Health is designed to provided quality health care for all veterans – past, present, and future – and their dependents. The GI Bill of Health calls for the Federal government to keep its promise of health care for life for all service-connected disabled veterans, military retirees and their families and economically disadvantaged veterans. All other veterans and their families, who bring their health care insurance dollars with them, would have access to the VA health care system. The GI Bill of Health is a responsible approach to fulfilling former President Lincoln's pledge to care for the veteran and his or her family with quality health care.

C. To avoid duplication of benefits and enhance the quality and continuity of care, the Administration will focus on providing high-quality care through a single source. Over 700,000 military retirees (all ages) are enrolled in both the DoD and VA health systems and may use either whenever they choose. As a result, DoD and VA encounter problems in allocating the necessary resources due to their difficulty estimating the number of people that will obtain health care services in each of the systems. The Administration will seek legislation to ensure that DoD beneficiaries who are also eligible for VA medical care enroll with only one of these agencies as their health care program. In addition, to ensure high-quality care and expanded access for the Nation's highest priority veterans, VA will focus its attention on treating disabled and low-income veterans.

Unfortunately, this is the one potential reform that The American Legion will adamantly oppose. VA was created to meet the health care needs of veterans, especially service-connected veterans. America has pledged to improve the best health care possible to those that must live with the scars (both visible and invisible) of war. This is a solemn pledge worthy of a grateful Nation.

No military retiree should ever have to lose this benefit, especially for the benefit of former employer. VA health care has an array of services not available in the DoD health care system

or TRICARE. If VA health care is the best health care the Federal government can provide to the service-connected veterans, why would a military retiree want to choose DoD health care over VA health care? Their choice will be based on the fact that their dependents are not currently eligible to use VA.

The American Legion believes VA, DoD and HHS could reach an agreement that would allow VA and DoD to work in close harmony to provide all veterans and their dependents with quality health care. The American Legion adamantly opposes the merger of these two systems because of their specific missions, but does see windows of opportunity to take care of America's veterans and their families. Substantial savings could be achieved through buying power through economy of scale.

Currently, VA and DoD heath care systems have similar infrastructures of established major medical facilities and outpatient clinics. VA's large infrastructure continues to grow, whereas DoD's smaller infrastructure may continue to decrease if additional base closures occur. They have numerous sharing agreements and, in some locations, they share physical plants. Both serve as medical training grounds, both VA is affiliated with over 100 medical training institutions. Both are Federal agencies dependent on annual discretionary funding. Both systems currently contract with private health care providers to meet under-served catchment areas. VA contracts directly with health care providers. DoD contracts with private for-profit companies that subcontract with health care providers.

VA is not allowed to compete for consideration of TRICARE contracts, even thought they share many of the same patient population. In fact, TRICARE has subcontracted with VA in many areas of the country for certain services. Therefore, in some cases, DoD is paying a for-profit company to send a veteran to a VA medical facility.

Currently, DoD and some TRICARE companies are renegotiating their initial contracts. Again, VA is not allowed to compete for a TRICARE contract.

D. VA has begun the assessment phase of an infrastructure reform initiative that will result in a health care system with enhanced capabilities to treat veterans with disabilities or lower incomes living in under-served geographic areas.

The American Legion supports this reform proposal. Should VA follow The American Legion's recommendation to expand it patient base to include dependents with health care coverage in under-served geographic areas, the patient population would add bargaining power and justification for contracted services with established, local health care providers.

E. Savings from the disposal of underused VA facilities will support these improvements. As VA awaits the recommendations from this multi-year assessment (referred to as CARES), it will continue to use expanded sharing agreements and contracting authorities with other health care providers.

The American Legion is deeply concerned with this potential reform. If CARES is based on the current patient population, it may recommend disposal of facilities that VA may wish to renovate

to meet the health care needs of a new patient base that would include dependents. The Veterans' Millennium Health Care Act also mandates Long-Term Care for certain veterans and optional for others. It would be unwise to dispose of properties in close physical proximity to VA health care facilities that could be renovated or razed to meet Long-Term Care, speciality or primary care needs.

F. VA will continue to reform its information technology. It will improve coordination among its administrations to plan for, implement, and use information technology to serve veterans. Reforms will include developing a common technological architecture, establishing common data definitions, and coordinating systems across VA, to improve cost-effectiveness and delivery of benefits and services to veterans.

The American Legion strongly supports this potential reform.

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Statement of

VIETNAM VETERANS OF AMERICA

Submitted by

Richard Weidman
Director, Government Relations
Vietnam Veterans of America

Before the
House Committee on Veterans' Affairs

Regarding
Department of Veterans Affairs Budget Request
For
Fiscal Year 2002

March 6, 2001

Vietnam Veterans of America

House Committee on Veterans' Affairs
Department of Veterans Affairs
Budget Request For Fiscal Year 2002
March 6, 2001

Mr. Chairman, on behalf of Vietnam Veterans of America (VVA), I thank you and your distinguished colleagues for the opportunity to present our views in regard to the President's proposed FY 2002 budget for the United States Department of Veterans Affairs (VA).

While we appreciate President Bush speaking with emphasis about the Nation's responsibility toward veterans, a one billion dollar increase in discretionary spending at VA is just not an acceptable increase. VVA is very concerned about what this grossly inadequate proposal, which does not even keep pace with medical inflation in the veterans health care system, will have on vitally needed services to veterans. In addition, VVA is equally concerned about the inadequate accountability whether the resources made available by the Congress are utilized for maximum positive impact, and whether VHA is actually spending funds in the manner directed by the Congress.

The rate of medical inflation in the United States varies from about 8% to 12% (+) per year. The reported $800 million dollar increase for the Veterans Health Administration (VHA) from FY 2001 to FY 2002 is approximately a 4% increase. In other words the Administration's proposal for VHA is less than half of the conservative estimate of what VHA needs in order to not have their ability to serve veterans properly to be further eroded. Put simply the Congress can and must do better than this.

Vietnam Veterans of America does enthusiastically endorse the Independent Veteran Service Organization (IBVSO) budget. At least $ 1.7 Billion in additional funds over the FY 2001 level is needed in the VHA just to keep up with inflation. This level of funding for VHA does not address the need to restore the organizational capacity needed to serve veterans properly that resulted from the virtually "flat lined" appropriations of FY 1996, FY 1997, and FY 1998.

The so-called specialized care services at VHA (e.g., spinal cord injury treatment, blind & visually impaired services, post traumatic stress disorder treatment (PTSD) programs and services, etc.) have all been dramatically eroded in the past five years. When the Veterans Eligibility Reform Act was enacted in 1996, Congress mandated that the level of resources and capacity to deliver the specialized services, which is really the heart of the VHA mission, be maintained at least at the FY1996 level of effort. That has not happened. Rather, such services have been diminished and truncated due to both lack of resources and a poor job of emphasis on these programs by key managers at the Veterans Health Administration at the local health care delivery level, the Veterans Integrated Services Network (VISN) level, and at the national level.

One example of this diminishment of services is to the Seriously & Chronically Mentally Ill (SCMI) patients, which includes PTSD treatment. The funding for SCMI has dropped dramatically below the funding provided in FY 1996, never mind adjustment for inflation. At least five VISNs have no inpatient or resident treatment for chronic, acute PTSD. Substance

Abuse treatment programs have disappeared or been dramatically cut. Yet VA maintains that they are in compliance with the capacity requirements of the 1996 law. The General Accounting Office (GAO) has determined that the management information systems and documentation of where it spends resources (much less the outcomes for the veteran) are woefully inadequate or non-existent. VVA believes that even without adequate systems it is clear that VA is not in compliance with the 1996 law, and needs to move to restore needed capacity, particularly in the specialized services.

Therefore, VVA recommends that an average of $1 Billion per year be dedicated to restoration of vitally capacity in VHA. This would probably be $600 million the first year, $ 1 Billion the second year, and $1.4 Billion the third year that would become part of VHA "baseline" funding. The overwhelming majority of these funds (i.e., 75% to 90%) should go to the specialized services, with the balance going in to staffing needs in acute care areas such as hepatitis c.

It is our belief at this point that centralized control of funding is required in the "specialized services" and some other key areas. The VA has been trusting the decentralized process of allocating all control of funds to the Directors of the Veterans Integrated Services Networks (VISNs) for the past five years has resulted in dramatic reductions in specialized services, including prosthetics. After the flood of complaints of denial of service from veterans who needed prosthetics to Congress, and the resulting seeming inability of VHA central management to win cooperation of the VISN Directors, it was determined that the only way to ensure that veterans could get proper prosthetics services, no matter where they lived in the United States, was to centralize the funding. That effort has proven to be a success.

VVA believes that the same centralized control of funding, along with adequate control being centralized, is necessary for all specialized services and other key areas, such as outreach, testing, and treatment of hepatitis C. This requirement for centralized control can be removed once the VHA has actually developed a sensible and workable computerized management information system, and has proven that there is a working system for holding VISN directors and other managers truly accountable for results and performance of the right measures.

The fact is that while VHA has done a great deal to address hepatitis c, there still has not been the kind of outreach, testing, treatment, and case management program needed in the face of the apparent magnitude of this problem. Nor has there generally been proper moves to acquire new staff at the medical center level needed to deal with the large number of veterans (more than 70,000) who have tested positive for the hepatitis c virus, even with only sporadic testing and virtually no outreach. Congress appropriated $350 million to deal with this problem, but VHA cannot account for where these funds went. The same could be said about any of the specialized services.

The bottom line is that VVA recommends at least $ 2.3 Billion be appropriated to VHA over the FY 2001 level, with special tight controls over at least $ 600 million of these funds to ensure that these funds are utilized as intended by the Congress (i.e., restoration of vitally needed organizational capacity, mostly in specialized services).

In regard to the Veterans Benefits Administration (VBA) we recommend at least $80 million increase, with the proviso that increased attention be paid to the hiring and proper training of new adjudicators, ensuring that these new personnel are attuned to knowledgeably, accurately, and equitably adjudicate veterans claims in a timely manner, with presumption in favor of approving a substantiated claim. To bring in new personnel and training them in a mind set of looking for reasons to deny a claim, as opposed to working to assist the veteran by identifying evidence to support the claim, is not acceptable, as we believe is occurring in some stations.

Furthermore, the VBA needs to take significant meaningful steps toward holding their staff, but particularly the supervisors and managers, a great deal more accountable for the accuracy and quality of their work. As of now, the predominant measurement emphasis is on volume of processed veteran claims, irrespective of how well or accurately the decision on that claim is determined. Because veterans know this, the number of appeals and remands by the Court of Veterans Appeals and the Board of Veterans Appeals back to the Regional Office of the Veterans Benefits is very high.

The reason why the number of appeals is so high is that individual veterans have lost any confidence in the system, and therefore appeal everything. The number of remands and Regional Office decisions eventually overturned would indicate that the veterans are correct to have little faith in the fairness and accuracy of decisions in many Regional Offices. Moreover, the high remand rate on appeal is directly responsible for increasing the pending claims backlog at the Regional Offices. Returned claims are afforded expedited consideration, pushing new claims that have been languishing in piles even further down the docket.

If we are ever going to eliminate the unacceptable backlog of claims, then the focus has to be on doing it right the first time. A few years ago the Ford Motor Company almost went out of business because the emphasis on the production line was solely on speed and volume, and not on quality. Once Ford changed the corporate culture to one of focusing on getting it right the first time, production costs went down, and the Ford Motor Company survived and earned the trust of the American people as a quality project.

The same sort or improvement in performance and results can also happen at the VA if the Congress moves to assist Secretary Principi in this task. While at least $80 million more is required for VBA, VVA is equally concerned about performance and results. Vietnam Veterans

of America (VVA) is very concerned about effective use the money that is being spent toward accomplishing the objectives set by the Congress and the Secretary.

The National Cemetery Administration needs a significant increase to keep pace with inflation, or at least $10 to $12 million. The Office of the Inspector General appropriation should be significantly increased, at the same time that the Congress assist them in refocusing the way they carry out their mission. Too much time is being spent on recurring reviews that result in few changes or improvements of services to veterans.

Mr. Chairman, Vietnam Veterans of America (VVA) urges you and your distinguished colleagues to push hard for a significant increase to the inadequate request for the FY 2002 VA appropriation from the Administration. VVA also urges that you push hard for some of the safeguards to ensure accountability for actual performance and results in all areas of the VA, including greater accountability placed on key managers.

Vietnam Veterans of America (VVA) strenuously objects to the proposal to transfer $235 million from the Veterans Health Administration (VHA) to the Department of Defense (DoD) to help pay for the recently expanded Tri Care benefits. This is an outrageous suggestion, and we urge the Congress to reject it out of hand. The Defense side of the budget has plenty of room under the cap to pay for these benefits that retirees have earned by virtue of longevity retirement. General Motors does not ask Medicare to pay part of the retiree benefits paid to their workers who retirees, nor should a resource rich DoD ask an under funded VA to pay their bills.

VVA also strongly urges you and the Committee to move forward with a series of oversight hearings this year focusing on what VA said they were going to do with both the money appropriated for FY 1999 and FY 2000. Since the Congress gave them significantly more funds than VA said they needed to accomplish the goals set forth in their submittal, the central theme question should be on what are the results and actual performance.

Mr. Chairman, Vietnam Veterans of America thanks you for this opportunity to share our views on the budget for FY 2002 for the Veterans Administration. We stand ready to actively support you and your colleagues on this committee in every way we can to achieve proper funding for vitally needed services and treatment of veterans, and to ensure that those funds are spent most effectively as possible.

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RICHARD WEIDMAN

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Mr. Weidman was part of the staff of VVA from 1979 to 1987, serving variously as Membership Services Director, Agency Liaison, and Director of Government Relations. He left VVA to serve in the Administration of Governor Mario M. Cuomo (NY) as Director of Veterans Employment & Training for the New York State Department of Labor.

He has served as Consultant on Legislative Affairs to the National Coalition for Homeless Veterans, and served at various times on the VA Readjustment Advisory Committee, the Secretary of Labor's Advisory Committee on Veterans Employment & Training, the President's Committee on Employment of Persons with Disabilities, Advisory Committee on Veterans' Entrepreneurship at the Small Business Administration, and numerous other advocacy posts in veterans affairs.

Mr. Weidman was an instructor and administrator at Johnson State College (Vermont) in 1970s, where he was also active in community and veterans affairs. He attended Colgate University, B.A., (1967), and did graduate study at the University of Vermont.

He is married and has four children.

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VIETNAM VETERANS OF AMERICA
Funding Statement
March 6, 2001

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:
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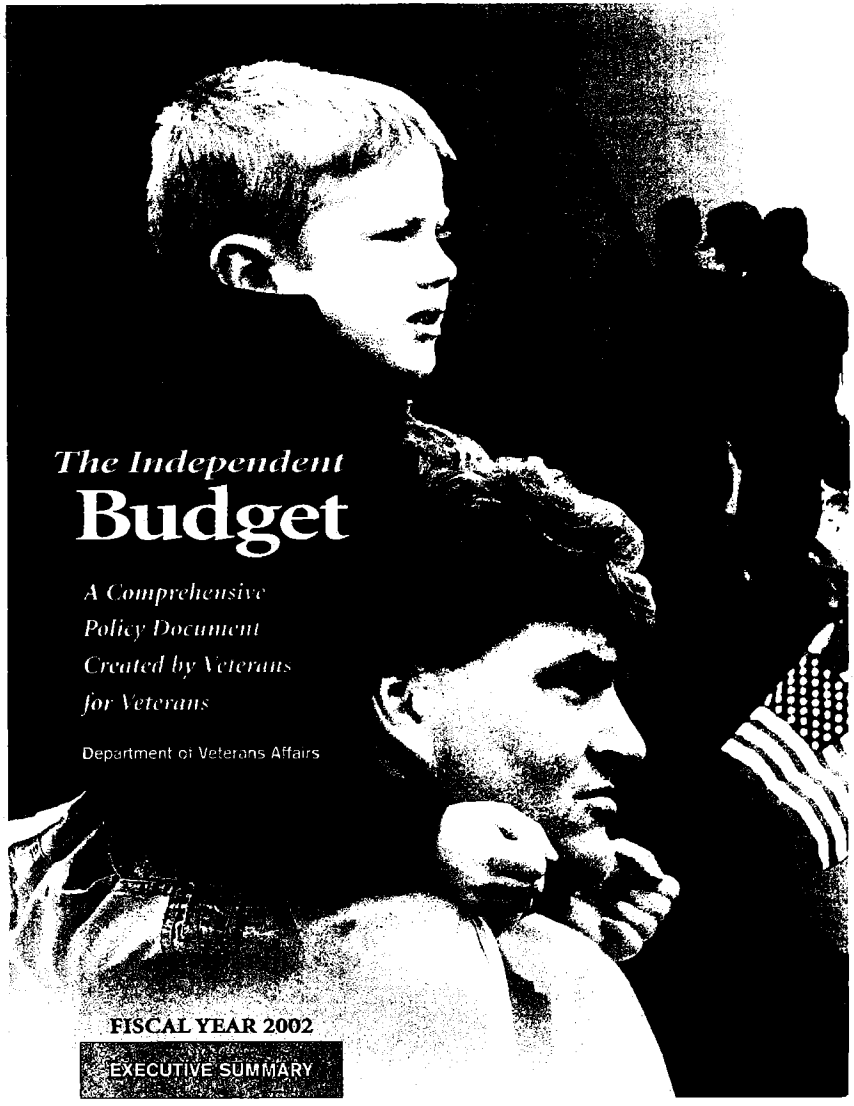
The Independent
Budget
A Comprehensive Policy Document Created by Veterans for Veterans
Department of Veterans Affairs
FISCAL YEAR 2002
EXECUTIVE SUMMARY

Prologue

The Independent Budget (IB) for FY 2002 is the fifteenth annual budget for the Department of Veterans Affairs (VA) developed by a coalition of four congressionally chartered veterans service organizations: AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars (the IBVSOs). *The Independent Budget*, developed by veterans, for veterans, should serve as a guide to the Congress and the new Administration as they develop VA budget and appropriations policy for FY 2002. This *Independent Budget* is intended to transmit our recommendations for this budget cycle and our long-range vision for the Department of Veterans Affairs.

Over the past two budget cycles, Congress and the administration have worked to find budget increases necessary to help VA programs, particularly medical care programs, begin the process of recovering from three years of virtual straight-line funding. We greatly appreciate those efforts. But more must be done to adapt to the rising costs of health care, meet the increasing needs of an aging veteran population, enhance and facilitate benefits delivery, and maintain the continuity of funding for VA programs as a whole.

The Independent Budget's funding recommendations are based on a systematic methodology that takes into account the size and age-structure of the veteran population, federal employee wage increases, medical care inflation, cost-of-living adjustments, construction needs, trends in health-care utilization, and estimates of the number of veterans to be laid to rest in our nation's cemeteries. We also take into consideration changes in medical and information technologies and their effects on the health-care and benefits delivery systems.

The Independent Budget is the voice of responsible advocacy. Our budget recommendations are rational, rigorous, and sound. We urge you to review these recommendations when considering veterans and their families during the FY 2002 budget process. America owes its freedom to its veterans. We must continue to acknowledge the sacrifices they made and to honor our commitment to them. They answered the call to service long ago; now we must answer back by ensuring them a secure and stable future.

Arthur C. Stahl
National Commander
AMVETS

Armando C. Albarran
National Commander
Disabled American Veterans

Joseph L. Fox, Sr.
National President
Paralyzed Veterans of America

John F. Gwizdak
Commander-in-Chief
Veterans of Foreign Wars
of the United States

FY 2002 INDEPENDENT BUDGET ENDORSERS

Administrators of Internal Medicine

Alliance for Aging Research

American Association of Dental Schools

American Association of Spinal Cord Injury Nurses

American Association of Spinal Cord Injury Psychologists and Social Workers

American College of Foot and Ankle Surgeons

American Ex-Prisoners of War

American Federation of Government Employees, AFL-CIO

American Geriatrics Society

American Gold Star Mothers, Inc.

American Lung Association

American Military Retirees Association

American Optometric Association

American Paraplegia Society

American Physiological Society

American Podiatric Medical Association

American Psychiatric Association

American Society of Nephrology

American Thoracic Society

Association for Assessment & Accreditation of Laboratory Animal Care

Association of American Medical Colleges

Association of Professors of Medicine

Association of Subspecialty Professors

Blinded Veterans Association

Catholic War Veterans of the U.S.A., Inc.

Clerkship Directors in Internal Medicine

Coalition for American Trauma Care

Diabetes Action Research & Education Foundation

Disabled Sports USA

Gerontological Society of America

Jewish War Veterans of the U.S.A.

Legion of Valor of the USA, Inc.

Marine Corps League, Inc.

Medical Device Manufactures Association

National Alliance for the Mentally Ill

National Amputation Foundation, Inc.

National Association of Atomic Veterans

National Association of Veterans Research and Education Foundations

National Coalition for Homeless Veterans

National Hispanic Council on Aging

National Mental Health Association

National Organization for Rare Disorders

National Veterans Affairs Council

New England Shelter for Homeless Veterans

Nurses Organization of Veterans Affairs

Research! America

Reserve Officers Association of the United States

Society for Neuroscience

Veterans Affairs Physicians Assistants Association

Vietnam Era Veterans Association

Vietnam Veterans Institute

Vietnam Veterans of America, Inc.

Guiding Principles

- Veterans must not have to wait for benefits to which they are entitled.
- Veterans must be ensured access to high-quality medical care.
- Veterans must be guaranteed access to the full continuum of health-care services, including long-term care.
- Veterans must be assured burial in state or national cemeteries in every state.
- Specialized care must remain the focus of the Department of Veterans Affairs (VA) medical system.
- VA's mission to support the military medical system in time of war or national emergency is essential to the Nation's security.
- VA's mission to conduct medical and prosthetics research in areas of veterans' special needs is critical to the integrity of the veterans health-care system and to the advancement of American medicine.
- VA's mission to support health professional education is vital to the health of all Americans.

ACKNOWLEDGEMENTS

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Summary of Recommendations

As the new administration takes office and the 107th Congress convenes, decisions must be made among competing demands for federal resources. In this process, it is vital that the national leadership demonstrate their firm, long-term commitment to those who have defended our Nation by ensuring that veterans benefits and services receive necessary support and funding. This support and funding must be consistent, year-in and year-out, not just during election cycles. While funding increases over the past two years have been welcomed, they did not erase years of virtually straight-line funding nor does such episodic budgeting support sound long-term planning.

The Nation must honor the commitment made to those who served in the Armed Forces through the wars, both hot and cold, of the last century. Meeting our commitments to those who served in uniform in prior years is the best way to demonstrate to those now in the military, as well as to those considering military service, that the Nation will honor their sacrifice and service.

Doing right by veterans can be achieved only by providing the Department of Veterans Affairs (VA) with the level of funding needed to carry out its congressionally mandated, comprehensive program of benefits and services through the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), and the National Cemetery Administration (NCA).

The Veterans Benefits Administration provides compensation and pension benefits to 2.3 million veterans and 3.2 million survivors and children annually, as well as an array of other benefits—vocational rehabilitation, housing, education, and insurance—earned by veterans' service. While much of VBA's routine workload is handled effectively and with military efficiency, years of less-than-adequate budgets have reduced the size and experience of its workforce, leading to various problems, most especially to unacceptable delays in the handling of complex claims. There must be an infusion of resources to counter these chronic funding shortfalls and to provide for essential training of current staff to enable VBA to respond in a more timely way to increased workload demands and to ensure better quality in the adjudication process.

The National Cemetery Administration maintains 119 national cemeteries, located in 39 states, the District of Columbia, and Puerto Rico, and administers the joint federal/state cemetery grant program. NCA is charged with responding to the burial demands of the veteran population and with the ongoing maintenance of existing graves, a challenge that has become particularly acute in recent years with the passing of many of the generation of men and women who defended freedom and democracy in World War II. The rate of interments continues to rise and NCA must receive the support needed to respond, with dignity, to the passing of the World War II generation.

The largest direct-services element in VA, and perhaps the part of VA best known to the public, is the Veterans Health Administration. VHA operates the largest health-care system in the United States, with 157 medical centers, 527 ambulatory care and community-based outpatient clinics, 134 nursing homes, 40 domiciliary-care facilities, and 72 comprehensive home-care programs. VHA provides a wide range of medical, surgical, and rehabilitative services, many of which are highly specialized and geared to treating conditions and problems that are particularly prevalent among veterans, such as amputations, spinal cord injury, blindness, brain trauma, and stress-induced psychological problems.

In fiscal year 2000, VA provided care to nearly 3.8 million of the 4.8 million enrolled individuals, the vast majority of whom have service-connected disabilities or qualify on the basis of low income. VA patients are older, sicker, and generally less affluent than the general population. They are more likely to have chronic diseases—such as diabetes, which affects 30% of the veteran population; congestive heart failure; lung disease; hypertension; and psychiatric disorders, which affect as many as 50% of hospitalized VA patients.

Some commentators have suggested that, since the overall veteran population is declining, the demand for VA health-care services should be lessening and that therefore support can be reduced. In fact, the opposite is true. As veterans age, their need for a wide variety of services—such as acute care for conditions that are more prevalent among older individuals, rehabilitative care following a stroke or cardiac event, or an array of long-term care services to help address chronic health-care problems—increases and their need for access to timely, quality service from VA becomes even greater.

Congress recognized the need to address access to long-term care services with the enactment of the Veterans Millennium Health Care and Benefits Act in 1999. While the long-term care provisions of that law make it clear that Congress saw long-term care services as an integral part of VA health care, the law has yet to be fully implemented and, even when it is, its scope must be expanded. Additionally, eligibility reform is not complete until all veterans who enroll for VA care have access to the full array of health-care services offered by VA, including both institutional and noninstitutional long-term care services.

It is vital that care be taken with the resources—both human and physical—of the VA health-care system. As a result of years of budgets that did not even cover inflation, many things have happened to diminish the system's ability to meet its multiple missions. For one thing, failure to address the impact of inflation has led to serious problems with the recruitment and retention of vital health-care professionals, most particularly VA's registered nurse staff. Also, VA has cut back on a variety of specialized, and often costly, services to the detriment of veterans, many with serious service-connected disabilities. VA must restore specialized services such as mental health treatment—especially various inpatient programs, blind rehabilitation, and treatment for spinal cord dysfunction as a first order of business.

New demands on the VA system, such as screening and treatment for hepatitis C, which is significantly more prevalent among veterans than in the general population, and mandated access to emergency care for veterans enrolled with VA, have also not been fully met because of the lack of sufficient funding. Finally, many of the system's physical facilities are at risk because of years of delayed maintenance. While the IBVSOs are not categorically opposed to any mission changes or facility closings, such actions cannot flow from a failure to maintain the physical infrastructure. Neglecting facilities until they are not worth saving is a failure of public policy, wastes needed resources, and fails to ensure that the system is available to meet the needs of veterans eligible for VA care.

The new administration and Congress have the opportunity and the ability to make good on the Nation's historic obligation to those who have served in the Armed Forces.

Recommended Appropriations:
VA Discretionary Programs
Discretionary Budget Authority for FY 2001 and
IB Recommended Appropriation for FY 2002
(Dollars in Thousands)

	FY 2001 Appropriation[1]	FY 2002 IB Recommended Appropriation
Veterans Health Administration		
Medical Care	$20,202,000	$22,869,000[2]
Medical and Prosthetic Research	350,000	395,000
Medical Administration and Miscellaneous Operating Expenses	62,000	74,000
Subtotal, Veterans Health Administration	$20,614,000	$23,338,000
Departmental Administration		
Veterans Benefits Administration (VBA)	$824,000	$910,000
General Administration	256,000	303,000
General Operating Expenses Subtotal (GOE)	$1,080,000	$1,213,000
National Cemetery Administration	109,000	119,000
Office of the Inspector General	46,000	50,000
Subtotal, Departmental Administration and Miscellaneous Programs	$1,235,000	$1,382,000
Other Veterans Benefit and Credit Reform Programs	$163,000	$171,000
Construction Programs		
Construction, Major Projects	$66,000	$374,000
Construction, Minor Projects	166,000	431,000
Parking Revolving Fund	6,000	6,000
Grants for Construction of State Extended Care Facilities	100,000	100,000
Grants for Construction of State Veterans Cemeteries	25,000	30,000
Subtotal, Construction Programs	$363,000	$941,000
Total, Discretionary Programs	**$22,375,000**	**$25,832,000**

[1] FY 2001 appropriation reflects a 0.22% recision ($80 million).
[2] The IB recommended appropriation for Medical Care is not offset by Medical Cost Collection Fund (MCCF) targets.

Key Independent Budget *Recommendations*

1. **Veterans do not have timely access to health-care services mandated by Congress.**

Many veterans wait weeks and months for diagnosis and treatment of serious health problems. A shortage of nurses has critically affected the ability of the Veterans Health Administration to provide inpatient, outpatient, and long-term care. The long-term care provisions of PL 106-117, The Veterans Millennium Health Care and Benefits Act, have yet to be fully implemented. There is continuing erosion of VHA's specialized services for veterans affected by blindness, serious mental illness, and other severely disabling conditions. Hepatitis C is prevalent in the veteran population and VHA must respond. Emergency care, an essential component of a comprehensive array of health-care services mandated by the Millennium Act, will present VHA with new expenses.

The ***Independent Budget*** for FY 2002 recommends an appropriation of $22.869 billion for medical care.

2. **Veterans and their insurers are constantly frustrated by inaccurate and inappropriate billing for health-care services.**

Veterans are being billed for treatment of service-connected conditions, double-billed for outpatient visits to multiple clinics, and back-billed for charges refused by insurance companies for inaccurate and incomplete documentation. While inadequate information and billing systems aggravate these problems, the root cause is the ill-conceived policy that prospectively reduces medical care appropriations based on the false assumption that budget shortfalls will be offset by collections.

The ***Independent Budget*** for FY 2002 again insists that any funds collected from veterans who are able to pay for treatment of nonservice-connected conditions should be used to improve quality and access by supplementing, not substituting for, adequate appropriations.

The ***Independent Budget*** for FY 2002 recommends funding of approximately $5 million to improve VHA billing systems.

3. **The Veterans Benefits Administration must do a better job of processing veterans' applications for compensation for service-connected disabilities.**

VA must have additional personnel to make up for unwarranted past reductions in claims adjudicators, to meet increased workload demands, to provide essential training, to ensure quality, and to achieve and maintain satisfactory timeliness in claims processing.

The ***Independent Budget*** for FY 2002 recommends an additional $60 million over current services to fund the addition of 830 FTEE for the Compensation and Pension Service.

4. **VA must not "realign" by default through neglect.**

The virtual elimination of VA's construction budget suggests a program of systematic dismantlement by neglect. Most VA hospitals need renovations; many are in critical need of repair. The scarcity of construction money has left network directors to patch together minor construction funds to meet pressing demands for modern clinical facilities. The Facilities Management staff in VA Headquarters has been decimated and can no longer provide effective oversight. Capital assets realignment will create new and immediate need for construction funds.

Funding for major and minor construction dropped precipitously in the 1990s. Funding for maintenance, renovation, and construction must be increased to keep VA facilities in first-rate condition. ***The Independent Budget*** for FY 2002 recommends $374 million for major construction, $431 million for minor construction, $100 million for construction of state extended care facilities, and $25 million for construction of state veterans cemeteries. ***The IB*** also calls for additional FTEE in the Office of Facilities Management.

5. **Medical, rehabilitation, and health services research programs were critically underfunded in the FY 2001 budget.**

VHA needs to make significant increases in this investment in the future to regain lost ground and continue to add to VHA's record of contribution to medical science and the quality of health care in America. Like the National Institutes of Health, VA research should be part of a national priority to develop tomorrow's health care.

The Independent Budget for FY 2002 recommends $395 million for medical, rehabilitation, and health services research.

6. **The National Cemetery Administration (NCA) is challenged to provide for the passing of the generation of men and women who defended freedom and democracy in World War II.**

In recent years, the NCA has struggled to maintain its 119 national cemeteries located in 39 states, the District of Colombia, and Puerto Rico. With the number of veterans' deaths expected to peak at over 600,000 per year in 2008, the rate of interments at national cemeteries will increase significantly in the next decade.

The Independent Budget for FY 2002 recommends funding of $119 million for the National Cemetery Administration.

7. **Congress and the Administration must oppose any proposal for vouchering and privatization of veterans health care.**

The *Independent Budget* was deeply troubled by legislation put forth in the 106th Congress that would have created a pilot program to shift medical services and veteran patients from VA to the private sector. The care afforded these veterans would have been paid for by the veterans' own private or public insurance with VA acting only as a secondary payer. We believe this vouchering scheme would not only signal VA's retreat from direct delivery of health-care services, but would allow disparate treatment of veterans depending on whether or not they have insurance. It would erode VHA's patient and resource base, undermining VHA's ability to maintain its specialized services programs, and endanger the well-being of veteran patients.

Congress and the Administration should oppose in principle any legislative proposal that would shift VA's responsibility to provide quality health care to veterans through vouchering or privatization.

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Recommendations to Congress

BENEFIT PROGRAMS

COMPENSATION AND PENSIONS

Compensation

Enact a COLA for all compensation benefits sufficient to offset the rise in the cost of living.

Enact legislation to repeal the inequitable requirement that veterans' military retired pay based on longevity be offset by an amount equal to their VA disability compensation.

Enact legislation to remove the requirement that military nondisability separation, severance, or readjustment pay be offset against VA disability compensation.

Categorically reject any proposal to means test compensation or DIC, or proposals even to study the prospects of means testing these benefits.

Reject any recommendation that it change the law to permit VA to discharge its future obligation to compensate service-connected disabilities through payment of lump-sum settlements to veterans.

Amend the law to provide for an exception to the 3-year limitation on amendment of tax returns in the case of erroneous taxation of disability severance pay or in the case of retroactive exemption of more than 3 years and should change the law to discontinue the withholding of taxes from disability severance pay.

Enact legislation to include the following diseases in the statutory presumption for service connection of radiation-related disabilities: lung cancer, bone cancer, skin cancer, colon cancer, posterior subcapsular cataracts, nonmalignant thyroid nodular disease, ovarian cancer, parathyroid adenoma, tumors of the brain and central nervous system, and rectal cancer.

Enact a statutory presumption of exposure to dioxin for any Vietnam veteran claiming such exposure.

Establish a presumption of service connection for amyotrophic lateral sclerosis affecting Persian Gulf War veterans.

Repeal its prohibition on service connection for smoking-related disabilities.

Enact a presumption of service connection for combat veterans and veterans that had military duties typically involving high levels of noise exposure who suffer from tinnitus or hearing loss of a type typically related to noise exposure or acoustic trauma, to apply when the record does not affirmatively prove such condition or conditions are unrelated to service.

Amend the law to authorize increased compensation on the basis of a temporary total rating for hospitalization or convalescence to be effective, for payment purposes, on the date of admission to the hospital or the date of treatment, surgery, or other circumstances necessitating convalescence.

Reject suggestions that it direct economic validation studies to intrude on the discretion exercised by the Secretary of Veterans Affairs in adopting or revising the *Schedule for Rating Disabilities*.

Burial Benefits

Amend 38 U.S.C. § 2306 to reinstate former subsection (d) which provided for reimbursement of the cost of acquiring a headstone or marker privately, in lieu of furnishing a Government headstone or marker.

Adjust the burial allowances to reflect the increases in burial costs since the allowances were adjusted many years ago.

Miscellaneous Assistance

Amend the Equal Access to Justice Act to permit payment of EAJA fees to unsupervised nonattorneys who represent appellants before the Court of Appeals for Veterans Claims.

READJUSTMENT BENEFITS

Montgomery GI Bill

Change the law to permit refund of an individual's MGIB contributions when his or her discharge was characterized as "general" or "under honorable conditions" because of minor infractions or inefficiency.

Vocational Rehabilitation

Extend the authority for unpaid work experience to private sector and not-for-profit sector employers who are willing to develop such unpaid work experience opportunities consistent with the veteran's training program.

Housing Grants

Increase the specially adapted housing grants and provide for future automatic annual adjustments indexed to the rise in the cost of living.

Establish a grant to cover the costs of home adaptations for veterans who replace their specially adapted homes with new housing.

Automobile Grants and Adaptive Equipment

Increase the automobile allowance to 80% of the average cost of a new automobile and provide for automatic annual adjustments in the future.

Home Loans

To keep pace with the rising costs of housing and to make VA-guaranteed home loans available for average-priced homes in high-cost areas, enact legislation to raise the maximum home loan guaranty amount to $63,175.

Insurance

Enact legislation to exempt the cash value of, and dividends and proceeds from, VA life insurance policies from consideration in determining entitlement under other Federal programs.

Service-Disabled Veterans Insurance (SDVI)

Enact legislation to authorize VA to revise its premium schedule for Service-Disabled Veterans Insurance to reflect current mortality tables.

OTHER SUGGESTED BENEFIT IMPROVEMENTS

Accrued Benefits

Enact legislation to remove the 2-year limitation on payment of accrued benefits.

Mentally Incompetent Veterans' Estates

Repeal 38 U.S.C. § 5503(b) to remove the discriminatory estate limit imposed on incompetent veterans.

GENERAL OPERATING EXPENSES

General Operating Expenses
Recommended Budget Appropriation
(Dollars in Thousands)

FY 2002 IB Recommendation by Type of Service	
Personnel Compensation	$819,458
Travel and Transportation of Persons	16,960
Transportation of Things	2,120
Rental Payments to GSA	80,817
Rental Payments to others	6,138
Communications, Utilities, and Misc. Charges	49,820
Printing and Reproduction	3,069
Other Services	143,220
Supplies and Materials	41,450
Equipment	49,667
IB Recommended FY 2002 Appropriation	$1,212,719

VETERANS BENEFITS ADMINISTRATION

Compensation and Pension Service

Include sufficient funding in VA's appropriations to increase FTE in Compensation and Pension Service by 830.

GENERAL ADMINISTRATION

Board of Veterans' Appeals

Unless VA acts in a timely fashion to amend 38 C.F.R. § 19.5 to remove its unlawful provision exempting BVA from VA manuals, circulars, and other Department directives, intervene to ensure this counter-productive problem is corrected.

JUDICIAL REVIEW OF VETERANS MATTERS

COURT OF APPEALS FOR VETERANS CLAIMS

Amend section 7261 of title 38, United States Code, to provide that the Court will hold unlawful and set aside any finding of material fact which is not reasonably supported by a preponderance of the evidence.

COURT OF APPEALS FOR THE FEDERAL CIRCUIT

Amend 38 U.S.C. § 502 to authorize the Court of Appeals for the Federal Circuit to review and set aside changes to the Schedule for Rating Disabilities found to be arbitrary and capricious or clearly in violation of statutory provisions.

Amend 38 U.S.C. § 7292 to give the Court of Appeals for the Federal Circuit jurisdiction to review decisions of the Court of Appeals for Veterans Claims on questions of law.

MEDICAL PROGRAMS

MEDICAL CARE

Medical Care Recommended Budget Appropriation

(Dollars in Thousands)

FY 2002 IB Recommendation by Type of Service	
Personnel Compensation	$12,471,830
Travel and Transportation of Persons	263,337
Transportation of Things	28,978
Rental Payments to GSA	22,840
Rental Payments to Others	77,265
Communications, Utilities, and Misc. Charges	637,635
Printing and Reproduction	11,549
Other Contractual Services (Includes Emergency Services)	2,211,524
VA Sponsored Medical Care	
Outpatient Dental Fees	20,968
Medical and Nursing Fees	418,743
Community Nursing Homes	381,578
Contract Hospitalization	187,676
Civilian Health and Medical Program of the VA	112,613
Supplies and Materials (Includes Pharmacy and Prosthetics)	4,480,191
Equipment	708,098
Land Structures	391,307
Grants, Subsidies and Contributions	440,404
Interest and Dividends	2,247
IB Recommended FY 2002 Appropriation	$22,868,782

Explanation of Increases for VHA
IB FY 2002 Recommended Increase over FY 2001 Appropriations
(Dollars in Thousands)

Total Increase	$2,667,000
Uncontrollables (inflation, salaries)	$1,296,000
Millennium Care Initiatives Total	$848,000
Institutional Care	$270,000
Assisted Living	$8,000
Noninstitutional Care	$570,000
Other Initiatives	$523,000
Mental Health Care	$100,000
New Patient Pharmacy	$65,000
Information Technology	$15,000
GRECC	$10,000
Rehabilitation Centers	$12,000
Restoring SCI/D Capacity	$25,000
Birth Defects	$2,000
Outpatient Clinic Activities	$20,000
Homeless Reintegration	$75,000
Filipino Veteran Health Care	$30,000
Non-Recurring Maintenance Initiative	$78,000
LTDC Capacity	$91,000

Financing Issues

With the Administration, base the VA medical care budget on the principle that third-party collections are to supplement, not substitute for, appropriations.

With the Administration, provide appropriations to fully cover the costs of the full range of medical care, including emergency services, for all enrolled veterans.

With the Administration, oppose in principle any legislative proposal that would shift VA's responsibility to provide quality health care to veterans through vouchering or privatization.

Require VA to recommend that clinicians not bill veterans for any secondary symptoms or conditions that relate to an original service-connected disability rating.

Require VHA to report collection rates for services provided to employees and other nonveterans to ensure that the costs of all care provided to anyone other than enrolled veterans are fully covered by collections.

Access and Quality Issues

Require VHA to report its reduction in waiting times and appointment delays regularly.

With VA, direct resources to find long-term solutions to solving the problem of the nurse shortage.

With the Administration, fund the Community-Based Outpatient Clinic initiative at $20 million.

Eligibility Reform Issues

Provide $848 million in new appropriations to cover the costs of institutional and noninstitutional long-term care mandated by Public Law 106-117.

Provide an additional $85 million for respite, homemaker, and state home grants not covered in the Veterans Millennium Health Care and Benefits Act initiative.

Monitor VHA to ensure the maintenance of capacity of its in-house extended care staffing and services and to ensure the operation of an extended care program for veterans, as required by law.

Appropriate an additional $30 million to expand health-care access for Filipino veterans.

Specialized Services Issues

Prosthetics and Sensory Aids

Ensure that appropriations are sufficient to meet prosthetics needs so that funding shortfalls in prosthetics will not compromise other programs.

Not approve any initiative that would cause the funding for the clothing allowance or automotive adaptive equipment programs to be displaced from mandatory spending accounts to those that are discretionary.

Serious Mental Illness, Posttraumatic Stress Disorder, and Addictive Disorders

Incrementally augment funding for seriously mentally ill veterans by $100 million each year from FY 2002 through FY 2004.

Require an annual report by VISNs to document the specialized mental health program capacity in place, the extent of resources committed, programmatic changes, the number of veterans served, and follow-up of veterans lost to care.

Spinal Cord Injury Medicine

Appropriate $25 million in new funding to begin restoration of the SCI program.

Gulf War Illness

Continue prudent and vigilant oversight to ensure that both VA and NAS adhere to the time limits imposed upon them so that they effectively and efficiently address the continuing health-care needs of Gulf War veterans.

Reject the recommendation by the Commission on Servicemembers and Veterans Transition Assistance to declare February 28, 1993, as the ending date of the Persian Gulf War. Hostilities in the Persian Gulf theater continue to place U.S. forces at considerable risk.

Fund intensified medical and scientific research on amyotrophic lateral sclerosis (ALS, commonly referred to as Lou Gehrig's disease). Studies indicate that this fatal disease is occurring among Gulf War veterans at an abnormal rate.

Homeless Veterans

Require VA to measure, report, and implement system-wide services to homeless veterans to develop a formal nationwide expedited claims process for homeless veterans.

Direct the secretary of Housing and Urban Development to take all necessary steps to ensure that homeless veterans are considered in the process for resource allocations in every state and in all 900 areas for distributions of HUD housing funds, as full partners in the process.

Appropriate $75 million to implement the Heather French Homeless Veterans Assistance Act of 2000.

Long-Term Care Issues

Pass permanent legislation to allow VA to finance assisted living.

Provide, and direct VHA to spend, $8 million for the implementation of assisted living initiatives. Of this, $6 million should fund the pilots mandated under Public Law 106-117 and $2 million should fund modification of existing buildings and domiciliary programs.

Allocate funding for four additional geriatric research, education, and clinical centers (GRECCs).

Finance the VA Special Fellowship Program in Geriatrics at an appropriate level.

Pass legislation requiring VA to report to Congress on the outcomes and effectiveness of internal and external review processes, as well as on patient satisfaction with these processes.

VA MEDICAL AND PROSTHETIC RESEARCH

Medical and Prosthetic Research Recommended Budget Appropriation
(Dollars in Thousands)

FY 2002 IB Recommendation by Type of Service	
Personnel Compensation	$161,581
Employee Travel	2,162
Communications, Utilities, and Misc. Charges	1,081
Printing and Reproduction	2,087
Research and Development Contracts	164,734
Supplies and Materials	42,228
Equipment	21,530
IB Recommended FY 2002 Appropriation	$395,403

Appropriate an additional $50 million in the minor construction account specifically for upgrading VA's research laboratories.

Pass legislation to enable the National Institutes of Health (NIH) to reimburse VHA for 15 percent of the indirect costs of NIH-sponsored VA research.

Recognize and support the Quality Enhancement Research Initiative (QUERI) and the progress made in its translation efforts.

MEDICAL ADMINISTRATION AND MISCELLANEOUS OPERATING EXPENSES (MAMOE)

MAMOE Recommended Budget Appropriation
(Dollars in Thousands)

FY 2002 IB Recommendation by Type of Service	
Personnel Compensation	$60,263
Travel and Transportation of Persons	1,107
Rental Payments to GSA	5,343
Communications, Utilities, and Misc. Charges	1,272
Other Services	3,286
Supplies and Materials	1,136
Equipment	1,149
IB Recommended FY 2002 Appropriation	$73,555

With the Administration, provide adequate funding to the MAMOE account to support VHA national headquarters' role of quality management, policy guidance, and information collection, analysis, and dissemination.

With the Administration, provide VHA headquarters with adequate funds to implement state-of-the-art information technology initiatives.

CONSTRUCTION PROGRAMS

Construction, Major Projects
Recommended Appropriation
(Dollars in Thousands)

FY 2002 IB Recommendation by Type of Service	
Medical Program (VHA)	
Seismic Improvements	$250,000
Clinical Improvements	5,000
Patient Environment	5,000
Advance Planning Fund	57,000
Asbestos Abatement	6,000
National Cemetery Administration	50,000
Claims Analyses	600
IB Recommended FY 2002 Appropriation	$373,600

Appropriate $374 million to the Major Construction account for FY 2002; allocate $250 million of this to correct seismic deficiencies.

Construction, Minor Projects
Recommended Appropriation
(Dollars in Thousands)

FY 2002 IB Recommendation by Type of Service	
Medical Program (VHA)	
Inpatient Care and Support	$128,000
Outpatient Care and Support	51,000
Infrastructure and Physical Plant	101,000
Research Infrastructure Upgrade	50,000
Historic Preservation Grant Program	20,000
Other	40,000
VBA Regional Office Program	2,500
National Cemetery Program	35,000
Staff Offices Program	2,600
Emergency Fund	400
IB Recommended FY 2002 Appropriation	$430,500

Appropriate $431 million to the Minor Construction account for FY 2002.

Provide sustained support for Major and Minor Construction so that planning and design for future projects can continue without interruption.

Increase the definition of Minor Construction to include projects costing up to $16 million.

Of the $374 million recommended for Major Construction in FY 2002, make half of the amount available to be directed by the secretary in accordance with decisions of the Capital Investment Board.

Require VA to document the process and rationale for Capital Investment Board decisions and use that documentation as a basis for Congress's decisions on spending the remainder of the Major Construction funds.

Impose a moratorium on real property divestitures until the results of the Capital Assets Realignment for Enhanced Services (CARES) process are considered.

Provide a $20 million grant program in FY 2002 to preserve and maintain VA's historic properties as assets and not liabilities. Of that sum, $2 million should be available for the identification, testing, and evaluation of potential efforts at VA facilities for the involvement of private entities in the redevelopment and management of historic properties.

VOCATIONAL REHABILITATION AND EMPLOYMENT

Make all disabled veterans eligible on a priority basis for all federally funded employment and training programs.

Amend section 1142(a) of title 10, United States Code, to authorize an extended time frame for providing individual transition services. Services should be offered as soon as 1 year before the anticipated date of separation or 2 years before the anticipated date of retirement, but not less than 90 days before the anticipated date of separation or retirement. In the event that notification of separation or retirement occurs less than 90 days before the end of active duty, transition services should begin as soon as possible following notification.

Amend section 7722 of title 38, United States Code, to mandate that the secretary of Veterans Affairs provide outreach services to members of the Armed Forces as a part of VA's transition program.

Consider various legislative changes to the Montgomery GI Bill to:

- Permit Montgomery GI Bill use for credentialing expenses.
- Reduce the penalty for use of the Montgomery GI Bill for tuition assistance during active duty.
- Reopen a window of opportunity to servicemembers who opted out of eligibility earlier in their tour of duty.
- Lift the 10-year deadline for use of the Montgomery GI Bill benefits.

Fund the Disabled Veterans Outreach Program (DVOP) and Local Veterans Employment Representative (LVER) programs at the statutorily mandated levels and ensure that sufficient staff is available to provide adequate services to veterans. Short of this goal, at a minimum, sufficient funding should be provided to the DVOP and LVER programs to ensure that they are still national programs, and that a DVOP or LVER position is assigned to each major office from which services are provided to the public. Enable the Veterans Employment and Training Service (VETS) to use the savings from lag time in hiring staff to support licenses and credential efforts on behalf of servicemembers and to provide performance awards or incentives to states in support of increased performance on behalf of special disabled, disabled veterans, and other eligible persons.

Fund the National Veterans Training Institute at an adequate level to ensure training is continued to state and federal personnel who provide direct employment and training services to veterans and servicemembers in an ever-changing environment.

The House or Senate Veterans' Affairs Committees should begin the process of reevaluation and reconfiguration of the delivery of employment and training services to veterans.

Enact legislation requiring the president to establish an independent organization, the Veterans Employment Network, for the purposes of:

- Raising employer awareness of the advantages of hiring separating servicemembers and recently separated veterans.
- Facilitating the employment of separating servicemembers and veterans through America's Career Kit, the national electronic labor exchange.
- Directing and coordinating departmental, state, and local marketing initiatives.

The Veterans Employment Network should include a board of directors consisting of high-level individuals representing constituencies integral to ensuring successful employment of servicemembers and veterans, including, but not be limited to, military services and joint chiefs of staff, major national corporations, national business associations, national labor and trade unions, state public labor exchange administrators, and veteran/military advocates.

Study the feasibility and practicality of alternative means of delivering employment services for veterans such as a competitive bidding process.

NATIONAL CEMETERY ADMINISTRATION

National Cemetery Administration
Recommended Budget Appropriation
(Dollars in Thousands)

FY 2002 IB Recommendation by Type of Service	
Personnel Compensation	$75,939
Travel and Transportation of Persons	1,084
Rental Payments to GSA	1,047
Communications, Utilities, and Misc. Charges	6,273
Other Services	12,558
Supplies and Materials	13,066
Equipment	9,526
IB Recommended FY 2002 Appropriation	$119,493

Fund the National Cemetery Administration operating account at $119 million for fiscal year 2002.

Fund the state cemetery grants program at a level of $30 million and encourage greater state participation in the program.

Increase the plot allowance from $150 to $600 and expand the eligibility for the plot allowance for all veterans who would be eligible for burial in a national cemetery and not just those who served during wartime.

Make funds available to ensure the proper planning and fast-track construction of needed national cemeteries.

Recommendations to the Administration

MEDICAL PROGRAMS

MEDICAL CARE

Financing Issues

With Congress, base the VA medical care budget on the principle that third-party collections are to supplement, not substitute for, appropriations.

With Congress, provide appropriations to fully cover the costs of the full range of medical care, including emergency services, for all enrolled veterans.

With Congress, oppose in principle any legislative proposal that would shift VA's responsibility to provide quality health care to veterans through vouchering or privatization.

Access and Quality Issues

With Congress, fund the community-based outpatient clinic initiative at $20 million.

Eligibility Reform Issues

Move the emergency care regulations and long-term care regulations, along with all regulations for the implementation of the Veterans Millennium Health Care and Benefits Act, for immediate public comment, revision, and speedy implementation.

Specialized Services Issues

Prosthetics and Sensory Aids

Not approve any initiative that would cause the funding for the clothing allowance or automotive adaptive equipment programs to be displaced from mandatory spending accounts to those that are discretionary.

MEDICAL ADMINISTRATION AND MISCELLANEOUS OPERATING EXPENSES (MAMOE)

With Congress, provide adequate funding to the MAMOE account to support VHA national headquarters' role of quality management, policy guidance, and information collection, analysis, and dissemination.

With Congress, provide VHA headquarters with adequate funds to implement state-of-the-art information technology initiatives.

Recommendations to the Department of Veterans Affairs

BENEFIT PROGRAMS

COMPENSATION AND PENSIONS

Compensation

Amend its *Schedule for Rating Disabilities* to provide a minimum 10% disability evaluation for any hearing loss for which a hearing aid is medically indicated.

Pensions

Conduct a study to determine if the removal of the presumption of permanent and total disability for pension purposes at age 65 results in savings or whether costs of VA examinations and record development outweigh potential savings.

GENERAL OPERATING EXPENSES

VETERANS BENEFITS ADMINISTRATION

VBA Management

To make the management structure in the Veterans Benefits Administration more effective for purposes of enforcing program standards and accountability for quality, VA's Under Secretary for Benefits should give VBA's program directors line authority over VA field office directors.

GENERAL ADMINISTRATION

Board of Veterans' Appeals

Amend 38 C.F.R. § 19.5 to remove its unlawful provision exempting BVA from VA manuals, circulars, and other Department directives.

MEDICAL PROGRAMS

MEDICAL CARE

Financing Issues

Through VHA, ensure that veterans are given preference over nonveterans in all treatment settings.

Report collection rates for services provided to employees and other nonveterans to ensure that the costs of all care provided to anyone other than enrolled veterans are fully covered by collections.

Access and Quality Issues

Direct VHA administrators to reduce waiting times and eliminate other barriers to access to services.

Direct VHA administrators to ensure that veterans are not forced to go through multiple gatekeepers to receive the services they need.

Direct VHA to report its reduction in waiting times and appointment delays regularly.

With Congress, direct resources to find long-term solutions to solving the problem of the nurse shortage.

Invest in education and training, commit to improving the health-care work environment, and adhere to staffing methodologies that support and promote quality patient care.

Through VHA, continue to improve outreach and access to testing and treatment of hepatitis C.

Through VHA, ensure that CBOCs are staffed by clinically appropriate health providers who can meet the special health-care needs of veterans wherever the specialized services workload justifies specialized resources.

Through VHA, develop clinically specified referral protocols to guide patient management in cases where patients' conditions call for expertise or equipment not available in the clinic.

Specialized Services Issues

Prosthetics and Sensory Aids

Continue to nationally centralize and fence all funding for prosthetics and sensory aids.

Ensure that national prosthetic policies are followed uniformly at all VA stations.

Continue to develop VHA's prosthetics clinical management program to improve the quality and accuracy of VA prosthetics prescriptions.

Prohibit VISN directors from making inappropriate VISN prosthetics representative selections.

Through VHA and its VISN directors, ensure that prosthetics and sensory aids departments are properly supported and fully staffed by appropriately qualified, trained, and classified (GS-14 or GS-15 level) prosthetic directors and teams.

Through VISN directors, ensure that sufficient training funds are reserved for sponsoring prosthetics training conferences and meetings for appropriate managerial, technical, and clinical personnel.

Reestablish VHA's national prosthetics representative training program, with responsibility and accountability assigned to the chief consultant for prosthetics and sensory aids, and allocate sufficient training funds and FTEE to ensure success.

Require all VISNs to adopt consistent operational parameters and authorities for reorganizing prosthetics services.

Allow VHA clinicians to prescribe prosthetic devices and sensory aids on the basis of patient need—not cost. VHA should ensure that its prosthetics and sensory aids policies and procedures, for both clinicians and administrators, are consistent regarding the appropriate provision of care and services. Such policies and procedures should address issues of prescribing, ordering, and purchasing based on patient needs—not cost—considerations.

Continue to exempt prosthetic devices and sensory aids from standardization efforts.

Continue VHA's efforts to review and implement appropriate recommendations defined in Booz-Allen & Hamilton's phase I study of the prosthetics and sensory aids program.

Serious Mental Illness, Posttraumatic Stress Disorder, and Addictive Disorders

Partner with mental health advocacy organizations such as the National Mental Health Association, National Alliance for the Mentally Ill, National Depressive Manic Association, and veterans service organizations to provide support services such as outreach, educational programs, family support services, and self-help resources.

Increase funding for Mental Illness Research Education and Clinical Care (MIRECC) Centers.

Reinvest savings from closing inpatient mental health programs to develop an outpatient continuum of care that includes case management, psychosocial rehabilitation, housing alternatives, and other support services for the severely and chronically mentally ill veteran.

Women Veterans

Through VHA headquarters, require VISNs to report any reduction in services for women veterans.

Require community-based outpatient clinics that serve women veterans to have at least one female clinician on staff.

Ensure that the integrity of the women veteran coordinator program is maintained.

Provide, at all VA medical centers, gender-appropriate treatment and facilities.

Educate women veterans about the availability of counseling and treatment through outreach activities such as public service announcements.

Blind Rehabilitation Services

Restore the bed capacity in the blind rehabilitation centers to the level that existed at the time of the passage of Public Law 104-262.

Rededicate itself to the excellence of programs for blinded veterans.

Require the veterans integrated service networks to restore clinical staff resources in both inpatient and outpatient blind rehabilitation programs.

At VHA Headquarters, undertake aggressive oversight to ensure appropriate staffing levels for blind rehabilitation specialists.

Increase the number of blind rehabilitation outpatient specialist positions.

Expand capacity to provide computer access evaluation and training for blinded veterans by contracting with qualified local providers when and where they can be identified.

Ensure that concurrence is obtained from the director of the Blind Rehabilitation Service (BRS) in VA Headquarters before a local VA facility selects and appoints key BRC management staff. When disputes over such selections cannot be resolved between the BRS director and local management, they must be elevated to the under secretary for health for resolution.

Implement liberal policies governing local prescription and issuance of aids for the blind.

Gulf War Illness

Continue to foster and maintain a close working relationship with NAS in the effort to ascertain what toxin exposures Gulf War veterans received and what illnesses may be associated with such exposure.

With DOD, conduct intensified medical and scientific research on amyotrophic lateral sclerosis (ALS, commonly referred to as Lou Gehrig's disease). Studies indicate that this fatal disease is occurring among Gulf War veterans at an abnormal rate.

Implement the Gulf War veterans advisory committee immediately.

Homeless Veterans

Expand the veteran work-study program sites to include homeless veteran community-based service providers.

Measure, report, and implement system-wide services to homeless veterans to develop a formal nationwide expedited claims process for homeless veterans.

Long-Term Care Issues

Ensure that nursing home stays are long enough to meet veterans' acute and long-term health-care needs and for all the planning and placement of the veteran within the appropriate health-care setting.

Ensure that discharge planning from VA health-care facilities includes community support options appropriate to the veteran's functional capacity to determine if nursing home placement is appropriate.

Ensure that nursing home programs are operated and maintained at least at the 1998 levels.

Aggressively pursue development of assisted living capacity within VA and through private sector partnerships.

Use minor construction funds to convert existing buildings to assisted living facilities.

Use its enhanced-use leasing authority to create assisted living capacity to care for veterans and their spouses.

Modify VHA's Directive 2000-044 to direct assisted living placement, at VA expense, for patients who do not have appropriate home care alternatives and for whom nursing home care is not clinically indicated.

Once provided by Congress, spend $8 million for the implementation of assisted living initiatives. Of this, $6 million should fund the pilots mandated under Public Law 106-117 and $2 million should fund modification of existing buildings and domiciliary programs.

Designate one new geriatric research, education, and clinical center (GRECC) to make aging with a spinal cord injury its primary research mission.

Administrative Issues

Develop internal and external review processes for clinical decisions. The process must include a mechanism for expedited review of urgent care.

Educate veterans about the internal and external review processes for clinical decisions.

Require patient advocates to inform veterans about representatives from veterans service organizations who can serve as their advocates.

Report to Congress on the outcomes and effectiveness of internal and external review processes, as well as on patient satisfaction with these processes.

In VHA facilities, designate a staff person with volunteer staff experience to be responsible for recruiting volunteers, developing volunteer assignments, and maintaining a program that formally recognizes volunteers for their contributions.

Develop volunteer activities in outpatient settings and encourage local volunteers to participate.

Factor VA Volunteer Service (VAVS) volunteer support into planning and activation of each community-based outpatient clinic.

Include VAVS volunteer productivity data in VHA facility productivity measurement systems and facility management performance standards to create incentives for facilities and managers to use VAVS volunteers.

Have VISN directors include a plan of action for the use of volunteer support in any documentation of the approval package for community-based outpatient clinics that is forwarded to the under secretary for health.

VA MEDICAL AND PROSTHETIC RESEARCH

Allocate research infrastructure improvement funds independently of the Veterans Health Care Eligibility Reform Act of 1996 (VERA), targeting priority laboratories where improvements will enhance the leveraging of VA research dollars with the National Institutes of Health (NIH) and academic partners.

Encourage VHA's local research programs to seek reimbursement for at least 15 percent of indirect costs from private organizations that sponsor VA research.

Work with university affiliates to negotiate indirect cost reimbursements from NIH that can then be passed along to support joint VHA-university research.

Continue its commitment to the Quality Enhancement Research Initiative (QUERI) process with support for integrated teams, institutionalization of a culture of rigorous critical thinking, and strong national leadership.

MEDICAL ADMINISTRATION AND MISCELLANEOUS OPERATING EXPENSES (MAMOE)

Have VHA national headquarters maintain hands-on oversight to protect and fulfill congressional mandates to monitor and maintain the capacity of specialized programs.

Have VHA headquarters redouble its efforts to monitor and improve veterans' access to health-care services.

Have VHA headquarters establish one physician assistant advisor FTEE position.

CONSTRUCTION PROGRAMS

Schedule facility improvement projects concurrently with seismic corrections.

Apply Major Construction funds to expeditiously implement VHA realignment and consolidation decisions. Future budgets should include Major Construction funds for these projects.

Provide sufficient resources—a percentage of the estimated cost of each construction project proposed in the annual strategic review of construction needs—to maintain adequate national management and oversight of all major construction within the Office of Facilities.

Increase staff and funds to allow for oversight and assistance to VISNs for administration of these more complex projects.

Direct no less than $391 million for nonrecurring maintenance in FY 2002. Make annual increments in nonrecurring maintenance in the future until 2% of the value of its buildings is budgeted and utilized for nonrecurring maintenance.

Document the process and rationale for Capital Investment Board decisions for use by Congress as a basis for its decisions on spending the remainder of the Major Construction funds.

Make every effort to involve veterans in the Capital Assets Realignment for Enhanced Services (CARES) process.

Reinvest any proceeds resulting from the divestiture of VA properties to enhance veterans services.

VOCATIONAL REHABILITATION AND EMPLOYMENT

Place a higher emphasis within the Veterans Benefits Administration on complementing the Vocational Rehabilitation and Employment Service's agency of original jurisdiction staffing requirements.

Continue efforts in VR&E to improve case management techniques and use state-of-the-art information technology.

Expedite VRE's rewrite of its operational policies and procedure manuals.

Recognize in VR&E that severely disabled veterans may need to receive academic training, employment services, and independent living services to achieve the goal of rehabilitation.

Develop plans and partnerships for VR&E to enhance the availability of entrepreneurial opportunities to disabled veterans.

Develop plans for VR&E to continue follow-up of rehabilitated veterans for at least two years to ensure that rehabilitation is successful.

Implement pilot programs to reward states, and individual employees, that are most effective in assisting veterans, particularly those with barriers to employment, find work.

Develop, through the Veterans Employment and Training Service, meaningful performance standards and reward states that exceed the standards by providing additional funding.

NATIONAL CEMETERY ADMINISTRATION

Through the National Cemetery Administration (NCA), find ways to effectively market the state cemetery grants program.

Establish a strategic plan for the NCA to address the time period 2003-2008 during which the system should experience the greatest demand for burial space.

▼ ▼ ▼

Recommendations to the Department of Defense

MEDICAL PROGRAMS

MEDICAL CARE

Specialized Services Issues

Gulf War Illness

With VA, conduct intensified medical and scientific research on amyotrophic lateral sclerosis (ALS, commonly referred to as Lou Gehrig's disease). Studies indicate that this fatal disease is occurring among Gulf War veterans at an abnormal rate.

VOCATIONAL REHABILITATION AND EMPLOYMENT

Merge the Disabled Transition Assistance Program with the Transition Assistance Program.

Make preseparation counseling optional for members being separated prior to completion of their first 180 days of active duty, unless separation is due to a service-connected disability.

Provide an Internet-accessible automated, interactive transition assistance platform aboard ships, as well as in remote and isolated duty areas.

Assist in:

- Dissemination of information.
- Involvement of certifying organizations.
- Coordinating efforts among federal agencies and private industry.
- Support and promote the expansion of state pilot programs throughout the Nation.
- Development of a proactive position and policy by DOD.
- Involvement of the National Skill Standards Board as a resource.

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UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

FISCAL YEAR 2002

BUDGET ESTIMATE

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UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

INTRODUCTION

The United States Court of Appeals for Veterans Claims is a court of record established under Article I of the Constitution by the Veterans' Judicial Review Act, Pub. L. No. 100-687, Division A (1988). The Act, as amended, is codified in part at 38 U.S.C. §§ 7251-7299. The Court is one of four created pursuant to Article I in the federal judicial system. It is composed of seven judges, one of whom serves as chief judge. The judges are appointed by the President, by and with the advice and consent of the Senate, for 15-year terms. Their conduct is governed by specific provisions in title 38, U.S. Code, and generally by the Code of Conduct for United States Judges. 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 United States Supreme Court.

The Court is empowered to review decisions of the Board of Veterans' Appeals (BVA) and may affirm, vacate, reverse, or remand such decisions as appropriate. Review 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 were unlawfully withheld or unreasonably delayed, and can set aside decisions, findings, conclusions, rules, and regulations issued or adopted by the Secretary, the BVA, or the BVA Chairman that are arbitrary or capricious, an abuse of discretion, or otherwise not in accordance with law, contrary to constitutional right, in excess of statutory jurisdiction or authority, or without observance of the procedures required by law. The Court is also empowered to hold unlawful and set aside findings of material fact if the findings are clearly erroneous.

The Court is required by statute, 38 U.S.C. § 7255, to be located in Washington, D.C.; however, it is a national court authorized to sit anywhere in the United States.

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

APPROPRIATION LANGUAGE
GENERAL AND SPECIAL FUND

SALARIES AND EXPENSES

For necessary expenses for the operation of the United States Court of Appeals for Veterans Claims as authorized by 38 U.S.C. §§ 7251- 7299, [$12,419,000] **$13,221,000**, of which [$895,000] **$895,000** 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 heading in Public Law 102-229. (Department of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 2001.)

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

PROGRAM JUSTIFICATION

Court Caseload Trends and Variations:

The Court began operations on October 16, 1989. The number of new cases filed in the Court fluctuated substantially during the first few years, and leveled off at slightly more than 1200 per year by FY 1995. New case filings increased by 27% in FY 1996, by 38% in FY 1997, and by 6% in FY 1998, and remained virtually unchanged in FY 1999 and FY 2000 at 2397 and 2442, respectively. This amounts to approximately 200 new cases per month. In addition, since the 1992 enactment of legislation extending the Equal Access to Justice Act (EAJA) to the Court, there has been an ever increasing number of EAJA applications; the Court acted on 776 applications in FY 2000, down slightly from the 826 applications in FY 1999.

Appeals to the Court come from the pool of cases in which the BVA has denied some or all benefits sought by claimants. The BVA does not report separately the number of its cases in which it denied some, but not all, benefits (those cases are not considered denials). It does report those cases in which it denied all benefits sought; that number decreased dramatically over several years until FY 1995, when a small increase was reported. In FY 1996, the number of BVA total denials increased by 63%; and, in FY 1997, total denials increased again by 52%. In FY 1998, FY 1999, and FY 2000, the number of denials decreased slightly each year. This chart shows the trends for BVA total denials and appeals to the Court and that since FY 1992 appeals have constituted, on the average, about 16 percent of BVA total denials:

	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
BVA TOTAL DENIALS	25082	10946	9734	6194	6407	10444	15865	15360	14881	14080
APPEALS TO USCAVC	2223	1742	1265	1142	1279	1620	2229	2371	2397	2442
APPEALS AS % OF DENIALS	8.9%	15.9%	13.0%	18.4%	20.0%	15.0%	14.0%	15.4%	16.1%	17.3%

Unrepresented Appeals:

In FY 2000, the Pro Bono Representation Program (the Program) continued to represent a high percentage of *pro se* appellants before the Court. The Program began in FY 1992 when the Court requested authority to keep $950,000 from that fiscal year's appropriation available through FY 1993 to implement a pilot Pro Bono Representation Program. Congress approved the Court's request in Public Law No. 102-229 (1992). Under this law, the Legal Services Corporation (LSC)

administered a Court-funded pilot grant program to provide pro bono representation and legal assistance to veterans and their survivors who had filed appeals in the Court and who were unable to afford representation.

The Program continues to receive funding through the Court's annual appropriation: $790,000 in FY 1994 and FY 1995 (Pub. L. Nos. 103-124 and 103-327) and $405,000 in FY 1996 (Pub. L. No. 104-134). In years prior to FY 1997, Congress gave the Court limited discretion over the Program's funding level. In FY 1997, however, Congress directed the Court to provide, from its annual appropriation, $700,000 to the Program (Pub. L. No. 104-204). In FY 1998, the level of directed funding was $790,000 (Pub. L. No. 105-65); in FY 1999, the level was $865,000 (Pub. L. No. 105-276); and in FY 2000 the level was $910,000 (Pub. L. No. 106-75). In FY 2001, the level is $895,000 (Pub. L. No. 106-377). During FY 1997 budget hearings, the Court sought unsuccessfully to separate the Program's funding from the Court's appropriation because of a concern by the Court's judges that this funding mechanism linked the Court to one class of litigants so as possibly to create an appearance of partiality. However, the Appropriations Subcommittees' consideration of the Program's request as separate from the Court's budget request and the removal of discretion from the Court over the Program's funding level has separated the Court, to the greatest extent possible under current legislation, from direct involvement in the Program.

Pursuant to Congress' direction, the Court includes the Program's FY 2002 request for $895,000 as an appendix to this submission, but offers no comment as to its substance other than to note that the amount has not increased over FY 2001 budget authority. Funding for the Program continues to be administered by the LSC, which provides monitoring, evaluation, and technical support, as it does for all of its grantees.

Staffing Requirements:

The Court requests funding for 88 full-time equivalent (FTE) positions. This represents no change in positions from the FY 2001 authorized level. The Court, as always, will monitor staffing to ensure that it is kept at the minimum level necessary to review in a timely fashion the cases brought before the Court. This will be especially important in the coming months as the Court experiences the full impact of the Veterans Claims Assistance Act of 2000 (Pub. L. No. 106-475) (VCAA) on case filings. There is no doubt that the VCAA will have significant impact on the work of the Court; however, to date the number of appeals filed with the Court since enactment of the VCAA in November 2000 shows no significant change.

Practice Registration Fund:

This fund is established under 38 U.S.C. § 7285. It is generated from registration fees paid by practitioners and receives no appropriations. It is available to employ independent counsel for disciplinary matters involving practitioners and to defray costs of implementing standards of practice.

FISCAL YEAR 2000 ACTIVITY

The Court's FY 2000 program accomplished the following:

Maintained arrangements with the United States Marshals Service (USMS) for court security, and with the Department of Agriculture's National Finance Center (NFC) for payroll/personnel, administrative payments, funds control, and support to financial, accounting, and reporting functions.

Continued the Pro Bono Representation Program under special procedures for the transfer of all funding, both grant and administrative, to the LSC. This separates the Court from direct involvement in the Program.

Implemented a new case-management system written for a Windows environment.

Enhanced the Court's Internet website, which provides information about Court rules, procedures, and decisions, to include case dockets. Case status may now be viewed on the Internet by any interested party by accessing the Court's website.

Upgraded computer hardware.

Renovated facilities to accommodate seven additional law clerks and one CLS staff attorney.

FISCAL YEAR 2001 PROGRAM

The Court's FY 2001 program includes the following:

Continuation of contractual arrangements with the USMS for security services and the NFC for the processing and reporting of pay, personnel records, and financial documents.

Continuation of the Pro Bono Representation Program under funding procedures adopted in FY 1997.

Refining the application of the Court's automated case-management system.

Enhancement of information technology capability, including installation of upgraded computer hardware and software.

Further upgrades for the Court's file servers.

Evaluation of need for and possible purchase of a new phone system.

FISCAL YEAR 2002 BUDGET REQUEST

The Court's FY 2002 budget request reflects the following in addition to maintaining and enhancing the FY 2001 initiatives:

Funding to maintain the Court's automated case-management system.

Budget restraint in non-personnel compensation/benefits costs.

SUMMARY OF FISCAL YEAR 2002 BUDGET REQUEST
(in thousands of dollars)

A summary of the FY 2002 funding requirements for conducting the Court's activities follows:

	2001 Budget	2002 Estimate	Change
FTE Positions	88	88	-0-
Personnel Compensation and Benefits	$7,965	$8,884	+$919
Other Objects	$3,559	$3,417	-$142
Grants	$ 895	$ 895	-0-
Budget Authority/Appropriation	$12,419	$13,221	+$ 777

FISCAL YEAR 2002 PROGRAM FUNDING CHANGES
(in thousands of dollars)

The FY 2002 budget request of $13,221,000 reflects a 6 percent increase over the budget authority for Court and Pro Bono Representation Program operations for FY 2001. Initial appropriations to the Court for FY 2001 were $12,445,000, but as a result of the final budget negotiations the Court incurred a $26,000 rescission.

Personnel Compensation and Benefits: **+919**

The entire increase in the Court's budget for 2002 is in personnel compensation and benefits. Economic Cost Indicator (ECI) pay raises and locality pay use as a base an FY 2001 pay figure reflecting a pay raise of 3.81% for nonjudicial personnel, including the total locality-pay adjustment due Washington area government employees. The budgeted FY 2002 pay raise for all Court personnel is 3.6% with no differentiation between the ECI pay raise and locality pay. In total, over 60 percent of the increase in this category is for nonjudicial personnel. Based on the actuarial estimates of the Court's actuary, the Court contribution to the Judges Retirement System (JRS) will increase substantially in FY 2002 due to all the participating judges' opting into the survivor annuity portion of the JRS and the statutory provision anticipating that all judges will ultimately join the JRS. Additionally, due to the retirement of one judge who opted into the JRS recently, a $134,000 annual payment, in addition to the regular Court contribution for active judges, must be made to amortize over twenty years the unfunded liability created by that retirement.

Total

Other Objects: **-142**

Overall, the budgeted amounts for all other object classes reflect a reduction in real dollars over FY 2001 budgeted amounts of over one-percent. This reduction is in uninflated dollars. The only significant increase is in rental payments billed to the Court by the General Services Administration.

Grants: **-0-**

The grantee explains its request in the appendix.

Total Changes: +777

DETAILS OF FISCAL YEAR 2002 FUNDING CHANGES

The following provides details for the funding changes from FY 2001 funding levels:

PERSONNEL COMPENSATION AND BENEFITS ..... **+$919,000**

In conformance with OMB economic assumptions, the request includes funding for a 3.6% pay adjustment for staff, with no differentiation between the ECI pay raise and locality pay, and includes necessary funding for benefits. No increase in the authorized FTE level is programmed for FY 2002. The benefits portion includes a Court contribution to the Judges Retirement Trust Fund that reflects all participating judges' opting into the JRS survivor annuity program and the statutory provision anticipating that all judges will ultimately join the Court's JRS. The increase in this category also includes an additional payment of $134,000 that, according to current actuarial estimates, will need to be paid annually for twenty years to the Retirement Trust Fund due to the retirement of a judge who did not join the JRS until recently.

OTHER OBJECTS ..... **-$142,000**

TRAVEL: (-0-)
No increase in travel over FY 2001 is budgeted.

TRANSPORTATION OF THINGS: (-0-)

RENTAL PAYMENTS TO GSA: (+200,000)
The increase reflects the added rental costs.

COMMUNICATIONS, UTILITIES AND MISCELLANEOUS CHARGES: (+1,000)
The increase reflects minimal increases in communication costs.

PRINTING AND REPRODUCTION: (-0-)

OTHER SERVICES: (-226,000)
No new initiatives are programmed for FY 2002. Other services will include only maintenance of the existing case-management system and the on-going costs of court security; federal occupational health; payroll, personnel, and financial services; and training.

SUPPLIES AND MATERIALS: (+7,000)
The increase reflects inflation plus increasing costs for legal subscriptions.

EQUIPMENT: (-99,000)
No large purchases of furniture or equipment are programmed.

GRANTS ..... **-0-**
The grantee explains its request in the appendix.

UNITED STATES COURT APPEALS FOR VETERANS CLAIMS

Program and Financing (in thousands of dollars)

		2000 actual	2001 approved	2002 estimate
OBLIGATIONS BY PROGRAM ACTIVITY				
10.00	Total obligations	11,261	12,419	13,221
BUDGETARY RESOURCES AVAILABLE FOR OBLIGATION				
21.40	Unobligated balance available, start of year	---	---	---
22.00	New budget authority (gross)	11,408	12,419	13,221
22.30	Unobligated balance expiring	-147	---	---
23.90	Total budgetary resources available for obligation			
23.95	New obligations	-11,261	-12,419	-13,221
24.40	Unobligated balance available, end of year	---	---	---
NEW BUDGET AUTHORITY (GROSS) DETAIL				
40.00	Appropriation	11,450	12,445	13,221
40.35	Appropriation rescinded	-42	—26	---
43.00	Appropriation (total)	11,408	12,419	13,221
CHANGE IN UNPAID OBLIGATIONS:				
72.40	Obligated balance, start of year	1,374	1,584	1,400
73.10	New obligations	11,261	12,419	13,221
73.20	Total outlays (gross)	-11,051	-12,603	-13,159
74.40	Obligated balance, end of year	1,584	1,400	1,462
OUTLAYS (GROSS), DETAIL				
86.90	Outlays from new current authority	9,983	11,019	11,759
86.93	Outlays from current balances	1,068	1,584	1,400
87.00	Total outlays	11,051	12,603	13,159
NET BUDGET AUTHORITY AND OUTLAYS				
89.00	Budget authority	11,408	12,419	13,221
90.00	Outlays	11,051	12,603	13,159

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

SALARIES AND EXPENSES

Object Classification (in thousands of dollars)

		2000 actual	2001 budget	2002 estimate
Direct Obligations:				
Personnel Compensation:				
11.1	Full-time permanent	5,298.9	5,925	6,385
11.5	Other personnel compensation	29.0	40	30
11.9	**Total personnel compensation**	**5,327.9**	**5,965**	**6,415**
12.1	Civilian personnel benefits	1,691.0	2,000	2,469
13.1	Unemployment Compensation	4.1		
21.0	Travel and transportation of persons	22.9	45	45
22.0	Transportation of things	.7	2	2
23.1	Rental payments to GSA	2,156.9	2,000	2,200
23.3	Communications, utilities, and miscellaneous charges.	89.1	99	100
24.0	Printing and reproduction	19.5	25	25
25.2	Other services	420.9	678	496
25.3	Purchases of goods and services from government sources	44.3	80	70
25.4	Operation and maintenance of facilities	120.0	20	5
25.7	Operation and maintenance of equipment	54.7	50	57
26.0	Supplies and materials	232.7	245	252
31.0	Equipment	166.6	315	190
41.0	Grants, subsidies, and contributions	910.0	895	895
99.9	**Total obligations**	**11,261.3**	**12,419**	**13,221**

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

COURT OF APPEALS FOR VETERANS CLAIMS RETIREMENT FUND

This fund, established under 38 U.S.C. § 7298, will be used for retired pay to judges and for annuities, refunds, and allowances to surviving spouses and dependent children. Participating judges pay 1 percent of their salaries to cover creditable service for retired pay purposes and 2.2 percent (decreased from 3.5 percent by Public Law 106-117, November 1999) of their salaries for survivor annuity purposes. Additional funds needed to cover the unfunded liability may be transferred to this fund from the Court's annual appropriation. The Court's contribution to the fund is estimated annually by an accounting firm retained by the Court. The fund is invested solely in government securities. In FY 2000, the Court continued to pay one survivor annuitant from fund assets. In FY 2001, the Court is paying one survivor annuitant and one retired judge.

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

COURT OF APPEALS FOR VETERANS CLAIMS RETIREMENT FUND
(in thousands of dollars)

		2000 actual	2001 budget	2002 estimate
Unavailable Collections Schedule:				
Balance, start of year:				
01.99	Balance, start of year	3,991	4,749	5,623
Receipts:				
02.01	Earnings on investment	246	250	250
02.02	Employer contributions	532	800	800
02.03	Employee contributions	11	11	11
02.99	Subtotal, receipts	789	1,061	1061
03.00	Offsetting collections	-31	-187	-195
04.00	Total: Balances and collections	4,749	5,623	6,489
Appropriations:				
05.01	Judges survivors annuity fund	-31	-187	-195
07.99	Balance, end of year	4,749	5,623	6,489

January 29, 2001

THE VETERANS CONSORTIUM PRO BONO PROGRAM FY 2002 BUDGET AND NARRATIVE

Overview

The Pro Bono Program is requesting an appropriation of new grant funds in the amount of $895,000 for FY 02. This is the same amount appropriated for the Program for the current FY 01.

The Program's proposed budget for FY 02 is attached. It contemplates expenditures totaling $943,949, which represent an increase of $34,386 (3.78 %) over the $909,563[1] anticipated by the budget for FY 01. However, the Program had some $48,949 of unspent grant funds at the end of FY 00, which it had been anticipated would be applied to FY 01 expenditures, but proved not to be needed; the result being that we now anticipate an equivalent surplus at the end of FY 01, which can be included in the budget for FY 02. We have, accordingly, deducted the amount of that anticipated year-end surplus from the budgeted expenditures for FY 02, to arrive at the figure for new grant funds, of $895,000.

The increase in budgeted expenditures reflects an increase in various costs, but no significant increase in the caseload handled by the Program, or in numbers of personnel to handle the caseload. The Program received over 430 new requests for assistance in calendar year 2000, a slight reduction from the 453 requests received in 1999. However, the Program conducted an evaluation of 455 cases in 2000, an increase over the 415 cases evaluated in 1999 – enabling us to reduce its backlog of cases. Significantly, 202 cases were referred to Program attorneys in 2000, an increase from the 165 referred to attorneys in 1999. The number of cases where representation was declined by the Program was essentially constant – 256 in 1999, and 251 in 2000. It is anticipated that the demand for Program services will remain in excess of 400 requests per year, as the number of final BVA decisions remains high: there were 34,028 decisions issued by the BVA in FY 2000, and a comparable level of BVA activity is projected for the current fiscal year. The number of appeals filed with the Court has remained fairly constant – approximately 2,200 to 2,300 appeals per year for the past several years.

Personnel costs – salary and benefits of those individuals performing services for the Program that are reimbursed from grant funds – account for 75% of the proposed FY 02 budget. These costs cover a portion of the time for personnel who staff the Outreach and Education Components, and all of the time of most of the personnel who staff the Case Evaluation and Placement Component. The services of the other staff are provided by constituent organizations free of charge to the Program. Staff who are reimbursed from grant funds, for all or a portion of their salary and benefits, are employees of either the National Veterans Legal Services Program (NVLSP) or the Paralyzed Veterans of America (PVA). Table A shows in summary form the

[1] This figure of $909,563 represents a modification and reduction of the FY 01 budget of $948,667 that was submitted with the original funding application. The $39,104 reduction, approved by the Consortium's Executive Board, results from the adjustment of certain anticipated costs to be incurred in FY 02.

number of persons providing services for each component, and the number of Full Time Equivalent (FTE) positions to be paid out of grant funds in FY 01 and FY 02.

Table A

PRO BONO PROGRAM PERSONNEL AND FTE DISTRIBUTION			
Component	Total Number of Personnel Providing Some Service to the Program	Total FTE Reimbursed by the Grant, FY 01	Total FTE Reimbursed by the Grant, FY 02
Outreach	6	0.23	0.23
Education	10	0.84	0.84
Case Evaluation and Placement	9	7.50	8.00
Direct Representation	1	0.50	0.50
Total	**26**	**9.07**	**9.57**

A fuller breakdown by Component follows.

I. Case Evaluation and Placement Component **$744,029**

The FY 02 budget contemplates an increase of $72,971 (10.9 %) over the FY 01 budget for the Case Evaluation and Placement Component (referred to in the attached budget, for brevity, as the "Screening Component"). Personnel costs of $67,267 represent 92% of the increase

A. Personnel

The three categories of personnel staffing this component – lawyers, non-lawyer veterans law specialists, and support staff -- will remain unchanged from FY 01.

Three *lawyers*, the Director, the Deputy Director for Case Evaluation and the Deputy Director for Placement, function full time as such in the Case Evaluation and Placement Component; their personnel costs are fully reimbursed by the Program – one position to PVA and two positions to NVLSP. The lawyer FTE for this Component reimbursed from grant funds, in both FY 01 and FY 02, is 3.0.

Veterans law specialists review the VA claims file and BVA decision to determine whether each case contains an issue that justifies referral to a lawyer. Veterans law specialists come from the constituent Veterans Service Organizations (VSOs) and are among the most experienced non-lawyer service officers these organizations have to offer.

We expect to have four full time veterans law specialists (VLS) in the Case Evaluation and Placement Component in FY 02 – two of these positions being supplied by PVA, on a reimbursable basis and two VLS positions to be donated by Disabled American Veterans (DAV) and by the American Legion.

There are three full time administrative support staff in the Case Evaluation and Placement Component, all employees of NVLSP, and all reimbursed out of Program funds.

The increase of $67,267 (12.6%) in personnel costs for the Case Evaluation and Placement Component represents the combination of a modest cost of living and merit raises and the cost of a half-time veterans law specialist in FY 01 increasing to full time in FY 02.

The level of salaries and benefits paid to the personnel who staff the Program is governed by the personnel policies of the constituent organizations of which they are employees – i.e., NVLSP and PVA – and to which they may return in the event of termination of the Program or rotation of personnel by the organizations involved. Both NVLSP and PVA expect to increase their staff salaries up to 5%, of which 3% will be a cost of living increase and 2% will be allocated for merit raises. Increases are reflected in the personnel costs of all four Components of the Program in the FY 02 budget.

B. Space - Rent

The increase of $ 3,394 for FY 02 provides for an anticipated increase in the rental cost for the space presently occupied, and a nominal increase in monthly occupancy expenses shared by all lessees in the building.

C. Equipment Rental and Maintenance

The increase of $250 from FY 01 provides for a 5% rate adjustment for the maintenance contracts/ service agreements on office equipment and telephone system.

D. Office Supplies and Expenses

The increase of $400 over the amount budgeted for FY 01 is based on actual experience in FY 00.

E. Telephone

The increase of $475 over the amount budgeted for FY 01 is based on actual experience in FY 00.

F. Travel/Continuing Legal Education

The nominal increase of $225 provides for out-of-state travel to the spring and fall National Organization of Veterans Advocates seminars generally attended by the director and/or the deputy directors.

G. Library

The increase of $200 is budgeted to allow for acquisition of new materials for the library and subscriptions to publications that were not had available in the past.

H. Insurance

The increase of $90 over the amount budgeted for FY 01 is based on actual experience in FY 00.

I. Dues and Fees

The increase of $15 over the amount budgeted for FY 01 is based on actual experience in FY 00.

J. Audit

The increase of $155 represents an anticipated 5% rate increase over the amount budgeted for FY 01.

K. Property Acquisition

The increase of $500 represents replacement costs for minor office equipment in FY 02.

L. Contract Services

We expect the cost of contract services to remain at the same amount budgeted for in FY 01.

II. Direct Representation Component **$ 45,203**

PVA, has committed to accepting 20 cases at a cost of $2,260.15 per case, representing a $2,153 aggregate increase over the FY 01 budget. The total resulting figure of $45,203 represents 50% of the salary and fringe benefits for a full time lawyer, the remaining 50% being donated by PVA.

III. Outreach Component **$ 50,018**

Overall, the FY 02 budget calls for a $4,005 increase (8.7%) over the FY 01 budget for the Outreach Component. Personnel costs of $1,826 represent 45% of the increase and $2,179 of non-personnel costs represent 55% of the increase.

A. Personnel

The staff composition for the Outreach Component will remain unchanged in FY 02. The personnel costs budgeted to increase by $1,826 represents the cost of living and merit raise of 5% .

Three NVLSP *lawyers* and three NVLSP *non-lawyers* are planned to continue to devote a portion of their time to the Outreach Component; and the Program reimburses NVLSP for that portion of their personnel costs. .

Only minor adjustments were made in the other line items and the net result of these adjustments is an increase in the budget by $2,179 over the FY 01 budget.

V. Education Component **$104,699**

The proposed FY 02 budget for the Education Component reflects a decrease of $19,743 from the budget for FY 01.

A. Personnel

Personnel costs are projected to increase by $3,497 to reflect adjustments similar to those indicated for the Outreach Component.

The FY 02 staff positions remain unchanged from FY 01. A total of 6 NVLSP *lawyers* and four NVLSP *non-lawyers* are planned to continue to function in the Education Component and a portion of their personnel costs are reimbursed by the Program.

B. Other

Combined non-personnel expenses are expected to decrease by a total of $23,240, from $54,498 in FY 01 to $31,258 in FY 02. This 43% decrease represents a reduction of publications and training materials for the newly recruited attorneys anticipated for FY 02.

V. LSC Oversight **$ -0-**

LSC has indicated that the $25,000 budgeted costs of oversight for FY 02 will be provided from unspent oversight funds accumulated over the past few years.

TOTAL BUDGET	**$943,949**
LESS: ANTICIPATED FY 01 CARRYOVER	**(48,949)**
TOTAL FY 2002 FUNDING REQUESTED	**$895,000**

Veterans Consortium Pro Bono Program
FY 2002--Proposed Budget

		Outreach FY 02	Education FY 02	Screening FY 02	Direct Rep FY 02	Proposed Budget 1/01/02-12/31/02	Outreach FY 01	Education FY 01	Screening FY 01	Direct Rep FY 01	FY '01 Budget 1/01/01-12/31/01	Projected Variance FY 02 over FY 01	% of Increase/ Decrease
Salaries - Attorneys	1	12,729	37,334	220,410	0	270,473	12,123	35,556	209,914	0	257,593	12,880	5.00%
Salaries Non-attorney representatives	2	0	0	121,276	0	121,276	0	0	86,625	0	86,625	34,651	40.00%
Salaries - Administration & Support	3	16,767	19,160	118,361	0	154,288	15,969	18,247	112,070	0	146,286	8,002	5.47%
Employee Benefits	4	8,849	16,947	140,178	0	165,974	8,427	16,141	124,348	0	148,916	17,058	11.45%
Total Personnel		38,345	73,441	600,224	0	712,010	36,519	69,944	532,957	0	639,420	72,590	11.35%
Space - Rent	6	4,615	5,468	95,795	0	105,878	4,395	5,208	92,401	0	102,004	3,874	3.80%
Equipment Rental & Maintenance	9	630	840	5,250	0	6,720	600	800	5,000	0	6,400	320	5.00%
Office Supplies & Expense	10	2,100	2,835	8,400	0	13,335	2,000	2,700	8,000	0	12,700	635	5.00%
Telephone	11	350	525	9,975	0	10,850	330	500	9,500	0	10,330	520	5.03%
Travel/Continuing Legal Education	12	630	1,890	4,725	0	7,245	600	1,800	4,500	0	6,900	345	5.00%
Library	15	735	1,050	4,200	0	5,985	700	1,000	4,000	0	5,700	285	5.00%
Insurance	16	210	525	1,890	0	2,625	200	500	1,800	0	2,500	125	5.00%
Dues and Fees	17	105	210	315	0	630	100	200	300	0	600	30	5.00%
Audit	18	599	2,615	3,255	0	6,468	570	2,490	3,100	0	6,160	308	5.00%
Property Acquisition	19	0	0	2,000	0	2,000	0	0	1,500	0	1,500	500	33.33%
Contract Services	21	0	0	8,000	45,203	53,203	0	0	8,000	43,050	51,050	2,153	4.22%
Other	22	1,700	15,300	0	0	17,000	0	39,300	0	0	39,300	(22,300)	-56.74%
Total Non-Personnel		11,673	31,258	143,805	45,203	231,939	9,494	54,498	138,101	43,050	202,092	29,847	14.77%
Total Budget		50,018	104,699	744,029	45,203	943,949	46,013	124,442	671,058	43,050	884,563	59,386	6.71%
LSC Oversight**						0					25,000	(25,000)	
Total Budget & LSC Oversight						943,949					909,563	34,386	
Less: Estimated Carryover						(48,949)					(17,144)		
Total Grant Request						895,000					892,419		

**Paid by existing LSC oversight fund balance

Veterans Consortium Pro Bono Program
FY 2002 Budget - Other Costs

Outreach

Attorney Recruitment Brochure		1,700

Education

Tommy	(150@10)	1,500
TVA subscription	(150@$27)	4,050
VBM (Supplement 2002)	(150 @$75)	11,250
		15,300

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CONGRESSMAN BROWN TO DEPARTMENT OF VETERANS AFFAIRS

Post Hearing Question

Hearing on the Department of Veterans Affairs Budget Request for Fiscal Year 2002
Tuesday, March 6, 2001
U.S. House of Representatives
Committee on Veterans' Affairs

As discussed to facilitate correcting a question asked by Congressman Henry Brown:

Question

Transcript page 67, lines 1631 to 1638

Question should read:

Mr. Secretary, I'm from Charleston, South Carolina. We have a goodly number of veterans down in our area, and we have a veterans' medical center. It has 87 beds utilized. We have 119 available.

I'm just wondering, is part of your program that you would maybe look into upgrading that medical center back to its capacity. We have plenty of space, we just don't have the personnel.

Response

Transcript page 69, lines 1675 to 1677

Response should read:

Charleston, we certainly will look into that situation on the medical center beds to see why we're not up to capacity, and we'll get back to you on that.

Explanation

The essence of the original question was the inadequate staffing level at the VA Medical Center in Charleston. We already know the inadequate staffing level is the cause for only 87 of the 119 bed capacity being utilized. Also, this medical center is turning away patients daily due to inadequate staffing levels. We need an answer that reflects the VA's plan to increase staffing at this medical center.

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

May 25, 2001

The Honorable Christopher H. Smith
Chairman, Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Enclosed are the Department's responses to post hearing questions submitted in your letter of March 22, 2001, related to the House Veterans' Affairs Committee hearing of March 6, 2001.

I look forward to continuing our work together.

Sincerely yours,

Anthony J. Principi

Enclosure

Chairman Chris Smith

Question 1: Mr. Secretary, your budget adds $1 billion to this year's appropriation level for discretionary programs. Assuming a 4.3 percent health inflation rate, which is the reported rate for the past year in the U.S., and applying this rate to the fiscal 2001 appropriation level for the VA health care, the result is $800 million as the amount necessary to cover just inflation. This means that VHA would have a difficult time living within the President's requested level of funding, while computing to further extending access to care as you reported in your statement. Therefore, please elaborate on your statement and the discussion we had during the hearing as to how you will employ an increase of less than $1 billion in the health care account to achieve the goals of the VA health care system.

Answer: The budget includes four items that either increase the resource availability or decrease overall budgetary obligations in FY 2002.

- An increase of $100 million in medical collections is estimated. Collections are already increasing this year—currently averaging $57 million per month.
- An increase of $121 million in the Veterans Millennium Health Care and Benefits Act-related collections associated primarily with increasing the prescription co-payment and additional enhanced use lease revenue. These dollars are to be transferred to Medical Care in FY 2002.
- An offset of $235 million associated with the budget policy initiative that estimates 65,000 military retirees currently enrolled in the VA health care system will elect to use the new TRICARE for Life program for their health care in FY 2002. The level of health benefits available by DoD to retirees was significantly expanded with last year's Department of Defense Authorization Act. The shift associated with this initiative decreases the overall resource obligation for VA Medical Care.
- A baseline adjustment of $746 million reduces the budget request for FY 2002 associated with projected under-spending in three programs from the FY 2001 budget request. These programs are long-term care, hepatitis C, and pharmacy. This initiative adjusts and corrects the baseline funding for these three programs before programmatic increases are requested in FY 2002.

The total budgetary resources, after these four items are considered, provide enough to fund uncontrollable cost increases (payroll and inflation) and initiative increases contained in the FY 2002 budget request.

Question 2: Mr. Secretary: Last year Congress approved authority for the Secretary to close the Ft. Lyon, Colorado VA medical center so that the State of Colorado could convert the facility to a state prison. Part of the negotiations leading to this decision affirmed the need for a new VA nursing home facility along the "Front Range," near either Colorado Springs or Pueblo. What is the status of VA's efforts to establish a nursing home care unit in that part of Colorado, and when do you expect it will open?

Answer: VA awarded a lease for a 40-bed nursing home care unit in Pueblo, Colorado on April 20, 2001. This project will be "built to suit" in accordance with VA requirements, and we expect to award the lease shortly. Design will start immediately after the award, and construction will begin after that. Construction is projected to be completed in 2001. Once complete, the remaining patients at Fort Lyon will be moved to the new Pueblo VA Nursing Home Care Unit.

Question 3: Mr. Secretary and Dr. Garthwaite: While this Committee supported VA's decentralization of authority to Network Directors, we expect VA to hold its officials accountable. The Committee receives numerous complaints and concerns from veterans about inadequate health care services and long waiting times for some specialties and even routine primary care in a number of community-based outpatient clinics. Please explain how you intend to hold VHA officials accountable for providing the services to veterans mandated by Congress and your own policies.

Answer: Perhaps the principal distinction between the VA health care system at the beginning of the last decade and today is the degree to which service delivery is integrated across discrete geographic areas. This has been, in large measure, the result of the Network organizational structure adopted by VHA in the early 1990s. This model, now a hallmark of high performing private health care delivery systems, has been instrumental in VA's impressive progress in controlling costs and unnecessary utilization while dramatically improving service delivery, patient safety and quality. These strides have allowed the VA health care system to emerge from the last decade as an acknowledged leader in the health care industry. Another principal strength of the VISN management structure is its operational ability to keep pace with a rapidly changing health care environment. The VISN structure allows VHA to maximize policy oversight and compliance while maintaining the flexibility to respond to local health needs and stakeholders more quickly.

VA emphasizes managing health care versus managing facilities. Through a major transformation effort, VA has improved safety and quality of care, veteran satisfaction, enhanced veterans' access to care, reduced gaps and overlaps in services and reduced administrative overhead. It also emphasizes collaborations with other federal agencies, academic affiliates and community partners to achieve these goals.

As the Department continues to improve services for our nation's veterans, we have imposed a number of requirements on the field such as the need for each facility and Network to have dedicated information security officers and dedicated patient safety staff. VHA's performance management system tracks critical indicators of performance regarding quality of care, access, patient satisfaction, care processes and outcomes, specialized program capacity, and cost effectiveness. Each network's performance against these national performance goals is reviewed continuously and is formally discussed in quarterly Network Director performance reviews.

VA has established aggressive national goals to reduce waiting times for regular primary care and specialty appointments to 30 days and to see patients within 20 minutes of their scheduled appointment time by the end of FY 2003. I am paying close attention to waiting times for pharmacy and clinic appointments, and feel confident that the Network Directors will continue to make improvements in these areas.

VHA also monitors the quality of care at CBOCs through the Performance Measurement Program. Specifically, Network Directors are held accountable for the following waiting time measures:

> Waiting Times—Clinic: By September 30, 2001, the average waiting time will decrease for the following DSS identifier categories (clinics): eye care, audiology, orthopedics, cardiology, urology, and primary care
>
> Achievement Levels: Fully Successful - 45 Days—Exceptional – 30 Days or Less

This measure applies to both medical centers and CBOC clinics. VHA studies have shown that the quality of care at CBOCs is comparable to care provided at the medical center clinics, with the exception of ophthalmology. The finding regarding ophthalmology was not surprising, given that it is a specialty service

and is more likely to be available at a VA medical setting where specialized equipment is required for an evaluation.

Question 4: Dr. Garthwaite, what are your plans for VA health care in the next year to two years, and what do you see to be your biggest challenges as the new Under Secretary?

Answer: The April 3, 2001, hearing conducted by the Subcommittee on Health comprehensively reviewed the current challenges facing VA health care and our goals for the future. A copy of my statement is attached.

Attachment to Chairman Smith's Question 4

Statement
of

Thomas L. Garthwaite, MD
Under Secretary for Health
Department of Veterans Affairs

Before the

Subcommittee on Health
Committee on Veterans' Affairs
U. S. House of Representatives

April 3, 2001

Mr. Chairman and members of the Subcommittee, I am pleased to be here today to discuss the progress, challenges, and future direction of health care in the Department of Veterans Affairs (VA).

Since 1995, we have dramatically transformed the VA health care system. We have moved from an inpatient model of care characterized by limited facilities often far from patients' homes to an outpatient model with more than 350 additional sites of care. While we still provide comprehensive specialty care, we now also emphasize the coordination of care through the universal assignment of primary care providers and teams. We emphasize disease prevention and early intervention, allowing veterans to avoid illnesses and complications and allowing us to avoid the added costs of their treatment. As a result of these strategies, VA today is able to provide higher quality care to more that 500,000 additional veterans with 25,000 fewer employees than it did just six years ago. Moreover, since 1997, VHA has reduced the cost per patient by 24 percent.

The key goal that underlies VA's transformation and continues to drive our strategies for the future is a quest for health care value. We have defined value as quality divided by cost. While we do not yet have a perfect system to measure either quality or cost, we have made significant progress in measuring

both. We have defined and developed measures across four domains of quality (technical quality, access, patient satisfaction, and functional status) and continue to improve our measurement of cost. The quality and cost measures are directly translated into our value framework and the "six for 2006" goals.

Before I detail our progress and current strategies toward the "six for 2006," I would like to comment on some of the overarching themes and strategies that pertain to most or all of the 2006 goals. The following issues are important areas of concentration for us and will directly impact our success in achieving our key goals. They are workforce development, information technology, performance measurement, quality and capacity in our special emphasis programs, enhancement of our academic missions of teaching and research, the Veterans Health Initiative, rationalization and modernization of our facilities (CARES), distribution of funding (VERA), and continuous self assessment using the Baldrige process.

Workforce Development. VA's health care workforce is the key to achieving all of our goals. We must recruit, retain, and develop the best staff if we are to continue to improve. Recently, we have noted shortages of nurses and pharmacists in some parts of the country and the projected shortages in these and other professions are alarming. Increasingly, we have difficulty matching private sector pay levels in such critical areas as physician specialists and computer experts. We also must continuously invest in the education of our workforce to allow them to keep pace with changing patient needs and rapid changes in health care technology. Last year, I established a taskforce to recommend a comprehensive set of actions to address these and other workforce issues. The recommendations of this taskforce are currently under review.

Information technology. Information technology is at the heart of most changes in VHA. We use technology to process clinical and administrative information, to automate previously manual processes, to deliver care across

distances, to train staff, and to conduct research. Examples of the use of technology include the computerized patient record, a cost accounting and analysis system (DSS), consolidated mail out pharmacy (CMOP), simulated patient training in surgery and anesthesia, gamma-knife radiation therapy, advanced neuro-imaging, bar-coding to aid in the accuracy of medication administration, tele-health, and many others.

Two key principles in the development of our computerized medical record are that it is owned by the veteran and that it must be compatible with emerging and established standards such that a veteran can take his/her electronic record to or bring it from any other health care service provider. If a veteran chooses VA to maintain the health record, we must preserve its integrity and security and use it only for the benefit of the veteran or society – and only with his/her permission. We call our initiative for a veteran-controlled health data repository and associated functionalities "HealtheVet."

Performance measurement. The performance measurement system used in VA has played a key role in the transformation of the system and will continue to be a key strategy in the continued evolution of the system. Each year, approximately twenty key measures are selected for emphasis and become the significant component of a performance contract between network directors or chief officers and the Under Secretary for Health. Some of the detailed results are presented below. The power of the system is derived from the focus on defining the most important goals for the year, the development of measures to chart progress toward those goals, the open feedback about the progress (or lack of progress) toward those goals and the necessity that administrators must team with front line staff to make the outcomes for patients change.

Quality and capacity in special emphasis programs. Since 1996, we have moved from inpatient care to outpatient models in medicine, surgery, and mental health. The numbers of patients seen with serious mental illness, for homelessness, or suffering with PTSD have increased. The number of patients

with substance abuse treated has decreased, especially between FY 1999 and FY 2000. We are working to understand the reasons for this drop and to assure access to substance abuse programs in our clinics as well as in our larger facilities. To this end, I plan to establish a National Mental Health Improvement Program (NMHIP). This program will be modeled after a number of well-established VA data-driven improvement programs, such as the Continuous Improvement in Cardiac Surgery Program (CICSP), the National Surgical Quality Improvement Program (NSQIP), the VA Diabetes Program, the Pharmacy Benefits Management Program (PBM), and the Spinal Cord Injury/Dysfunction National Program. This new program will use validated data collection, expert analysis, and active intervention by an oversight team to continuously improve the access, outcomes, and function of patients in need of our mental health programs. These programs include those for patients who are Seriously Chronically Mentally Ill, or who suffer from Post Traumatic Stress Disorder, Substance Abuse, or Homelessness. This program will draw upon existing resources in our Health Services Research and Development Service (HSR&D) including existing initiatives in our Quality Enhancement Research Initiative (QUERI) and our Mental Health Strategic Health Care Group (MHSHG) including the Northeast Program Evaluation Center (NEPEC).

The number of patients treated for spinal cord injury and dysfunction, blind rehabilitation, and traumatic brain injury has increased over the 1996 baseline. Fortunately, the number of patients needing amputation has decreased due to our aggressive management of vascular disease and diabetes.

Academic missions. The academic missions of research and health professions education are part of our "six for 2006" goal to "build healthy communities." However, they are also a critical strategy to deliver high quality and efficient care. These missions allow us to attract the very best and brightest clinical staff and enable us to be early adopters of new advances in medical knowledge and practice. We must challenge our academic staff to turn their creative talent loose on the development of new care delivery models that can

simultaneously address quality, convenience, research, and education. We will engage them in that quest.

Veterans Health Initiative. The Veterans Health Initiative was established in September 1999 to recognize the connection between certain health effects and military service, prepare health care providers to better serve veteran patients, and to provide a data base for further study. The development for this initiative began with the Military Service History project, which involved a pocket card for medical residents. This card details the important components of a military service history, summarizes some of the health risks associated with various periods of service, addresses more generic health issues of concern to all veterans, and specifies Web sites containing references relevant to the issues.

The components of the initiative will be a provider education program leading to certification in veterans' health; a comprehensive military history that will be coded in a registry and be available for education, outcomes analysis, and research; a database for any veteran to register his military history and to automatically receive updated and relevant information on issues of concern to him/her (only as requested); and a Web site where any veteran or health care provider can access the latest scientific evidence on the health effects of military service.

Aligning capital assets to veterans' needs. CARES (Capital Asset Realignment for Enhanced Services) will affect every network in VHA. We have embarked on a significant new planning process with the goal of enhancing health care services to veterans by realigning capital assets. The CARES process starts with the objective assessment of veterans' current and future health care needs within each network and proceeds with the identification of service delivery options to meet those needs and the strategic realignment of capital assets and related resources to better serve the needs of veterans. Through CARES, networks will develop plans for enhanced services that are

based upon objective criteria and analysis, cost-effectiveness and may include capital asset restructuring. These plans will take into account future directions in health care delivery, demographic projections, physical plant capacity, community health care capacity and workforce requirements. Network capital asset realignment proposals will be evaluated and ranked by VHA using a structured decision methodology. All savings generated through implementation of CARES will be reinvested in meeting veterans' health care needs.

Resource allocation. To date, no ideal system to allocate resources in health care has been devised. Fee for service plans lead to overuse of procedures and high costs while managed care plans are criticized for restriction of choice of provider and of access to specialty care. VA uses a risk adjusted, capitated model called VERA (Veterans Equitable Resource Allocation) to allocate resources among VHA's 22 networks. Distribution within each network is based on a set of principles, but in the absence of an ideal system, we have not mandated a single method for all networks. Ideally, VERA would be simple, fair, and promote quality of care. We do not believe that any models have been able to drive quality, therefore, we keep the allocation system simple and work hard to measure the quality of care provided.

VERA has undergone extensive scrutiny since VHA implemented it in 1997. The effectiveness of VERA has been assessed by PricewaterhouseCoopers and by two GAO reviews. All three studies viewed VERA in positive terms. PricewaterhouseCoopers reported that VERA, which allocates resources based on objective measures of need, is ahead of other budget allocation systems, which typically depend on historical allocations with periodic adjustments.

We reviewed the recommendations from PricewaterhouseCoopers and GAO and implemented many of them. For FY 2001, the following VERA policy changes or refinements were approved for the network budget allocations:

- VERA Basic and Complex patient classes and criteria were developed for hepatitis C patients.

- The Complex Care projection methodology was adjusted to delete the veteran population factor in favor of historical utilization.
- Research support funds were passed through VERA directly to each VA medical center.
- VHA changed the workload factor for computing the labor index that weights Basic and Complex Care workload consistent with recent costs.
- The three-year phase-in of Non-Recurring Maintenance (NRM) based fully on patient care workload and the cost of construction was completed.

We are currently examining several additional areas of possible refinements to VERA for implementation in FY 2002 or later, but no conclusions have been made yet. These areas include patient classifications, priority 7 veterans and market share, the cost impact of treating patients above age 75, the existing geographic price adjustment formula to include contracted salary rates and energy expenditures, and the use of risk adjustment models to account for differences in age and disease burden in the population served. We remain committed to the evaluation of all reasonable explanations for variance in the model.

Baldrige and the future. VHA will apply for the President's Quality Award in the fall of 2001 and for the Malcolm Baldrige National Quality Award in May of 2002. We do not undertake these processes for the awards themselves, although we aim to win. Rather, we seek the experience, the outside feedback, and the development of skills in critical self-assessment. We have been struck by the economic success of previous award winners and by their achievements in service quality. We believe that we can identify gaps in our systems and can improve the integration of all we do. The Baldrige criteria will provide a structured and integrated framework for many of the processes we perform today. In the end, sober self-assessment is a skill that should benefit any organization.

Within the last year we have updated VHA's strategic framework to reflect six organizational goals that closely match our six domains of health care value. I will now review our progress and plans for achieving these goals, which are known as the "six for 2006."

Put Quality First until First in Quality. A major force in the transformation of the VA health care system was the implementation of the Performance Measurement System. This system was initiated to meet challenges of improving health care quality, patient satisfaction, and economic efficiencies. The foundation of the Performance Measurement System is broad, statistically reliable, ongoing measurement of performance objectives. As a result of this system, VHA is increasingly able to measure and report on quality. Moreover, the ability to measure allows us to identify areas for improvement.

VHA's quality is not merely good -- in many areas it surpasses government targets and private sector performance. VHA's record regarding post-operative morbidity and mortality is as good as or better than that found in any published study of non-VA surgical programs. Our immunization rates for pneumococcal pneumonia and for influenza far exceed the goals established for the U.S. population. Our breast and cervical cancer screening rates are also well above the national average performance in these areas. VA patients receive life-saving aspirin and beta-blocker administration after heart attacks 96 percent of the time, whereas Medicare patients receive this therapy in only 68 percent of cases.

VHA recognized that the use of evidence-based, clinical practice guidelines would have an appreciable impact on patient care and initiated development of National Clinical Practice Guidelines in 1995. Guidelines were established for many high volume, high risk diseases. A joint effort between VA and DoD has led to the development of more than a dozen clinical practice guidelines intended to assure quality and continuity of care.

VHA's strides in quality and its leadership in health care quality management were specifically cited at the recent Institute of Medicine briefing

accompanying the publication of their report, "Crossing the Quality Chasm." To further our efforts in quality improvement, we will continue to use and update our extensive quality and performance measurement tools. For example, the expanded Prevention Index and the Chronic Disease Care Index, which now encompasses the clinical practice guidelines, were recently revised on the basis of the current medical literature and expert opinion.

In 1998, VA launched the Quality Enhancement Research Initiative (QUERI). The QUERI mission is to translate research discoveries and innovations into better patient care and systems improvements. It is founded on the principle that practice needs determine the research agenda, and research results determine interventions that improve the quality of patient care. The Institute of Medicine, in its report "Crossing the Quality Chasm," specifically noted QUERI as a model for translating the best research evidence into the best patient care.

VHA has also been recognized as a leader in efforts to prevent health care errors and improve patient safety. Improved patient safety requires reporting systems to identify and understand adverse events and close calls and the design and deployment of systems that reduce such vulnerabilities. VHA has introduced a mandatory reporting system for adverse events and close calls that is coupled with rigorous root cause analysis. This system has been operational for over a year and has resulted in a 900-fold increase in close calls reported. Close call analysis is the preferable way to learn of system vulnerabilities, because they can be identified without patient injury.

VA also believes that health care will discover additional vulnerabilities by instituting a separate, voluntary, and anonymous reporting system. To that end, VA formed an agreement with NASA to develop a Patient Safety Reporting System (PSRS) patterned after one that has been used successfully in aviation. The system's guiding principles are voluntary participation, confidentiality protection, and non-punitive reporting. It is designed to be a complementary external system to our current internal reporting system. VA's National Center for Patient Safety and NASA have been working on the design and development

of this system. Pilot testing will begin this year with the entire system on line by the beginning of FY2002.

The discovery of system weaknesses must be followed by system redesign. Examples of system improvements include: national implementation of Bar Code Medication Administration (BCMA) that improves the accuracy of medication administration, extensive deployment of computerized order entry that eliminates handwriting and other common errors, the removal of bulk medications from nursing wards to minimize mixing errors, and working through an interactive fix of a design flaw in a temporary transvenous pacemaker with the manufacturer.

Provide Easy Access to Medical Knowledge, Expertise, and Care. Traditionally, access to care has addressed issues of travel times, waiting times, and insurance. This goal includes those issues as well as access to knowledge via the telephone or Internet and access to the knowledge of specialists where appropriate.

As VA has shifted from an inpatient-focused system to one that is outpatient-based, we have extended care to 350 additional sites, for a total of more than 1,300. Approximately, 100 additional community-based outpatient clinics have received congressional approval and are slated to be phased in over the next several months. Telephone triage and advice programs have been implemented at all hospitals, and health education is available on the Internet. Last year, VA did more than 350,000 consultations via telemedicine (the patient or a diagnostic image and the provider were connected via voice and usually video). Telemedicine and home-care teleconsultation initiatives have also been implemented for spinal cord injury patients. In 1998 and 1999, the Vet Center program implemented the Vet Center-Linked Primary Care project. Telemedicine is used in 20 Vet Centers to promote access to primary care for high-risk, under-served veterans in locations closer to their respective communities.

Applying for VA health care has never been easier. We have eliminated almost three-fourths of the health care-related forms we once required. Veterans

can now obtain applications for enrollment and medical care over the Internet. Veterans may send the forms electronically to the VA health care facilities they have selected or they can print out the completed forms and mail them.

Eligibility reform and community clinics have enhanced access but in some areas demand has preceded recruitment resulting in extended waiting times for appointments. VHA is committed to providing timely care to the veterans enrolled in our health care system. We have recently developed a data system and performance expectations with regard to waiting times for primary care and specialist consultation. We believe that our performance goals for waiting times, commonly known as "30-30-20," are industry leading and fully support patient expectations for timely access to care. Our strategic goal is to provide 90 percent of new primary care and specialty care visits within 30 days, and see 90 percent of patients within 20 minutes of their scheduled appointment time. Of course, patients with emergencies or urgent needs are seen as quickly as is medically appropriate. VHA is now working with the Institute for Healthcare Improvement (IHI) on a major initiative that will focus on the rapid spread of the most successful actions underway within each VISN to achieve the "30-30-20" performance goals. VHA has already seen system-wide improvements in average clinic waiting times between the start in April 2000 to December 2000.

While the early progress on waiting times is encouraging, we have more to do in the broader field of access. We must eliminate barriers to care which result from such things as poverty, race, gender, geography, language, age, and bias. We will evolve strategies to provide care to vulnerable populations including the homeless, the mentally ill, the aged, and those infected by the Hepatitis C virus. We also have developed a body of knowledge about veterans' health issues that we will make available to any veteran or any health care provider.

VHA has been faced with access issues in extended and long term care. VA has expanded programs targeted for the elderly, including Geriatric Evaluation and Management (GEM) Programs, home-based primary care initiatives, and pilot programs in long-term care and assisted living as authorized by the Veterans Millennium Health care and Benefits Act, Public Law 106-117.

Enhance, Preserve, and Restore Patient Function. The restoration of function (rehabilitation) is the cornerstone of VA's health care mission. VA has nationally recognized programs for the rehabilitation of veterans who are blind, suffering from brain dysfunction, afflicted with spinal cord injuries, or who are amputees. Notable progress is being made in the development of outcome measures that evaluate functional improvements in each of these special programs. Amputation rates in VA are lower than age-matched private sector populations and continue to decrease. Activities are underway to further integrate all of VA's low vision and blind programs to improve the continuity of care. A recent report comparing VA spinal cord care with that in the U. S. private sector and in Sweden concluded that the totality of VA's benefits package is unmatched. VA provided far greater continuity and breadth of care than did the private sector. Life-long, integrated, and comprehensive care for spinal cord patients is provided in VA and Sweden, but not in other venues. The Traumatic Brain Injury (TBI) Network of Care provides case-managed, comprehensive, specialized rehabilitation spanning the period from discharge from the acute surgical treatment unit until permanent living arrangements can be made. A significant number of these patients are referred to VA facilities from the military. Nine research centers of excellence conduct studies emphasizing wheelchair design and technology, brain rehabilitation, spinal cord injury and multiple sclerosis, early detection of hearing loss, orientation techniques for blind persons, and amputation prevention and joint replacement.

VA also provides comprehensive mental health services across a continuum of care, from intensive inpatient mental health units for acutely ill persons to residential care settings, outpatient clinics, Day Hospital, and Day Treatment programs. The number of veterans receiving mental health care in the VA health care system has steadily increased since 1996. VHA will continue to monitor care and work with networks to improve and maintain both the capacity and the quality of care for all veterans with serious mental illness. Recent initiatives have been undertaken to increase mental health treatment in

community-based outpatient clinics, increase use of assistive community treatment for the most seriously mentally ill veterans, and increased use of opiate substitution clinics in major urban centers. It is also worth noting that VA is the only federal agency that provides substantial hands-on assistance directly to homeless veterans and has the largest network of homeless assistance programs in the country.

The primary objective of all special programs is to provide the best possible care and achieve the maximum independence for patients by restoring lost function or decreasing the impact of their disabilities. We will continue to enhance our programs in rehabilitation, sharpening our focus on improved functional capacity for veterans who suffer from spinal cord injury, blindness, amputations, brain dysfunction, and mental illness. To improve the integration of activities and to assure VA has adequate capacity to meet the specialized health care needs of veterans, VHA has created a position in headquarters to serve as the coordinator for special disability programs and has designated a clinical coordinator in each VISN to work with individual facilities and headquarters offices to monitor capacity and maintain specialized services.

Exceed Patients' Expectations. VA created the National Customer Feedback Center (now the National Performance Data Feedback Center, or NPDFC) in 1993 to measure and improve patient satisfaction with care and to allow comparison with other health care systems. Annual inpatient and outpatient patient satisfaction surveys based on the Picker instrument were developed using focus groups of patients and their families. Patient service standards were also developed, and specialty surveys, such as long-term care, have been added over the years. Beginning in FY 2001, VHA's new Performance Analysis Center for Excellence (PACE) will refine and expand the data feedback, satisfaction surveying, and other objectives accomplished by the NPDFC. PACE will use clinical literature and VA data to identify new clinically and operationally important performance improvement opportunities, aligning activities with the strategic objectives of VHA's "6 for 2006."

The overall customer satisfaction scores from VHA's inpatient and outpatient surveys have remained relatively flat for the last several years, with approximately 65 percent of patients rating VA's services as "very good" and "excellent." However, when we consider the significant structural and programmatic realignments the VA health care system has undergone in the last six years, it is gratifying that veterans continue to show a high level of satisfaction and confidence in VA health care. Nonetheless, we believe that a more focused approach will have a strong impact on improving our performance. Therefore, in FY 2001 VHA will begin to focus on three key areas of patient satisfaction: patient education, visit coordination, and pharmacy services. These are areas in which our surveys indicate that we have the greatest opportunity and need for improvement. In addition, we will further focus the system on the patient by emphasizing the goal of ensuring that veterans participate fully in decisions affecting their health care and understand those decisions completely.

The American Customer Satisfaction Index (ACSI) provides an independent assessment to be used with VA's own data. This Index, a cross-industry/government measure of customer satisfaction released December 22, 2000 asked questions about veterans' overall satisfaction with their experiences in a recent visit to a VA medical center. Overall, VA's customer satisfaction index was 78 on a 100-point scale, seven points above the customer satisfaction score of 71 given by the general public for all sectors of business, and eight points above the score for private hospitals. Customer service, perceived in terms of courtesy and professionalism, was the highest of VA's three measurement areas, an average score of 87. ACSI considers scores above 80 to be "high." On questions about patients' likely return to VA medical centers and willingness to say positive things about VA, VA scored an 88.

Maximize Resource Use to Benefit Veterans. Since 1997, VHA has reduced the cost of care per veteran treated by 24 percent. But while a reduction in costs is a significant accomplishment, it does not, by itself, assure that we are obtaining or providing the best health care value for the dollars we spend.

Therefore, we have developed a VALUE index that includes both cost and other domains of value such as quality, access, and satisfaction in order to express meaningful outcomes for VHA's resource investments. Unlike a simple cost measure that can lead to false impressions of efficiency, the VALUE measure demonstrates a balanced perspective of cost efficiency along with desired outcomes. The measure portrays the desired outcomes that VHA purchases with its budgeted resources by establishing a value relationship of Quality-Access-Satisfaction to dollars (QAS/cost). The use of the QAS/Cost VALUE measure will establish an understandable value relationship of outcomes to dollars.

We must also expand our partnerships with federal, state, local, and private entities to minimize redundancy in programs and services and to leverage our buying power. Through multiple partnerships, VA will be in a position to manage its services in such a way as to enhance the quality and coordination of care provided to veterans.

Build Healthy Communities. Veterans can only reach their maximum health potential if they live in healthy communities and healthy environments. We will continue our work in detecting emerging pathogens, in the immunization of large populations, and in the understanding of the long-term effects of toxic agents on health. Our research and educational roles will continue to benefit veterans and non-veterans alike. Our pioneering work in patient safety has the potential to improve health care for all. We will work with community partners to combat homelessness and to coordinate care for veterans. VA's influence on the nation's health goes well beyond its primary mission of providing care for veterans.

We will continue our efforts to integrate our research and educational roles with our rapidly changing care delivery system. VA's research program, the recipient of three Nobel Prizes and a plethora of other awards, concentrates on health care concerns that are prevalent among veterans. VA fosters multidisciplinary research, pilot studies, and research training for teams of

investigators unraveling questions concerning such health issues as cancer, multiple sclerosis, Hepatitis C, kidney disease, depression, stroke, Alzheimer's disease, heart attack, lung disease, bone disease, Parkinson's disease, diabetes, gastrointestinal disorders, and wound healing. VA's research program also pursues research at the interface of health care systems, patients, and health care outcomes. The priorities have expanded to include access to health care, managed care strategies, the effect of facility integrations, changes in clinical services organization with line management, and ethnic, cultural, and gender issues as they relate to health services use. Many VA research studies have been used within and outside VA to assess new technologies, explore strategies for improving health outcomes, and evaluate the cost-effectiveness of services and therapies.

VA's research program will continue its decidedly clinical focus as a unique national asset. To this end, VA Research intends to lead the nation in multi-site clinical trials, rehabilitation research and development, and health services research and development. The majority of research allocations will continue to be devoted to health services research and research with potential clinical applications. Lastly, VA's research program, through the high quality of its research offerings, will attract and retain highly trained clinician researchers who will continue to enhance the VA's patient care mission.

VA's training mission is accomplished through academic affiliations with many of the nations' medical schools and other schools in health sciences, an important and unique characteristic of the VA health care system. VA remains the nation's largest provider of graduate medical education. Affiliations with 107 of the nation's 125 medical schools provide the context for training that annually affects over one-third of the nation's medical resident trainees, including half the nation's third and fourth year medical students. In addition, over 54,000 associated health trainees in nursing, psychology, pharmacy, and over 40 other disciplines receive part or all of their clinical training in VA facilities. We currently fund approximately 9,000 positions in graduate medical education. As residents rotate through these positions, they are exposed to the best evidence-based

medical practices in the country. They take this knowledge with them as they complete their training and begin their careers in the care of veterans and non-veterans. VA can claim it has trained, at least in part, more than half of the nation's practicing physicians.

VA's academic affiliations are robust and provide vigorous opportunities for providing the best approaches for continuous improvement of health care for veterans while contributing to strengthened academic medical institutions throughout the country. We must work hard to keep them healthy.

In providing medical contingency backup for the Department of Defense, VA supports DoD's medical system during wartime. VA also assists the Public Health Service, The Federal Emergency Management Agency (FEMA) and the National Disaster Medical System (NDMS) in providing emergency care to victims of natural and other disasters. Under Presidential Decision Directive 62 (Combating Terrorism), VA works with the Department of Health and Human Services to procure stockpiles of antidote and other necessary pharmaceuticals, and to train medical personnel in NDMS hospitals for responding to the health consequences of the use of weapons of mass destruction. VA is uniquely positioned to do this training since it represents a large portion of the Nation's medical capability and has facilities located throughout the country. I cannot stress too much the importance of VA's role in emergency preparedness and response, and I will work to ensure that VA remains able to meets its obligations.

In summary, Mr. Chairman, VHA has chosen goals that would challenge any organization. Our organization has undertaken a profound transformation and should be justifiably proud of its accomplishments. However, we must continue to change and adapt as changes in information technology, biotechnology, health care financing, and public accountability impact all health care systems. Additional gains in health care value are possible if we are able to manage health information more effectively, improve care coordination and communications with our patients, eliminate variability in care and change our infrastructure as needed to meet current needs. As we look to the future of VA

health care, we are very optimistic that VA will meet the challenges it faces and will be viewed as a model health system for its many accomplishments.

Question 5: Dr. Garthwaite: I understand that VHA has a good record in the area of treating patients with Alzheimer's Disease and other brain disorders that strike older veterans. However, the Committee is concerned that more needs to be done. This Committee recommended on March 12, 2001 in its budget report to the Committee on the Budget that additional funds be added to VA's requested budget for fiscal year 2002 for Alzheimer's Disease and other dementias. Should additional funding be available for these brain disorders, how will you ensure VHA meets its objectives in these areas?

Answer: The current President's Budget supports several programs related to brain disorders. VHA would consider expanding existing programs if additional funding is provided for this purpose. These existing programs include:

- Dementia special care units which use the Bedford VA GRECC (Geriatric Research, Education and Clinical Center) palliative care model.
- Home-Based Primary Care Teams participate in the AHEAD (Advances in Home-Based Primary Care for End of Life in Advancing Dementia) rapid-cycle, quality improvement project.
- Adult Day Health Care services for veterans with dementia, includes specialized VA-operated programs and increased contract capacity.
- VA networks participate in the Chronic Care Networks for Alzheimer's Disease replication project.
- Many VA facilities have an UPBEAT (Unified Psychogeriatric Biopsychosocial Evaluation and Treatment) program that includes dementia services.

Question 6: Mr. Secretary: The President's budget "Blue Print" proposes a special Presidential panel this year to examine the VA health care system. What more can you advise the Committee about the goals and timetable of the President's task force? Also, will Congressional representation be afforded on the task force itself?

Answer: Both the budget and the President's National Security Directive on Military Quality of Life reflect the Administration's commitment to improve VA health care for those veterans eligible for treatment in the system by enhancing access to timely, high-quality care. The President will convene a Veterans Health Care Task Force to include individuals from VA and DoD, leaders of veterans and military service organizations, and leaders in health care quality to make recommendations for improvements. The exact composition of the task force has yet to be determined.

I have had preliminary discussions with Secretary Rumsfeld regarding the Task Force and the need for better coordination of health care benefits between VA and DoD. At this time, we are consulting with the Administration to work out the details of our approach.

Question 7: Mr. Secretary: In our hearing you briefly touched upon the Administration's intent to seek legislation to ensure that DOD beneficiaries who are eligible for VA medical care enroll with only one of these agencies as their health care program. Would the enrollment be irrevocable for a specific period? Would exceptions be made for some forms of long-term care or subspecialties that DOD may not presently provide? How would the veteran's choices relate to use of Medicare and Medicaid programs? When do you anticipate we will receive this proposal?

Answer: The Administration intends that beneficiaries can change their enrollment annually between agencies if desired—an "open-season" approach. We anticipate that all VA medical centers will become network providers within

the TRICARE networks, and specialty programs that VA excels at, including long-term care would be available through that avenue. Currently, 137 VA medical centers are TRICARE providers. We are very cognizant of the unique strengths of both our system and DoD's system and will continue to work to assure that veterans' medical care needs are provided in the most appropriate setting. Veterans would continue to be eligible for Medicare and Medicaid. This enrollment process would only relate to the use of DoD and VA medical care services. Hopefully, in the future, we can start to discuss a coordinated federal medical benefit. This legislative proposal is included in the General Purpose language of the President's DoD Budget.

Question 8: Mr. Secretary: VA is mandated by law to maintain capacity for a number of specialized programs (VA's list includes Spinal Cord Injury, Traumatic Brain Injury, seriously mentally ill and substance-use disorders, blind rehabilitation, and PTSD inpatient programs) at the level that existed on September 30, 1996. The law also imposes a capacity floor on VA's long-term care programs at the level of capacity that existed on September 30, 1998. It does not appear to the Committee that VA is maintaining some of these capacities as required. What actions do you plan to take to reverse this trend?

Answer: Since 1996, we have moved from inpatient care to outpatient models in medicine, surgery, and mental health. The number of patients treated for spinal cord injury and dysfunction, blind rehabilitation, and traumatic brain injury has increased over the 1996 baseline. Also, the numbers of patients seen with serious mental illness, for homelessness, or suffering with PTSD have increased. Fortunately, the number of patients needing amputation has decreased due to our aggressive management of vascular disease and diabetes. VA will continue to monitor these programs through VHA's performance management program which includes outcome, care process and capacity measures for the special disability programs.

The number of patients with substance abuse treated has decreased, especially between FY 1999 and FY 2000. Early this year, as authorized by the Veterans Millennium Health Care and Benefits Act, we provided over $9.0 million in funding to 31 facilities to expand substance abuse treatment capacity. We expect this increased funding will begin to increase treatment capacity during this year. However, we are working to better understand the reasons for this decrease in use of specialized substance abuse treatment programs and to assure access to substance abuse programs in our clinics as well as in our larger facilities. To this end, I plan to establish a National Mental Health Improvement Program (NMHIP). This program will be modeled after a number of well-established VA data-driven improvement programs, such as the Continuous Improvement in Cardiac Surgery Program (CICSP), the National Surgical Quality Improvement Program (NSQIP), the VA Diabetes Program, the Pharmacy Benefits Management Program (PBM), and the Spinal Cord Injury/Dysfunction National Program. This new program will use validated data collection, expert analysis, and active intervention by an oversight team to continuously improve the access, outcomes, and function of patients in need of our mental health programs. These programs include those for patients who are Seriously Chronically Mentally Ill, or who suffer from Post Traumatic Stress Disorder, Substance Abuse, or Homelessness. This program will draw upon existing resources in our Health Services Research and Development Service (HSR&D) including existing initiatives in our Quality Enhancement Research Initiative (QUERI) and our Mental Health Strategic Health Care Group (MHSHG) including the Northeast Program Evaluation Center (NEPEC).

Regarding the requirement of the Veterans Millennium Health Care and Benefits Act to maintain long-term care capacity, VHA is reviewing the FY 1998 baseline data and plans to issue a directive to Networks by the end of May to establish plans, performance monitoring, and Headquarters oversight for meeting this requirement. Early indications from the data may show a decline in some workload and staffing from FY 1998. This is particularly the case when only VA-

operated services are considered, namely, VA Nursing Homes, VA Domiciliaries, VA Home Based Primary Care and VA Adult Day Health Care Programs. However, when contract and State Home Programs are added to the direct VA effort, the capacity requirement is nearly met, especially for the areas of patients treated and average census. Using the broader definition of extended care services, implementation of the FY 2002 budget will resolve any deficits in capacity.

Question 9: Mr. Secretary: In November 1999, the Veterans Millennium Health Care and Benefits Act was signed into law. Many of the implementing regulations are still pending promulgation, including the reduction of the VA outpatient care co-payment from approximately $50 to $12 or $15. In my view, there is no sound reason to delay this regulation to reduce outpatient co-payments, and I believe further delay is unnecessary. Will VA expedite the co-payment regulation? When can the Committee expect its publication?

Answer: After I reviewed the proposed regulation to reduce the outpatient co-payment, I requested that the Under Secretary for Health update the initial analysis on outpatient co-payments and provide additional recommendations. A work group has been tasked to complete this process by the end of this month. Upon receipt of the updated recommendations, I will decide the outpatient co-payment amount, and proposed regulations will be written. We will work with OMB to expedite the review and publication of the proposed regulations. Given the lengthy regulatory process, we estimate the revised outpatient co-payment will be implemented in early 2002. We will make every effort to expedite this process and hope that we can implement the changes sooner than our projected date.

Question 10: Mr. Secretary: As indicated above, we required VA to hold capacity of its long-term care programs up to the level that existed on September 30, 1998. Although 16 months have passed, the parameters of measurement for this baseline have not been established. The Committee plans to vigorously monitor long-term care capacity. Please inform the Committee what the status of VA's compliance is.

Answer: VHA is reviewing the FY 1998 baseline data on long-term care capacity and plans to issue a directive to Networks by the end of May to establish the parameters for meeting this requirement. The directive will include performance monitors, as well as Headquarters oversight for meeting this requirement. Early indications from the data may show a decline in some workload and staffing from FY 1998. This is particularly the case when only VA-operated services are considered, namely, VA Nursing Homes, VA Domiciliaries, VA Home Based Primary Care and VA Adult Day Health Care Programs. However, when contract and State Home Programs are added to the direct VA effort, the capacity requirement is nearly met, especially for the areas of patients treated and average census. We believe that the additional funding requested for extended care services in the FY 2002 budget will resolve any deficits in capacity.

Question 11: Dr. Garthwaite: At the end of the last Congress, the Committee dealt with a number of bills by individual Members authorizing land transfers from VA to various interests. Many of these bills became law as a part of Public Law 106-419, the Veterans Benefits and Health Care Improvement Act of 2000. Given VA's extensive land holdings, please examine the potential for additional land transfers this year and next year and provide the Committee with advance information concerning the potential for such transfers, along with VA's assessment of the cost benefit of making them.

Answer: VA recognizes that some percentage of its holdings may be underutilized. VHA's Capital Asset Realignment for Enhanced Services (CARES) program has been implemented to improve access and quality of veterans' health care through realignment of our capital assets. Ultimately, land transfer or other disposal may be determined as the most beneficial alternative

for some of these underutilized assets. However, we have not identified any particular parcels for transfer at this time and feel that a departmental evaluation and planning process should be the basis for future decisions.

Question 12: The Department of Veterans Affairs Act (Public Law 100-527) established a statutory staffing floor for the Office of Inspector General of 417 FTE. Section 9 of the Act requires that the budget transmitted to Congress for each fiscal year be sufficient to support the statutory floor. This requirement is codified in U.S.C. 38, Section 312. In September 1999, the IG testified that the IG's staffing was 360 FTE. What is the IG's current staffing? Does the VA have any intention to budget to staff the IG to the statutory floor? How much money would this take?

Answer: The OIG's budget for FY 2001 supports 369 FTE funded by direct appropriation. As of March 31, 2001, the OIG had 356 FTE on board with open vacancy announcements to fill the remaining positions. The FY 2002 request for the OIG will fund 366 FTE. To reach the statutory floor of 417 FTE the OIG needs another 51 FTE, at an additional cost of $7.5 million. VA will consider resource needs for the OIG along with other Department priorities.

Congressman Lane Evans

Question 1: As you know, waiting times for outpatient care appointments continue to be problematic. We are told that although VA requested and we provided additional resources ($77 million) in FY 2001 for specific initiatives to alleviate waiting times, VA was unsure that the resources were spent on these initiatives and, in fact, had no means of tracking how these funds may have been used. Do you have a plan for dealing with waiting times, and if so, will the plan require additional resources?

Answer: VA has established aggressive national goals to reduce waiting times for regular primary care and specialty appointments to 30 days and to see patients within 20 minutes of their scheduled appointment time by the end of FY 2003. To assist in this effort, in July 1999, VHA and the Institute for Healthcare Improvement (IHI) launched a Breakthrough Series Collaborative on Reducing Delays and Wait Times. 132 facility teams from each of the 22 VISNs participated. Over the course of the six- month collaboration, these teams reduced the median wait for an appointment for both primary and specialty care clinics from 48 to 22 days, an improvement of 54 percent (26 days). Recognizing the need and the challenge to continue to spread or diffuse improvements made in one site, facility and/or VISN to other areas across the system, VHA is again collaborating with IHI to continue the work already started on improving our waiting times and delays.

This initiative will focus on spreading changes to six clinics highlighted in the network performance contract, specifically, orthopedics, urology, cardiology, audiology, primary care, and eye care. IHI will work with VHA to:

- Enhance, strengthen, and re-direct, if needed, the current spread activities going on within each VISN to help VHA achieve the performance targets.
- Develop a prototype infrastructure for managing the spread innovation based on the previous collaboration that can be applied to other clinic and operational topics.

In addition to our work with IHI, we have made a concerted effort to accurately measure clinic appointment waiting times. In February 2001, VHA enhanced our measuring system so that waiting times for nearly every patient treated by VHA is being measured. The software used for creating the measurements has been improved so that it is simpler and easier to work with, thereby, improving the accuracy of the information derived from this system.

The following information provides a status of the progress made in the six clinics identified in the network performance contracts.

	VHA	2000 Apr	2000 May	2000 Jun	2000 Jul	2000 Aug	2000 Sep	2000 Oct	2000 Nov	2000 Dec	2001 Jan	2001 Feb	Dif Feb-Apr	% Dif
Waits	Prim	65.1	64.4	63.8	62.8	61.8	60.4	60.5	58.2	58.5	56.1	54.6	-10.5	-16.1%
Waits	Eye	101.0	94.2	93.6	88.0	90.1	83.7	86.7	89.8	89.1	80.6	83.7	-17.3	-17.1%
Waits	Audio	49.9	50.1	52.1	50.2	47.1	40.3	43.8	44.4	47.1	43.9	45.3	-4.6	-9.2%
Waits	Cardio	51.7	53.0	48.0	47.0	45.4	44.5	44.3	43.6	44.7	41.8	40.8	-11.1	-21.5%
Waits	Ortho	44.6	46.7	44.8	42.0	44.6	40.1	43.3	43.4	43.1	45.3	40.8	-4.0	-9.0%
Waits	Urol	80.7	78.7	74.1	72.5	69.3	69.1	67.8	71.6	74.1	77.1	67.8	-12.9	-16.0%

Question 2: Congress was asked to provide additional funds for Hepatitis C in the FY 2001, but we have since discovered that those funds were not used to care for veterans with Hepatitis C. Yesterday, we learned that VA Chicago's Gastroenterology (GI) Clinic has waiting times of up to 214 days due to the

growth in its Hepatitis C workload. Is there a plan for ensuring that the funding you request from Congress is used for its intended purpose?

Answer: VA overestimated its hepatitis funding need in the FY 2001 budget request. Last year's budget identified an estimate of $340 million for hepatitis C. The latest estimate is $152 million, and the associated baseline adjustment in the FY 2002 submission is thus a reduction of $188 million ($340 million minus $152 million). This corrects the funding base for this program to the $152 million level in FY 2001 before an initiative increase of $20 million is requested in FY 2002. For FY 2001, VA changed the VERA methodology to fund hepatitis C in both Basic and Complex Care, based on appropriate diagnostic and active therapy.

To ensure veterans with hepatitis C receive state-of-art health care services and treatments, VA continues to expand and refine implementation of its hepatitis C initiatives. Screening for hepatitis C risk factors, followed by blood tests when appropriate, is performed throughout the VA health care system. For veterans who are hepatitis C positive, treatment options are available when clinically appropriate to patients. All drugs and diagnostic tests approved for the treatment of hepatitis C are available for use in VA. If treatment for hepatitis C is not appropriate, veterans receive education and counseling in risk reduction and further transmission, as well as long-term monitoring or "watchful waiting." In order to reach out to veterans with specific concerns about hepatitis C, VA has worked with the American Liver Foundation to develop an informational brochure to provide all veterans with important information about hepatitis C risk factors, natural history, and testing. This brochure will be distributed to approximately 3.5 million veterans currently utilizing VA medical services.

VHA recently provided a comprehensive report on hepatitis C to the House and Senate, VA, HUD and Independent Agencies Appropriations Subcommittees. A copy of that report is attached.

Relative to the VA Chicago Health Care System, the most recent waiting times data through February 2001, demonstrates that the waiting times to a first available GI appointment at VACHCS (Lakeside and Westside) is 112 days. At the Lakeside Division, where overall waiting times are longer, the average wait time for a first appointment for patients with hepatitis C is 34 days. The average wait time for GI endoscopy is 4 days at Westside and 0 days at Lakeside.

To help resolve the waiting times problem, a new GI clinic was started in December 2000 at the Lakeside Division. The data for this fiscal year will be reviewed to determine the effect of the second clinic on waiting times for the first appointment.

In addition, all medical records of scheduled GI patients (new and old) will be systematically reviewed. Emphasis will be on identifying the reason for referral, the patient's linkage to a primary care physician, any adverse effect related to the waiting time, the frequency and number of follow-up visits within the GI clinic and the need for ongoing GI care in patients being repeatedly seen in the GI clinic.

Department of Veterans Affairs
Veterans Health Administration

White Paper to Inform Congress on Decisions for Hepatitis C Funding

Purpose: As stipulated by the Conference Report 106-988 (page 8) to accompany the FY 2001 Appropriations Act, Public Law 106-377, the conferees direct the Department of Veterans Affairs (VA) to continue adjusting hepatitis C testing and treatment funds as more is learned about the prevalence of the disease and to keep the Committees on Appropriations informed about funding levels and decisions. The purpose of this white paper, pursuant to the requirement in the Conference Report 106-988, is to inform the Congress on decisions for hepatitis C funding.

Background: The House Report 106-674 contains language directing VA to reimburse hepatitis C treatment as a complex care component of VERA starting in fiscal year 2001. In the Conference Report 106-988, the conferees recognized VA for releasing $20 million from the National Reserve Fund in June 2000 to address the growing need for treatment and the geographic differences in prevalence of the disease. The conferees also noted the action by VA in August 2000 to amend the VERA policy to reimburse hepatitis C treatment as a complex care component effective fiscal year 2001.

Implementation Status: On August 24, 2000, the Veterans Health Administration (VHA) Policy Board approved a new VERA allocation format for hepatitis C patients. Specifically, those patients on therapy for hepatitis C will be funded at the complex care level. Hepatitis C patients who are not on therapy will be funded at the basic care level. Therefore, the FY 2001 VERA funding methodology includes recognition of the costs and distribution of hepatitis C patient care workload. The FY 2001 network budget allocations based on the VERA methodology were distributed to VA's 22 health care networks on November 9, 2000.

Attached are detailed analyses that provide a response to the Conference Committee's request for a report regarding hepatitis C expenditures by VHA's Veterans Intergrated Service Networks (VISN) and a summary of FY 1999 and FY 2000 data concerning workload and resource use for hepatitis C diagnosis and treatment in VHA.

Attachments

Response to the Conference Committee's Request for a Report Regarding Hepatitis C Expenditures by VHA

House concerns:

1. The conferees requested a report, by VISN, of the amount of fiscal year 2000 resources spent on hepatitis C testing and treatment, the number of veterans tested and treated for hepatitis C, and the percentage of tested veterans who are infected with hepatitis C. Attachment 1 provides this information with the following caveats:

- The ability to identify and track expenditures for hepatitis C testing and treatment are limited, as explained in Attachment 2.
- Because of duplicate testing, the number of tests exceeds the number of veterans tested. The percentage of tests that are positive should not be interpreted as a prevalence figure, as patients tested are not representative of the entire VA population.
- Expenditures for treatment are based on Pharmacy Benefits Management (PBM) data for the drugs most commonly used to treat hepatitis C. The Allocation Resource Center (ARC) reports $45.2 million in excess pharmacy expenditures for hepatitis C patients. Excess pharmacy costs are calculated by taking the difference between the total pharmacy costs of patients with hepatitis C and the average pharmacy costs of patients in the same classification category.

2. The conferees requested information regarding how FY 2001 funds will be allocated for hepatitis C testing and treatment.

The total amount identified in the FY 2001 budget for hepatitis C-related testing and treatment is $151,627,000 (revised downward from initial projection of $340 million). This is part of the patient care funding distributed to the VISNs according to the VERA model, which is based on workload over the past 2 years for hepatitis C basic and complex classes.

3. The conferees request an examination of whether the Department's allocation methodology provides adequate funding for VISNs with statistically higher percentages of veterans testing positive for hepatitis C.

The VERA model utilizes past workload data in order to direct resources to the areas with the greatest need. For the first time, in the FY 2001 network budget allocations, hepatitis C patients on anti-viral therapy are categorized as "complex care" patients with reimbursement to the VISNs of approximately $43,000 for each year that the veteran is in treatment. This will help to alleviate discrepancies in funding related to geographic variation in the prevalence of hepatitis C infection.

The question of the adequacy of funding is difficult to answer. Globally, while past accounting of hepatitis C expenditures is lower than projected estimates, we believe that current systems are currently not capable of identifying hepatitis C-related care. The overall number of patients treated is also lower than projected estimates. In this case, we believe that some of the estimates were unrealistically high. Furthermore, the acceptance on the part of patients and providers of the benefits of therapy has probably been lower in the past than it will be in the future as more effective and better tolerated therapies are developed. However, we cannot be certain that local choices regarding allocation of available resources amongst a number of critical patient care areas have not created potential disincentives to the diagnosis and treatment of hepatitis C infection. This possibility is being actively investigated by the General Accounting Office (GAO) and by VHA's Office for Public Health and Environmental Hazards. Recent changes to the VERA system will categorize all hepatitis C patients who receive anti-viral therapy as "complex care". The higher reimbursement for care of these patients should help to minimize the financial pressures resulting from differences in local or regional hepatitis C workload.

On a local level, it is possible that VISNs that have provided little hepatitis C care in the past, due to limited resources will not receive as much of the additional allocations for complex care as those which have had the resources to treat many patients. We believe that the best way to examine this possibility is to look for excessive variance in treatment rates, average duration of treatment, treatment results, and other outcome measures among the VISNs. Preliminary analyses in this area do not reveal large variance in the total patient-months of treatment provided in FY 2000 when standardized by the number of known hepatitis C-positive patients. The implementation of the clinical reminders enhancements to the Clinical Patient Record System (CPRS) should enable further investigation of regional and local variance in screening and testing activities.

Senate concerns:

1. The committee was concerned that expenditures for FY 2000 appeared to be considerably lower than estimates. The committee requested that VA report on final FY 2000 expenditures with a full accounting for the discrepancy between original estimates and final expenditures.

The attached report (Attachment 2) provides a detailed examination of how estimates were derived, how workload and costs are accounted, and some of the reasons for differences during FY 1999 and FY 2000. As noted above, an area of large discrepancy involves the number of patients being treated with specific drugs for hepatitis C. It is important to point out that there is continued medical uncertainty about some aspects of hepatitis C treatment, including for many patients with minimal clinical disease, the value of treatment versus the risk of

side effects from treatment. Since hepatitis C infection may persist for decades without clinical symptoms or signs of liver damage, some patients and their providers may opt to defer therapy until more effective, and better-tolerated therapies are available.

We believe that the magnitude of the difference between previous models and actual experience justifies a reexamination of the models and assumptions currently used to project hepatitis C expenditures. As a preliminary step in this direction, the Department has revised the projections for FY 2001 to $151,627,000. The budget planning process for FY 2003 will include a more comprehensive revision of the hepatitis C model.

2. The Committee also directed the Department to expeditiously establish performance goals for hepatitis C initiatives to be included in the FY 2002 budget request.

The Department is aware of the need to establish and monitor goals for quality of care in hepatitis C. As a result of a recent reorganization, the hepatitis C initiatives are now the responsibility of the program offices previously charged with HIV programs. There is already in existence a Center for Quality Management in HIV (Palo Alto), which has taken on hepatitis C quality management as well as database responsibilities for hepatitis C. The Center for Quality Management, the leadership of the Office for Public Health and Environmental Hazards, and the Office of Quality and Performance are currently working together to identify meaningful and measurable indicators of quality and will incorporate these into performance goals for the FY 2003 budget. The plans for creation of a national database which will facilitate this quality management process is further detailed in Attachment 3.

Attachment 1:

VISN	FY 00 estimated expenditures for hepatitis C care (per ARC)	FY 00 Number of blood tests for hepatitis C performed *	FY 00 Number of positive hepatitis C tests *	FY 00 Number of unique hepatitis C positive patients identified	Number of patients with hepatitis C related condition who received medical care in VA during FY 00 **
1	3,207,865	10109	3565	1560	2989
2	1,664,834	7155	2264	684	1307
3	7,745,831	18943	6571	2856	5517
4	5,589,590	18540	12613	2536	4960
5	2,519,966	6756	5260	1372	2976
6	5,198,772	9745	4038	1737	3415
7	4,594,708	15348	4643	1850	3675
8	8,661,677	39319	11897	3332	7410
9	4,548,914	11453	1707	1213	2944
10	3,705,511	14247	4772	1839	3342
11	2,980,355	9112	2136	1072	2512
12	3,807,028	10799	3395	1621	3278
13	1,911,667	13050	1609	745	1423
14	1,809,695	11548	765	602	1064
15	3,624,924	9899	3219	1519	3106
16	8,107,585	39152	7767	3646	7450
17	4,847,919	9865	3925	1725	3701
18	4,123,286	11631	2982	1255	3496
19	2,724,992	7224	1238	645	1815
20	5,607,975	15062	4572	2049	4268
21	5,831,184	14861	4848	2078	5165
22	7,490,944	29964	13723	3490	6273
TOTAL	100,325,222	333,782	107,509	39,426	77,886

* Per Emerging Pathogens Index (EPI). Fourth quarter data for FY 00 are not currently available. More than one test may be performed per patient due to need for confirmation of test results.

** Includes 63,348 patients with hepatitis C who had: 1) an inpatient diagnosis related to hepatitis C *or*, 2) at least two episodes of outpatient care identified as primarily related to hepatitis C, *or* 3) pharmacy costs that exceeded the average for patient of the same age and VERA classification. Also included are 14,538 hepatitis C patients who did not meet any of these criteria.

Attachment 2

Summary of FY 1999 and FY 2000 Data Concerning Workload and Resource Use for Hepatitis C Diagnosis and Treatment In Veterans Health Administration (VHA)

1. Introduction

Hepatitis C infection is a major public health problem with enormous and growing implications. Up to 10,000 deaths per year in the U.S. are attributable to hepatitis C, and chronic liver disease is the 10th leading cause of death among American adults. Unless there are significant improvements in therapy, the number of hepatitis C-related deaths is expected to triple in the next 10 to 20 years.

Hepatitis C infection is a major concern for the Veterans Health Administration (VHA). With a large number of veterans known to be infected with hepatitis C, VHA has given the highest priority to addressing this public health problem. The exact prevalence of hepatitis C infection in the veteran population is unknown. Previous budget models, based on limited survey data, have estimated a prevalence of 6.6 percent. Over 70,000 current users of VA medical services are known to have tested positive for hepatitis C. These figures indicate that the number of veterans with hepatitis C infection is very large, but the data currently available are insufficient to define accurately the extent of the problem.

2. Reconciling projections and actual figures for workload and costs

Recognizing that there were indications of extraordinary needs associated with hepatitis C diagnosis and treatment within VA, efforts have been underway to estimate the required workload and resource allocation. Specific funding for hepatitis C screening, diagnosis, and treatment made up part of VHA's budget for FY 2000 and 2001.

As we have begun to gather actual data, we realize that there are significant limitations to both the formulas used to calculate the estimates and the accounting of actual costs associated with hepatitis C testing and treatment. The following attempts to bridge some of the differences between estimated and actual costs and to explain some of the limitations of the original estimates and of the available data. Following this summary is an outline of some of the plans in place to improve our access and utilization of data to rectify some of these limitations.

3. Data overview

The hepatitis C data contained in this document are displayed along treatment components. The data labeled "Projected" indicate the values forecasted from VA's model. The VA model used treatment and implementation assumptions for hepatitis C based on information available during the formulation of the FY 2000 budget. The values labeled "Actual" are preliminary figures based on the Emerging Pathogens Initiative (EPI) and the Pharmacy Benefits Management (PBM) group. These represent the best values that VHA's financial system can directly relate to hepatitis C, but do not include all related costs. The values labeled "ARC estimate" are the values VHA reports as its actual obligations since ARC derives the associated hepatitis C treatment costs and this reflects VA's best capturing of these costs. The ARC data include treatment pattern assumptions as explained in the report. VHA plans to revise hepatitis C future projections based on actual experience and improved research to more accurately project and capture the costs associated with the treatment of hepatitis C.

Number of veterans screened for hepatitis C risk factors:

	FY 99	FY 00
Projected[1]:	413,277	984,930
Actual[2]	143,286	353,096
ARC estimate [3]	303,924	478,152

[1]The projected number is based on estimates of the total number of both new and current users, and estimates of the proportion of those who will be evaluated (screened for risk factors or received a blood test) for hepatitis C.

[2]The actual number is a preliminary figure derived from enhancements to the EPI system, which permitted collection of data from the clinical reminders package of the Clinical Patient Record System (CPRS). The clinical reminder (to screen for hepatitis C infection) is satisfied when there is a positive or negative antibody test result, or a hepatitis C-related diagnostic code, or a manual entry indicating that screening has been completed. Since the provider-interface portion of the package is still not fully implemented, data on screening for risk factors and offering of hepatitis C tests is not being fully captured. Thus, these numbers should be considered the minimum number of patients screened.

[3]The ARC estimate is based upon a formula of 1.2 times the number of people tested. This estimate is based on limited survey data, which suggested that approximately 80 percent of patients who were screened had the presence of risk factors which indicated the need for a blood test

Number of antibody tests:	FY 99	FY 00
Projected[1]	unknown	unknown
Actual[2]	235,262	333,782
ARC estimate[3]	253,270	398,460

[1]The budget projection combines screening for risk factors and serologic (blood) testing into "evaluation." Therefore, the projections do not distinguish the patients who are screened from those who are tested.

[2]The actual number comes from the EPI surveillance system, which collects data from each facility each month. Approximately 95 percent of possible months of hepatitis C virus (HCV) data for FY 00 have been forwarded to EPI. The number of unique persons tested is lower than the number of tests due to redundant testing for confirmation of initial test results. The number of unique persons tested was 161,143 in FY 99 and 214,750 in FY 00.

[3]The ARC estimate is based on a formula of 10 times the number of unique persons with a positive test (i.e. 10 percent of people tested will have a positive test result). Thus, this number estimates the number of unique persons tested rather than the total number of tests.

Number of unique hepatitis C patients identified:		
	FY 99	FY 00
Projected[1]	27,276	65,005
Actual[2]	34,841	39,846

[1]The projected number assumes a 6.6 percent positive rate among patients evaluated. This is based upon prevalence estimates of HCV infection in the VA population. There is, in fact, no reliable measurement of prevalence for the entire VA population.

[2]The actual number is based on unique patients with a positive test in that year from the EPI surveillance program.

Number initiating therapy:	FY 99	FY 00
Projected[1]	4,612	13,674
Actual[2]	2,830	4,455

[1]The projected number is based upon an estimate that 20 percent of patients will be eligible for therapy (i.e. they will have appropriate indications based on liver histology and other indicators of disease stage) and that 80 percent of those will accept treatment (no contraindications and agree to treatment). These estimates were based on scientific literature and the professional estimates of our VA liver disease experts available at the time.

[2]The actual numbers come from PBM data. This includes patients treated with combination therapy (interferon plus ribavirin) and those on interferon monotherapy. The portion of patients receiving combination therapy was 74 percent in FY 99 and 92 percent in FY 00.

Average duration of therapy:	FY 99	FY 00
Projected[1]	10.2 months	10.2 months
Actual[2]	4.8 months	5.0 months

[1]The projection estimates that 30 percent of patients will complete 6 months of treatment and the remaining 70 percent will complete 12 months of treatment.

[2]The actual average duration of therapy is based on PBM data and suggests that the model overestimated duration of therapy. It is likely that in real world settings (as opposed to research trials), a far larger percentage of patients discontinue therapy early due to lack of response or to side effects.

Total hepatitis C anti-viral drugs:	FY 99	FY 00
Projected costs[1]	$15,171,000	$90,900,000
Actual costs[2]	$10,644,934	$19,727,832
Excess pharmacy costs:[3]	$20,853,922	$45,239,562

[1] The projected costs are based on an estimated cost of $1,144 per month for drug treatment. The budget model spreads the costs for patients initiating therapy in any given year over two years.

[2]The actual figures are from PBM data.

[3]Excess pharmacy costs are those that exceed pharmacy costs expected for patients in the same VERA classification.

Total costs:	FY 99	FY 00
Projected	$46,280,000	$195,089,000
Actual	unknown	unknown
ARC estimate[1]	$46,054,919	$100,325,222

[1]Following is a summary of the accounting methods used by ARC to calculate the yearly total costs associated with hepatitis C screening, testing, and treatment.

Patient identification. A cumulative list of hepatitis C patients is maintained. The following diagnoses are used for both inpatient and outpatient care: 070.41 (acute or unspecified hepatitis C with hepatic coma); 070.44 (chronic hepatitis C with hepatic coma); 070.51 (acute or unspecified hepatitis C without mention of hepatic coma); and 070.54 (chronic hepatitis C without mention of hepatic coma). Patients are identified by the following criteria:

Inpatient Diagnosis. A patient is included in the cumulative list if: a) the patient has a primary diagnosis from the list above, *or* b) if the patient has a secondary diagnosis from the list above and a primary diagnosis of MDC 7, Diseases and Disorders of the Hepatobiliary System and Pancreas (DRGs 191-208).

Outpatient Diagnosis. If a patient has two or more outpatient encounters with a diagnosis from the above list.
Positive Lab Test. Information is retrieved from the EPI database which maintains a list of all positive lab tests for hepatitis C.

Cost Identification. Specific costs are calculated for services used by patients identified in the above criteria. There is also an imputed cost for screening, testing, and counseling.

Inpatient Cost. All costs associated with an admission where there is a primary diagnosis or for care received in MDC 7.
Outpatient Cost. All costs associated with care provided where the primary diagnosis is for hepatitis C.
Pharmacy Cost. Pharmacy costs for the above identified individuals are included that exceed the average pharmacy cost that would be expected for patients of that type (VERA classification) and age.
Counseling Cost. All patients who have tested positive in the current fiscal year are expected to be counseled. The cost estimate is $100 per counseling episode.
Lab Test Cost. The cost of a lab test is estimated at $30. The anticipated positive rate is 10 percent. Therefore, the number of lab tests is calculated at 10 times the number of positive tests. Costs are assigned for both positive and negative tests.
Screening. Some survey data from selected sites have suggested that approximately 80 percent of individuals who are screened have sufficient risk to be tested. Therefore, the number of screened individuals is estimated in the model by multiplying the number of lab tests by 1.2. The estimated cost for screening is $30.

3. Summary

The potential magnitude of the hepatitis C problem in VA was recognized early, as was the need to plan accordingly by developing estimates and projections of the resource needs for responding to the hepatitis C epidemic. Unfortunately, there were few data available upon which to base these projections and estimates. Furthermore, there was no comprehensive system in place to collect information about the actual workload and costs associated with hepatitis C care. To some extent, these deficiencies in data (due to both gaps in our knowledge about the epidemiology of hepatitis C in the VA population as well as limitations in available data collection systems) still exist, although steps have been taken to remedy these problems. Now that we have some reliable data, we know the methods used earlier to estimate the projections and the actual costs can be refined.

- The **projections** were based on formulas that relied upon untested assumptions about hepatitis C prevalence and treatment rates. These assumptions were informed by very limited data relevant specifically to VA, and upon expert opinion (best guesses), but could not be based on any real data pertinent to VA populations, since no data existed at the time.

- The **ARC estimated expenditures** are based on a combination of calculated estimates (working back from the number of positive tests) as well as on attempts to actually account for hepatitis C-related expenditures and workload. This accounting system must frequently rely upon indirect identification of hepatitis C patients (hepatitis C patients are identified through the diagnostic coding of individual episodes of care) and the inadequate identification of hepatitis C-related care based on a system of diagnostic coding which provides no incentive or feedback to the coders to so identify episodes of care. For example, patients receiving or contemplating hepatitis C anti-viral therapy may need alcohol cessation therapy, treatment for depression (which is frequently related to or exacerbated by interferon therapy), or more frequent monitoring of co-morbid conditions which may be affected by hepatitis C therapy. It is unlikely that these episodes of care would be coded as primarily related to hepatitis C. Therefore, it is very likely that this system of accounting seriously underestimates the real utilization of resources in the field.

Specific limitations in the **projections** include:

1. The true prevalence of hepatitis C in veterans who utilize VA medical care services is unknown. This is a key factor in the projection formula.
2. Since most patients are tested because of known risks or clinical evidence suggestive of hepatitis, the prevalence rate for hepatitis C among those already tested is probably much higher than for VHA users as a whole. Thus the extrapolation of current prevalence estimates to the entire VA population results in overestimates of the number of new cases expected to be identified.
3. The projection formula estimates that 20 percent of cases are 'treatable' and that 80 percent of these patients will accept treatment recommendations to begin anti-viral drugs. Data show that 4 to 5 percent of patients with a hepatitis C diagnosis are actually being treated currently. This large difference may be due to the fact that more people than originally hypothesized are ineligible (due to contraindications), are not appropriate candidates for treatment according to current treatment guidelines, or have decided to defer therapy based on the slow pace of disease progression and the expectation that better therapies may be available soon.

4. The average duration of therapy estimates were best-case scenarios based on experiences in the clinical trail settings. As with many therapies, the number of patients who can adhere to and tolerate treatment is much lower in the real clinical settings.

Specific limitations in accounting for **ARC estimated expenditures** include:

1. Identification of patients with hepatitis C is done partly through coding of inpatient and outpatient diagnoses. Because funds allocation of funds for care to VISNs and facilities is largely independent of coding, reliance on coding data likely under-represents actual costs.
2. This measurement error is magnified by only assigning costs to those episodes of care that carry diagnostic coding for hepatitis C. Thus, when there is undercoding due to multiple diagnoses, costs of care may be unaccounted even for those who were previously identified as hepatitis C patients.
3. Specifically, costs for a wide range of care required for optimal hepatitis C care (including care for toxicities of treatment, substance and alcohol abuse, mental health, and complications of advanced hepatitis) will be missed unless a hepatitis C DRG is coded as an inpatient or outpatient diagnosis.
4. This model includes pharmacy costs, which exceed normal. Thus, it does not identify costs for hepatitis C-related conditions or costs that are considered to be within a normal range.
5. The estimated expenditures that are reported for screening and testing are derived from a formula based on the number of positive hepatitis C tests. These estimates may be incorrect. In particular, the estimate that only 1.2 times the number of patients tested has received risk factor screening is very conservative.

Attachment 3

Plans for improving VHA hepatitis C data collection and management

In order to better estimate the scope of hepatitis C infection and its associated costs within the VHA system, there is a need to augment current systems of data collection. Many of the limitations of current data and estimates have been clearly defined in other portions of this report.

VHA, in response to this need, is working on several fronts to improve hepatitis C-specific data, with the goals of:

1. More reliably measuring the prevalence of hepatitis C infection within VHA.
2. Ensuring adequate funding and resource allocation to care for infected veterans.
3. Measuring treatment outcomes across the VHA system.
4. Measuring the short- and long-term effectiveness of current treatment protocols to improve clinical standards.
5. Improving the efficiency and quality of VHA hepatitis C care.
6. More accurately measuring the full range of services provided to hepatitis C-infected veterans which will lead to more accurate measurement of expenditures.

To achieve these important goals, we plan to: maximize the utility of existing data sources, create a new hepatitis C data registry and conduct appropriate scientific research to better understand the scope of hepatitis C within VHA.

A. Maximizing the utility of existing data sources
(not specific for hepatitis C but containing relevant data):

Current VHA sources of data about hepatitis C are limited. The EPI system is a surveillance tool designed for the limited purpose of monitoring trends in rates of important infectious diseases. In 1997, the EPI database began to track the number of people tested for hepatitis C in the VA system and the number of individuals with positive tests. Recent enhancements to the system have created the potential for supplementing this information with additional clinical, laboratory and treatment data, as well as the collection of information regarding screening for hepatitis C risks. These enhancements were installed nationally in August 2000 and FY 2000 fourth quarter reports should have improved capture on rates of hepatitis C screening and test.

In addition to EPI data, VHA obtains information from PBM data and from the Austin Automation Center (AAC) on health care utilization. The PBM data are limited to the review of specific drug utilization (e.g., those used to treat hepatitis C) and provide no information about the patients or the outcomes of therapy. PBM data are very useful but have limitations. For example, we cannot

determine in every case whether these drugs were prescribed for hepatitis C treatment since some are used to treat other conditions as well. AAC data, primarily the outpatient and inpatient packages, provide a limited picture of resource utilization and are dependent upon provider coding of clinical encounters.

In order to maximize the utility of these data sets and to improve communication between VA program offices and the managers of these data sets, standardized hepatitis C-specific reports from these national databases are in development and will be provided to the Office for Public Health and Environmental Hazards quarterly and semi-annually in FY 2001.

B. Creation of Hepatitis C Registry

To ensure accurate and timely specific data on veterans with hepatitis C to be used for program oversight as well as quality improvement, we propose the creation of an electronic database for the monitoring of patients with hepatitis C infection in the VA system. The proposed hepatitis C registry will contain important demographic and clinical data on all VHA patients identified with hepatitis C infection. The registry will be linked to existing pharmacy, laboratory, and pathology databases in order to provide the key clinical information needed to track disease stage, disease progression, and response to treatment. Once a patient is in the registry, links to the existing AAC/Decision Support Systems will capture workload in terms of clinic visits, hospital stays, etc., regardless of the diagnostic coding of individual episodes of care.

The specific aims for developing a hepatitis C registry include:

1. Identifying veterans known to have hepatitis C infection.
2. Describing their spectrum of disease, as identified by clinical information.
3. Describing the patterns of care they receive—specifically focusing on hepatitis C therapy.
4. Describing patient responsiveness to therapy—based on clinical laboratory markers.
5. Describing long-term outcomes (i.e., rates of morbidity, development of end-stage liver disease, liver transplant, liver cancer, and death).
6. Identifying emerging associated health problems, whether related directly to hepatitis C infection, common co-morbid illnesses, or hepatitis C treatment.
7. Developing proactive quality improvement mechanisms to improve hepatitis C care practices and patient safety.

The implementation of such a registry will require the development of a new national software system to interface with existing electronic medical records. Such a system will not only require significant programming and development time, but also ongoing staffing to assure data collection accuracy and consistent

data definitions across VHA facilities and databases. Specialized attention must be paid to issues of record security and confidentiality.

VHA staff have been designated to take the lead on this project and preliminary specifications are in development. Depending on the final format determined for the database, actual software development is expected to begin within six months, including pilot testing and data validation. The software will then be launched nationally (second to third quarter of FY 2002) and data collection will be in place by the fourth quarter of FY 2002.

C. VA National Hepatitis C Prevalence Study

The true prevalence of hepatitis C among users of VHA facilities and/or veterans as a group is unknown. Risk factors specifically associated with *veterans'* exposure to hepatitis C are also unknown. Risk factors hypothesized include blood exposure during combat, tattooing, drug use during active service or after discharge, or other lifestyle factors. VHA will launch a scientifically sound study, supported by VHA Research Service, to measure hepatitis C prevalence among VA users, and to identify risk factors associated with hepatitis C infection. The study is expected to begin in the third quarter of FY 2001 with results available in the third quarter of FY 2002.

Question 3: As you have already heard, Congress is concerned about VA's failure to comply with its requirement to maintain capacity in its specialized programs for disabled veterans. While programs for substance abuse and for the seriously mentally ill veterans with substance abuse problems have clearly dropped workload, VA seems to be treating as many patients as it is required in other specialized programs. However, in almost every program, VA is not spending the same amount as it did (in constant dollars) in specialized services in FY 1996. Are you considering a plan for restoring capacity to the specialized services, and if so, do you believe it will require resources?

Answer: Since 1996, we have moved from inpatient care to outpatient models in medicine, surgery, and mental health. The number of patients treated for spinal cord injury and dysfunction, blind rehabilitation, and traumatic brain injury has increased over the 1996 baseline. Also, the numbers of patients seen with serious mental illness, for homelessness, or suffering with PTSD have increased. Fortunately, the number of patients needing amputation has decreased due to our aggressive management of vascular disease and diabetes.

The number of patients treated for substance abuse decreased, especially between FY 1999 and FY 2000. Early this year, as authorized by the Veterans Millennium Health Care and Benefits Act, we provided over $9.0 million funding to 31 facilities to expand substance abuse treatment capacity. We expect this increased funding will begin to increase treatment capacity during this year. However, we are working to better understand the reasons for this decrease in use of specialized substance abuse treatment programs and to assure access to substance abuse programs in our clinics as well as in our larger facilities. To this end, I plan to establish a National Mental Health Improvement Program (NMHIP). This program will be modeled after a number of well-established VA data-driven improvement programs, such as the Continuous Improvement in Cardiac Surgery Program (CICSP), the National Surgical Quality Improvement Program (NSQIP), the VA Diabetes Program, the Pharmacy Benefits Management Program (PBM), and the Spinal Cord Injury/Dysfunction National Program. This new program will use validated data collection, expert analysis, and active intervention by an oversight team to continuously improve the access, outcomes, and function of patients in need of our mental health programs. These programs include those for patients who are Seriously Chronically Mentally Ill, or who suffer from Post Traumatic Stress Disorder, Substance Abuse, or Homelessness. This program will draw upon existing resources in our Health Services Research and Development Service (HSR&D) including existing initiatives in our Quality Enhancement Research Initiative (QUERI) and our Mental Health Strategic Health Care Group (MHSHG) including the Northeast Program Evaluation Center (NEPEC).

VHA is reviewing the FY 1998 baseline data on long-term care capacity and will issue a directive to Networks by the end of May to establish plans, performance monitoring, and Headquarters oversight for meeting this requirement. Early indications from the data may show a decline in some workload and staffing from FY 1998. This is particularly the case when only VA-operated services are considered, namely, VA Nursing Homes, VA Domiciliaries, VA Home Based Primary Care and VA Adult Day Health Care Programs. However, when contract and State Home Programs are added to the direct VA effort, the capacity requirement is nearly met, especially for the areas of patients treated and average census. Using the broader definition of extended care services, implementation of the FY 2002 budget will resolve any deficits in capacity.

Question 4: Dr. Garthwaite has suggested that his staff is attempting to decrease the variability in access to substance abuse services across the system. Can you briefly describe some of the steps VA Headquarters is taking in this regard?

Answer: VHA has begun the task of decreasing variability in access to substance abuse treatment. Early this year additional funding was distributed to

31 facilities to expand substance abuse treatment. This includes the funding of three additional methadone treatment programs and the development of three additional residential treatment facilities. In addition, we are undertaking a comprehensive review as described in response to question 3 above.

Question 5: While VA has made great progress in expanding veterans access to community-based primary care, this access may have come at the price of increased waiting times for specialized outpatient care and fewer funds for the specialized programs of disabled veterans. Dr. Garthwaite has indicated that there may be a new study to see how many CBOCs are necessary. First, will you provide the Committee with information about this study? What is your plan for approving new CBOCs in the interim.

Answer: There have, in fact, been two studies completed and a third is currently underway to gauge the impact of new outpatient clinics upon straight-line distance of our veterans to the closest VHA service site. As the previous studies have shown, there has been a decrease in distance due to the increased number of sites. From FY 1997 to FY 1999, there has been a decrease nationally from 17.2 miles to 16.2 miles with over 51 percent of enrolled veterans residing in an urban area and within six miles of a service site. For enrolled rural veterans, the average distance to the closest site is less than 28 miles. Overall, 86 percent of our enrolled patients in FY 1999 were within 30 miles of an outpatient clinic.

Studies currently underway seek to gauge the improvements to providing access to our Veterans. This study will identify where there are gaps in our service areas as well as provide information on where potential sites may be best located in terms of where our Veterans reside. Subsequent studies will assess distance better in terms of actual driving distances. As these studies are completed, they will be made available to all that are interested.

However, the decision to place a point of service involves more than placing a pin on a map. There are other considerations that each network has to weigh in terms of available resources, available health care providers, available transportation, and the needs of those veterans across our geographically disparate networks. As for approving new CBOCs, it is the responsibility of each network to assess the needs of their veterans and the best way in which to support those needs. Their business plans detail this vision and the way in which that vision will be attained.

Question 6: Mr. Secretary, in early November, I requested the Agency's views and estimates on a bill I plan to introduce this week, The Heather French Henry Homeless Veterans Assistance Act. While I have had a lot of informal input from VA officials, I have not yet received the Agency's views. When may I expect these? [Question was withdrawn by the Committee].

Question 7: A Blueprint for New Beginnings describes a task force that will study ways of improving access and quality. Will you describe the mission, composition, and process of this task force?

Answer: Both the budget and the President's National Security Directive on Military Quality of Life reflect the Administration's commitment to improve VA health care for those veterans eligible for treatment in the system by enhancing access to timely, high-quality care. The President will convene a Veterans Health Care Task Force to include individuals from VA and DoD, leaders of veterans and military service organizations, and leaders in health care quality to make recommendations for improvements. The exact composition of the task force has yet to be determined.

I have had preliminary discussions with Secretary Rumsfeld regarding the Task Force and the need for better coordination of health care benefits between VA and DoD. At this time, we are consulting with the Administration to work out the details of our approach.

Question 8: The Administration estimates that 27 percent of the military retirees it treats who will now also be eligible for TRICARE for Life will leave the VA system and use health care resources funded by the Department of Defense. It further estimates that VA will recognize savings from these retirees who elect to be served by TRICARE will amount to savings of $235 million. Can you describe the basis for the Administration's estimate and its plan to ensure that these savings accrue to VA?

Answer: The Administration estimated that approximately 27 percent of military retirees who are age 65 or older and currently enrolled in the VA health care system would voluntarily choose to shift their medical care to the TRICARE system. The following figures were used in the calculations:

- 64,540 enrollees at an average cost of $3,705 per enrollee equal $239,120,700.
- This amount is then reduced by the nearly $4 million in collections that would otherwise have been anticipated for those enrollees.
- The net savings is, thus, approximately $235 million.

Question 9: What factors will affect your decision about enrollment of new Priority 7 veterans into the health care system this summer?

Answer: The essential factor is assurance that VA can continue to provide a complete spectrum of services to the patients who enroll for VA health care. We will have to consider the effect of continuing enrollment of Priority 7 veterans on our services for service-connected, lower income veterans, and on our services for veterans seeking specialized care. We will also consider the impact of co-payment changes on resources available for Priority 7 veterans. In brief, the enrollment decision for FY 2002 will be made based upon our estimate of:

- Estimated enrollment and enrollees usage of veterans' health care;
- Impact of co-payments changes; and,
- Available resources.

Question 10: What do you believe VA's position should be with regard to filling prescriptions written by outside physicians?

Answer: I believe that one of VA's greatest strengths in delivering health care to enrolled veterans lies in the quality of care achieved through the ability of all health professionals who interact with the patient to have access to the patient's medical record. Therefore I do not believe that VA should dispense prescriptions written by private sector physicians.

My belief is based on two important considerations. First, and most importantly, we believe that coordination of care by one provider is the cornerstone of high-quality health care. Without up-to-date information such as a detailed medical history, a complete medication use summary, and other pertinent clinical information that can only be provided by a single Primary Care Provider, there is risk that a course of treatment for an individual patient that is based on incomplete or inaccurate information could lead to significant negative outcomes. From a quality of care perspective, practicing pharmacy in a fragmented, non-integrated manner is conducive to greater medication misadventures. VA has much experience to demonstrate that providing pharmaceuticals as an integrated portion of VA's health care benefit is effective and efficient from both a qualitative and quantitative perspective.

Second, from an economic perspective, dispensing prescriptions prescribed by non-VA doctors would dramatically increase VA's outlays for pharmaceuticals above today's 11 percent of VA's health care dollars. VA's current outlays for

pharmaceuticals are below those of most managed care organizations in the United States partly because of the infrastructure in place to develop and promulgate drug treatment guidelines and an effective National Formulary process. Moreover, VA's pharmaceutical benefit is cost effective because clinical pharmacists function as members of the primary care team. We strongly believe that the quality of care provided by a comprehensive primary care approach is vastly superior to the fragmented, pharmaceutical delivery model that many Americans access today.

Question: Do you have any expectation that CARES will create any savings in the costs of infrastructure support in FY 2002? What is the earliest time you expect the initiative to recognize savings?

Answer: We expect CARES to reduce costs related to maintenance of underutilized or vacant space. However, in many instances, up front infrastructure changes will be required to achieve long-term savings. Phase I of CARES, a study of the VISN 12 markets, will be completed in the May-June 2001 time frame. Additional Congressional and other stakeholder reviews and resulting proposals to the Secretary are expected to continue through the end of FY 2001, at a minimum. Thereafter, formal approval of a preferred option for health care delivery is anticipated. Because of the length of time required to design the capital investment project(s) and the period for construction, it is likely that very little if any operating cost savings will be generated as a result of CARES implementation in FY 2002. Although the design should be completed, with construction/modernization underway in FY 2003, construction will likely not be completed and activated before FY 2004, at which time greater savings could be expected to begin.

Question 11: The Secretary has indicated an intention to centralize C&P training. Please explain the expected objectives, goals and benefits of C&P training centralization, and the one-time and recurring costs associated with or resulting from C&P training centralization. When will C&P training centralization be completed and operational?

Answer: VBA has developed a national training program designed to deliver uniform training in a compressed timeframe. VBA is challenged with hiring and training large numbers of Rating Veterans Service Representatives (RVSRs) and Veterans Service Representatives (VSRs). The objectives of centralized training are to minimize the impact to the resources of the individual Service Centers while providing standardized training and to have the students as productive as possible by the conclusion of the course.

This training is taking place at seven sites nationwide. These sites can accommodate a large number of students for classroom training and are equipped with high-end personal computers. The National curriculum allows the students the best chance to retain the knowledge they have received and become successful RVSRs and VSRs.

There are one time costs and recurring costs of centralized training. The one time costs include upgrades in personal computers for the national training sites ($402,000), training room upgrades ($128,000), and the cost of the workshop needed to develop the curriculum ($60,000). The recurring costs associated with the centralized training include travel expenses ($2.1 million) and miscellaneous/supplies ($27,000).

Centralized training is now operational. Twelve weeks of instruction have been designed for both incoming RVSRs and VSRs. For the RVSRs, six weeks are being taught at seven national training sites. The first three weeks of the training have recently been completed. The students have now returned to their home stations. These three weeks involved completion of the Original Compensation Module of the VBA Training and Performance Support System (TPSS). The students soon will return to the national training sites for three more weeks of

intensive training. Following completion of these three weeks, the students will return home to complete weeks ten through twelve. Curriculum for all remaining training not accomplished within the first twelve weeks (to include all remaining modules of TPSS) has been developed and will continue for another three months. Upon conclusion of formalized training, the students will continue to work with mentors and receive refresher training as they gain experience. The training program for new VSR staff commenced the week of Monday, April 2, 2001. A twelve-week program has been developed with the same goals and benefits of the RVSR training.

Question 12: The Secretary has indicated his support for establishing Service Delivery Network (SDN) Resources Centers to increase capacity. Please elaborate on the increased capacity resulting from establishing SDN Resources Centers. What are the one-time and annual costs of establishing SDN Resources Centers to increase capacity? Please explain the expected objectives, goals and benefits of establishing SDN Resources Centers to increase capacity.

Answer: VBA will have nine Service Delivery Network Resource Centers (SRCs) operational by June 1, 2001. The SRCs will be staffed with newly hired or promoted employees. These new employees are currently attending an intensive 12-week centralized training program that was developed in response to the need for additional rating capacity in a short time frame. The SRCs will concentrate on high volume rating issues (e.g. musculoskeletal conditions, hearing loss, etc.) in order to capitalize immediately on the increased capacity.

The establishment of these centers has increased Veterans Benefits Administration's (VBA's) capacity of core decision-makers by 180 employees. The one-time cost for establishing the centers includes the procurement of IT equipment, furniture and supplies. Some centers required minor construction funds to redesign space at the regional office. In addition to the non-payroll costs, VBA has increased their payroll costs by the equivalent of the 180 employees for the remainder of this fiscal year. The total cost for FY 2001 will be $6.8 million. The annual cost for operating these centers will be $9.5 million in payroll funds and $125 thousand in non-payroll funds. There are no travel funds required to operate the SRCs.

Question 13: In prepared testimony presented to the Committee, the Secretary has testified, "As we await the results of this assessment—referred to as "CARES"—we will continue to expand sharing agreements and contracting authorities with other health care providers."

Question 13a: Please provide the anticipated magnitude (number, cost) of expanding sharing agreements with other health care providers while awaiting the results of the "CARES" assessment?

Answer: VA has no estimate of the magnitude at this time. VA currently has a large number of ongoing sharing agreements for specialty services throughout the health care system. VA also has a large number of sharing agreements with DoD and 132 VA facilities are service providers for TRICARE beneficiaries. VA purchases health care services based on the needs of veterans and the local availability of those services from VA. The option of purchasing non-VA-owned health care services, where they are more cost effective, will also continue to be a key criterion in the development of community-based outpatient clinics (CBOCs).

Over the last three years, the use of sharing authority has grown at an annual rate of approximately 30 percent. In FY 1999, VA purchased $199 million in health care services from other community providers. In FY 2000, VA purchased $289 million. VA expects this trend to continue regardless of CARES. Decisions about sharing agreement initiatives are delegated to VISN and VAMC management.

Question 13b: Describe the process of selecting these other health care providers.

Answer: As a Federal agency, VA must comply with Federal Acquisition Regulations and Veterans Affairs Acquisition Regulations. Under VA sharing authority (38 U.S.C., § 8153), VA can sole-source with affiliated medical schools, and the majority of medical services purchased are with affiliated medical schools. All other contracts under VA sharing authority are awarded on competitive basis.

Question 13c: Describe the purpose of expanding sharing agreements with other health care providers while awaiting the results of the "CARES" assessment.

Answer: VA will continue to use sharing authority where appropriate to meet the health care needs of veterans. The purpose of these agreements is to meet the current health care needs of America's veterans.

Question 13d: Please provide the anticipated magnitude (number, cost) of expanding contracting authorities with other health care providers while awaiting the results of the "CARES" assessment?

Answer: VA expects the use of sharing authority to increase 10-30 percent a year. VA has no estimate on the impact that CARES will have in the number of future sharing agreements. No specific emphasis is being placed on increasing the number of agreements during the CARES process.

Question 13e: Describe the purpose of expanding contracting authorities with other health care providers while awaiting the results of the "CARES" assessment.

Answer: Decisions on contracting authorities are the prerogative of local or VISN management and depend on individual market needs for the provision of adequate services for veterans. The purpose of the use of this authority is to meet the needs of veterans.

Question 13f: Describe the process of selecting these other health care providers.

Answer: Please see our response to question 13b.

Question 14: What is the target date for VA developing "an integrated strategy for addressing our (VA) information systems and telecommunication"?

Answer: August 1, 2001

Question 14a: In terms a layman would be likely to understand, please describe the meaning of the phrase, "an integrated strategy for addressing our (VA) information systems and telecommunications."

Answer: If the VA's information systems and telecommunications were viewed as a large college campus then the phrase "an integrated strategy for addressing our (VA) information systems and telecommunication" might be explained as follows: The computer networks and telephone switches would be analogous to the water and sewerage pipes, pressure controls, faucets, and other components necessary to deliver the correct amount of water, at the right temperature, and at the correct pressure everywhere it is required throughout the campus. The databases might be seen as the appropriate storage and distribution facilities for the materials needed to teach, learn, eat, sleep, and live on this campus by the students, professors, and administrators. So the biology department will have appropriate storage facilities for its needs which may be different from the facilities required by the chemistry department and the library will have different

storage requirements than the dining hall or dormitory. However all of these storage facilities will have the same requirements for proper lighting, ventilation, and security which may be provided by a central, common facility. Finally the applications might be viewed as the living, learning, and teaching that goes on across this campus. In this analogy the current state of VA systems is that each of the departments creates its own infrastructure, digs their own wells, lays its own water pipes, and determines its own standards for how hot water is and how much pressure it flows at in their department. Each department contracts for its own plumbing support. They each decide what the storage facilities look like and where they are located. They decide, based on what is best for their department, who has access, who can store what and in what manner, and who knows where things are stored. In terms of the applications this might equate to each department viewing its curriculum in the most parochial manner, not taking into consideration that a student has other demands and interests or that in order for a student to understand physics they have to understand mathematics, be able to communicate well, do research, and eat and sleep well.

In this context an integrated strategy for addressing this situation would include:

- An architectural plan for all buildings that among other things requires compliance with plumbing standards and identifies a process for seeking exceptions to these required standards based on specific and justifiable needs.
- A common inventory of all storage facilities, an index of commonly stored materials, an accounting capability to insure availability and efficiency of procuring and distributing materials, and policies and procedures to insure that the security, privacy, currency, availability, and quality of all stored materials is maintained.
- A system of governance that views all of the infrastructure, processes, and outcomes from the vantage point of what is best for the primary stakeholders. This viewpoint allows for a common set of priorities, efficiencies of scale, consistent outcomes measurement, more efficient management and higher stakeholder satisfaction.

Question 14b: What is the anticipated cost of VA developing "an integrated strategy for addressing our (VA) information systems and telecommunication" and how many FTEE are currently working on VA developing, "an integrated strategy for addressing our (VA) information systems and telecommunication"?

Answer: The anticipated cost of the development (but not the implementation) of the integrated strategy is $1,100,000. There are five FTEE working on this development.

Question 14c: How many additional FTEE will also work on VA developing "an integrated strategy for addressing our (VA) information systems and telecommunication"?

Answer: Four.

Question 14d: Identity the anticipated benefits and costs of VA developing "an integrated strategy for addressing our (VA) information systems and telecommunication"?

Answer: The primary benefit for an integrated strategy is the ability to present a unified, consistent, intuitive user access capability. This will allow us to take *One VA* from a goal to a reality. In addition, an integrated strategy will allow:

- Economies of scale savings that will equate to better performance, enhanced management capabilities, and lower overall cost of

operation.

- Enhanced data and information integrity that will equate to better customer service and satisfaction, reduced time to completion, and higher quality data for management decision-making.
- Higher levels of information security and privacy protection.
- Ability to comply with new laws and regulations such as the Clinger-Cohen Act, The Government Paperwork Elimination Act, and the Health Insurance Portability and Accountability Act.

Question 15: VA has reportedly received a number of "Hammer" and "Scissor" awards.

Question 15a: Does VA have a complete record of all such awards? Which VA office or employee(s) maintains this record?

Answer: Yes. A complete record is maintained on all such awards, and is located in the Office of Policy and Planning, Management Improvement Service.

Question 15b: Typically, "Hammer" and "Scissor" awards are presented for practice or process improvement or innovation. Describe VA's efforts to systematically provide information on and encourage the use of practice or process improvements or innovations for which a "Hammer" and "Scissor" has been awarded to VA. Which VA office or employee(s) are accountable for these activities?

Answer: The Office of Policy and Planning, Management Improvement Service (MIS) is responsible for collecting and sharing information about quality awards and best practices. VA's Administrations and Staff Offices have responsibility for further promoting the broad application of best practices throughout the Department. The MIS uses a number of methods to communicate best practices throughout VA. This information is published and distributed within the VA, both with a hard copy and electronic format.

- In 1999, VA published its first annual quality awards and best practices report. The report entitled, "1999 Annual Report of Quality Awards & Best Practices" (attached) was distributed to all facilities and offices throughout the Department. The information will be made available through the VA Virtual Learning Center, and accessible via VA's Intranet. A report for 2000 is currently under production by the MIS, and will be released in the near future.
- A report is in preparation for publication, which documents all 165 VA Hammer Awards from 1994-2000.
- In addition to the Hammers and Scissors, the Annual Carey Award (Baldrige-based organizational assessment criteria) is another way that VA systematically provides information regarding best practices of annual winners. The information describing the winner's practices is available through the VA's Virtual Learning Center.
- The VA was a key participant in the Interagency Benchmarking and Best Practices Council that sponsored a number of conferences in Washington over the last five years. Attendance at these conferences has averaged over 300 federal employees. VA staff along with other Department and Agency representatives created a Web site. This Web site was recognized by Harvard as one of the best in Government.
- Over the past two years, VA has held a Quality Symposium (attended by over 120 employees each year) that has featured the staff of VA's quality award winning facilities describing their best practices. The MIS coordinates the planning and conduct of this

event.

Question 15c: Have the practice or process improvements or innovations for which a "Hammer" and "Scissor" has been awarded to VA been adopted generally throughout VA? What are the reasons these practice or process improvements or innovations may not have been adopted generally throughout VA?

Answer: At this time, there is no "systematic process" for determining which "Hammer" or "Scissor" best practice has been implemented throughout VA. The Department has several means of communicating best practices, but it is up to each individual Administration and Staff Office to promote them. Though we cannot verify that best practices have been implemented throughout the Department, there is evidence that shared best practices have been implemented at various facilities around the country. (See table listed below—Description of Best Practices and Status of Deployment.)

Although there is no way of knowing how widely best practices are being accepted and implemented in the Department, we have several modes of communication where all facilities in all Administrations have access. An excellent example is the VA Virtual Learning web site located on VA's Internet (www.va.gov/med/osp/default.asp). Best practices are listed on this site. The Management Improvement Service in the Office of Policy and Planning has sent the 1999 Annual Report of Quality Awards and Best Practices to each facility within the Department. A *One VA* Web site has been established and facilities are encouraged to submit good ideas to best practices. Each facility has access, are listed by state and encouraged to gather ideas from each other.

There have been several organizations that have been awarded a "Hammer" or "Scissor" and the best practice has not been replicated because of their uniqueness of application. Examples would be: the Florida National Cemetery at Bushnell entered into an agreement with the adjacent prison to use water reclaimed from the prison water treatment plant to irrigate the cemetery; the VBA Insurance Center in Philadelphia streamlined their process, which issued award payments to the beneficiaries of veterans holding Government Life Insurance policies at the time of their death. These applications have distinct characteristics to that location, but they are shared with all facilities within VA to encourage innovation throughout the Department.

Description of Best Practices and Status of Deployment

94-328	Self Directed Work Teams identified by N.Y. VBA Regional Office are now a wide spread practice.
94-309	Louisville VAMC developed electronic paperless travel management system. Similar system is now being used at VA Central Office.
95-313	New York City Medical Center and the Regional Office formed ClientConsortium on Homeless. Specialized homeless programs are now located in several cities (Atlanta, Tampa Bay, Orlando, etc.)
95-220	Houston construction to co-locate VBA to VHA site. This is becoming a more familiar practice.
95-315	Milwaukee program to provide oxygen in home care setting has expanded to over 19,000 patients nationally.
96-233	St. Louis, Missouri reengineered traditional limited canteen-type services into a VA Company Store with a broad array of products. Since then, expanded nationally.
96-290	Milwaukee's telepathology permitted pathological diagnosis, using microscope robotics on the Internet. Iron Mountain, Michigan joined in effort. Tampa expanded practice to remote outpatient clinics without pathologist.

97-357	Houston/San Antonio VAMC & RO Medical Information Exchange removed barriers and reduced time and cost of processing veteran benefit claims. Similar efforts introduced in Seattle, Nashville, etc.
97-467	The St. Louis, MO National Cemetery process used a second inscription on headstones and markers. This innovative practice has been emulated throughout the National Cemetery Administration.
98-555	The St. Paul, Minneapolis Regional Office provided telecommunications support for 13 states in the Midwest permitting increased access to veterans and other beneficiaries.
00-660	The Bar Code Medication Administration project was coordinated out of Washington, but is being implemented throughout the Veterans Health Care Administration. This project reinvented and automated the medical process of administering medications for medical inpatients. While the project saves money and improves services, its implementation is being expedited on the basis of electronic minimization of medical errors thus improving medication accuracy and patient safety.

Question 15d: What goals does VA have for these practice or process improvements or innovations being adopted generally throughout VA?

Answer: VA is fully committed to identifying and communicating both management and process best practices. This commitment is reflected in the new VA Strategic Plan for 2001-2006. The Plan includes an "Enabling Goal " that states our intent to "Create an environment that fosters the delivery of One VA World-Class service to veterans and their families through effective communication and management of people, technology, business processes, and financial resources." This goal has an objective that states that we intend to "Improve the overall governance of VA and the management of its crosscutting processes. " One of the key implementing strategies associated with improved governance is the sharing of best practices. Specifically, the VA Strategic Plan (page 63) indicates that: "VA will ensure that it uses best practices to foster high performance by individuals and teams. VA will establish communities of practice to share their best practices and determine how to expand their use throughout the Department. VA will also look at external best practices that can be imported to augment our business processes. This effort will enhance individual, team, and organizational accountability and help align training/development and incentives with organizational goals and objectives."

Question 16: With regard to "30-20-10," has VA achieved the goal of deriving 10 percent of annual health care funding from non-appropriated sources? If this goal has not been achieved, what are the most likely reasons it has not? Describe VA's current efforts to achieve this goal and the cost effectiveness of these efforts.

Answer: Achievement of the 10 percent goal (alternative revenues as a percentage of the medical care operating budget) was dependent on implementation of Medicare Subvention, enhanced collections, and a flat-line appropriation. The first two conditions have not been realized, and the appropriation increased by 15 percent over a two-year period (FY 2000 - FY 2001). Prior to FY 2000, the Networks achieved significant increases in the 30 percent goal (lowering per patient costs) and the 20 percent goal (increasing patients) but, for the reasons cited above, made little progress on the 10 percent goal.

However, increasing collections is essential for improving the overall availability of health care resources. With the implementation of Reasonable Charges, health care recoveries are currently averaging $57 million per month and we are now projecting that we will collect $675 million for the year. We have every reason to believe that this increase in collections will continue into the future.

Question 17: According to representatives of the Department of Defense, the DoD-Medicare Subvention Project has not produced additional revenue for DoD health care as had been expected. Does VA still want VA-Medicare Subvention? Based on the results to date of the DoD-Medicare Subvention Project, how much additional revenue for health care does VA expect to receive annually as a result of VA-Medicare Subvention? Please provide the basis for this estimate.

Answer: The Administration has not had an opportunity yet to review its policy concerning VA-Medicare subvention. The current VA/HCFA memorandum of agreement (MOA) warrants a review and reconsideration, so we are not prepared at this time to comment on this.

Question 18: Currently, some veterans enrolled in VA health care are able to elect to have non-emergent health care provided in a non-VA facility for which VA is the payer. Should all veterans have this option? Please explain your answer and discuss the role of VA as a provider or payer of health care for veterans.

Answer: VA provides comprehensive health care to enrolled veterans through a system of hospitals, outpatient clinics, and community-based clinics. However, when VA is unable to provide such care, or when it is more economical to provide care in a non-VA facility, because a VA facility is geographically inaccessible; VA may approve non-emergent, fee basis care for veterans under certain conditions and circumstances. Veterans with service-connected disabilities and veterans discharged for a disability incurred or aggravated in the line of duty may be authorized hospital care and outpatient medical care for the treatment of their service-connected conditions. Women veterans may be authorized hospital care. Other veterans, including those previously mentioned, may be authorized outpatient medical care for non-service-connected conditions being treated by VA when additional care is necessary to complete the treatment. Veterans approved for non-emergent care are routinely issued a Fee Basis ID card, which authorizes the veteran to receive specific care from a private physician of the veteran's own choice. We believe that the current rules governing provision of non-emergent health care in non-VA facilities afford appropriate coverage for veterans enrolled in the VA health care system. The current system allows VA to appropriately manage the care of enrolled veterans. Currently, we are not in favor of changes to those rules. Any change would require a thorough review of their impact on resources, access, and health care quality.

Question 19: According to the prepared testimony presented to the Committee, Secretary Principi testified that for veterans' health care, "Our primary commitment (is) to provide high-quality medical care to veterans with service-connected disabilities or low incomes." For VA what is "high-quality medical care to veterans with service-connected disabilities or low incomes," who are receiving health care from VA? Describe the strategy of VA to provide "high quality medical care to veterans with service-connected disabilities or low incomes" who are receiving health care from VA. Identify the additional resources needed by VA to fully and consistently meet its "primary commitment to provide high-quality medical care to veterans with service-connected disabilities or low incomes."

Answer: First, let me make it very clear that VA provides high-quality care to all of our veteran patients. By "commitment," I was referring to the system of veteran enrollment priorities enacted by the eligibility reform legislation, Public Law 104-262. Under this legislation, service-connected veterans and non-service-connected veterans whose incomes are under established limits have higher enrollment priorities than do non-service-connected veterans whose incomes are over the established limits.

As I have already mentioned, I will make the decision regarding continued enrollment of Priority 7 veterans in August of this year based on estimated enrollment and costs, revenue increases and overall funding availability, and

assuring that services provided to service-connected and "lower-income" veterans and services to veterans seeking specialized care will be maintained.

Question 20: Please provide for fiscal year 2000 the total cost of VA care provided to category 7 veterans. Provide the total amount of reimbursement sought by VA for care provided during fiscal year 2000 to category 7 veterans. Provide the total amount of reimbursement received by VA for care it provided during fiscal year 2000 to category 7 veterans. Please explain any differences in these amounts.

Answer: The cost of care for Priority 7 veterans was $1.059 billion, or 6 percent of the total expenditures for all users in FY 2000. In FY 2000, we estimate that we billed $468.7 million and collected $140.2 million for care provided to Priority 7 veterans. This includes both first and third party charges. The principal reason for the difference in billed versus collected amounts is that VHA bills full charges to insurers regardless of coverage. For example, Medigap policies are billed full charges although the policies generally only cover the Medicare co-payment.

Question 21: VA assumes it will increase third-party collections by an estimated $200 million or 33 percent during fiscal year 2002. Provide the basis for this estimate.

Answer: Two factors contribute to the estimated $200 million additional Medical Care Cost Fund collections. First, collections for the Medical Care Cost Funds are well above our FY 2001 goal. We are currently collecting at a rate of $57 million a month for the first five months. As you know, we now bill reasonable charges rather than a per diem rate. This has greatly contributed to the increased collections, which we believe will continue in future years. The second factor is the increased revenue that we are anticipating from increased co-payments as authorized by the Veterans Millennium Health Care and Benefits Act.

Question 22: Does the goal of VA enrolling and treating as many veterans as possible diminish in any manner or fashion the resources available to VA to provide high-quality medical care to veterans with service-connected disabilities or low incomes? Please explain your answer.

Answer: VA's goal is to provide high quality health care to the veterans who enroll to receive our care. As explained earlier, in making the enrollment decision, I intend to carefully consider the likely enrollment, cost for care, additional revenues, and resource availability. Assuring that we retain the ability to provide quality health care for service-connected veterans, veterans who are poor, and veterans who need VA's specialized services will be the first consideration. Clearly, we would have to curtail the number of enrollees if the quality of care, or special programs would be otherwise diminished.

Question 23: Nationally, the mean length of stay (LOS) in a VA Domiciliary Care for Homeless Veterans (DCHV) Program has declined from 137.4 days in fiscal year 1992 to 101.9 days in fiscal year 1999. Please explain this reduction in LOS. Please provide the per capita cost for a DCHV day of staff in fiscal year 1992 and fiscal year 1999. How many unique veterans participated in the DCHV program in fiscal year 1992 and in fiscal year 1999?

Answer: The LOS in DCHV programs has declined in response to several factors. First, there is greater availability of additional residential treatment resources in the community due, in part, to the Homeless Veterans Grant and Per Diem Program. Thus DCHV patients can be transferred to other facilities for less intensive care when they are ready. Second, DCHV lengths of stay have declined because domiciliary programs have been used to address the unmet need for residential substance abuse treatment, thus resulting in shorter lengths of stay.

Cost for DCHV Day-of-Stay [per capita]	
1992 [estimate]	$42.72
1999 [estimate]	$70.42

DCHV Program Participation [unique veterans]	
1992	2,811
1999	5,568

Question 24: The Committee understands that nationally 18.5 percent of veterans discharged from a DCHV program in fiscal year 1999 were homeless at discharge and 26.9 percent were unemployed at discharge. Please comment on these statistics.

Answer: The homelessness figures in the DCHV reports actually represent veterans that are either known to be homeless, or their housing status is unknown. For example, just over 10 percent of veterans leave the program prematurely, by choice, before housing arrangements are made, and a similar percentage return to substance use and are required to pursue treatment elsewhere, often within VA, but do not have housing arrangements when they are discharged. These outcome rates are comparable to other VA and non-VA programs. The unemployment figure is also characteristic of outcomes for homeless service programs. We have developed several initiatives this year to improve employment outcomes. One will provide individual assistance with placement and support through a demonstration project at 10 VA programs (including 4 DCHV programs), and there will also be an expansion of the CWT program for homeless veterans.

Question 25: The Committee understands the CHALENG report to be issued later this year by VA will report the estimated need for new beds to meet current homeless veteran needs are 10,946 emergency beds, 12,513 transitional beds and 22,260 permanent beds. How many of these estimated new beds will VA provide alone or together with other organizations during the next five years? During the next ten years? Please describe VA's current strategy to provide the estimated number of new beds now needed by homeless veterans and the other services these veterans require.

Answer: Estimated bed need is a locally determined process. Once the need is identified, VA works through many avenues—including interagency coalitions, partnerships, memoranda of understanding, support of grant applications, etc.—to bring needed bed capacity online. VA can provide support for transitional housing through the VA Grants and Per Diem Program, contract residential care funding, and the VA Loan Guarantee for Multifamily Housing for Homeless Veterans Program. Although VA cannot provide funding for emergency and permanent housing, VA also works indirectly with local agencies to support community efforts to obtain funding for these types of housing. During FY 2000, an additional 8,599 beds (emergency, transitional, and permanent) were generated through combined VA-community partnering efforts.

VA and community agencies will continue in the future to work to meet the full spectrum of housing needs clearly identified through the CHALENG process. Future VA transitional housing initiatives include another round of Grants and Per Diem Program funding this fiscal year and the expectation that the VA Loan Guarantee for Multifamily Housing for Homeless Veterans Program will create an additional 5,000 community-based transitional housing beds once this program is fully implemented.

In addition to addressing unmet bed needs, the CHALENG process locally identifies needs for "other services." In FY 2000, 3,331 community and VA

service providers, as well as homeless veterans, rated the level of unmet need in 35 different service need areas (e.g., medical care, food, substance abuse treatment, vocational counseling, etc.). This is a local determination of efforts to address need, and these efforts evolve over time: Once a specific need is identified, VA and the community develop and implement actions to address specific needs and report back through CHALENG the following year on the success of their joint efforts.

Question 26: For several years, VA's budget has assumed that the A-76 study proposed for property management activities in the home loan program would result in a reduction of FTE who could be transferred into claims adjudication. Please provide a status report on this study.

Answer: The A-76 study has been taking longer than originally planned. The Request for Proposal (RFP) was released on April 27, 2001. We still anticipate FTE savings once the final outcome is known and implemented.

Question 27: Has it been possible to transfer employee positions from the home loan program to claims adjudication without any degradation in services to home loan beneficiaries? Please discuss the impact of these transfers on the home loan program.

Answer: Yes. VBA has been able to transfer employees to claims adjudication. VBA has been able to achieve economies of scale through a recently completed restructuring of field station operations. This restructuring resulted in the consolidation of activities at selected sites. In addition, VA has made significant improvements in the use of information technology. This has allowed the organization to provide a high level of service to veterans as Loan Guaranty Program employment has decreased.

Question 28: Since records and record locations are not computerized at the National Personnel Records Center (NPRC), manual tracking and retrieval of records is extremely labor intensive. Has VA undertaken any discussions with staff of the National Archives concerning technological improvements needed to improve the quality of services, such as a computerized locator system? Please provide a status report on the PIES initiatives and any improvements VA believes would improve service by NPRC.

Answer: NPRC has a computerized registry of personnel and medical record locations for all Army, Air Force, and Coast Guard files. Record locations are also computerized for all Navy and Marine Corps files relating to veterans who served after the mid-1960s. The VA Personnel Information Exchange System (PIES) application runs against the computerized database of these holdings, which is called NPRC Registry. PIES is programmed to identify from the Registry which records are "matches" for files needed to respond to VA requests and sequence the requests for these records according to their file locations.

Unfortunately, Navy and Marine Corps files for veterans serving before the mid-1960s are not in the registry. These are referred to as non-registry records. PIES requests for non-registry records must be sorted into separate PIES batches for processing and searched by different filing systems. This is time consuming and makes it difficult to know instantaneously whether or not a record exists.

The VA PIES unit has undertaken the following initiatives to work with NPRC to better deal with NPRC records systems and work procedures as they currently exist:

> We are currently working with our local Information Resources Management (IRM) team to develop changes to allow our VA tracking system to merge records requests for cases where dual records are needed for us to make our response.

We are working on a Project Initiation Request to have the VA Data Center in Hines change the part of the PIES programming that sorts records identified for retrieval. We intend to use logic prepared by NPRC to write a program to sort our identified records into 22 search categories. This will mirror the way NPRC has decided to run their records retrieval operation.

Question 29: VBA has historically tracked timeliness of claims processing by End Product Codes. Although a veteran has a year to submit evidence or appeal a decision, VA has typically closed claims and had timeliness computed when a veteran did not provide information in 30 or 60 days. If the veteran responded within the one-year time frame allowed, it was treated as a new claim for the purpose of timeliness data and End Product Codes. Has VA ever analyzed the number of End Product Codes taken from the time a veteran files an original claim for compensation and the time a final non-decision is rendered by the regional office, regardless of the number of intervening end products?

Answer: Title 38 Code of Federal Regulations, Section 3.160(d), stipulates that a claim is a "finally adjudicated claim" after it has been allowed or disallowed by the agency of original jurisdiction and one year has expired since notification. Prior to the Veterans Claims Assistance Act of 2000, procedures allowed for a 60-day control on evidence requests. Once the 60-day control had expired, either a decision was rendered based on the evidence of record or a disallowance for "failure to prosecute" was administratively processed. Veterans have always had the option to "re-open" a claim prior to the decision becoming "final" as defined above.

For tracking purposes, a new end-product control is established on all re-opened claims. To date, analysis has not been conducted to ascertain the number of times, on average, a claim is "re-opened" within the one-year time period between notification of a decision (favorable or unfavorable) and the date the decision becomes "final." Although formal analysis has not been initiated, our experience suggests that a claim reopened is the exception rather than the rule. In addition, in many cases a claim is expanded to include new issues on an existing claim with no additional work-credit assigned to the case.

It is important to note that the rules of evidence have changed substantially since passage of the Veterans Claims Assistance Act of 2000. Claims can no longer be denied for "failure to prosecute" after the 60-day control has expired. VBA is now required, after the initial 60-day control, to develop for any cited evidence and also notify the claimant of any evidence deficiency. A final decision must be deferred for an additional 30-day control period under the new requirements. This adds to the length of time required to render a decision and also requires an additional step in the development process.

Question 30: Does VA have any data indicating the average retroactive benefits paid on original compensation, pension and DIC claims? If so, please provide this information. If not, please indicate how such information could be obtained and tracked.

Answer: During FY 2000, VBA paid approximately 660,000 beneficiaries retroactive payment awards totaling over $1.8 billion. This was determined by using budget and workload trend data as well as information received from the Hines Finance Center. Compensation and Pensions include both live and death benefits. The estimated average retroactive payment to beneficiary by program is estimated to be:

Compensation	$2,729
Pensions	$3,167
Burial	$1,940

There is no data available at the present time to provide retroactive figures by type of claim. A unique program would have to be written to track such information.

Question 31: The Committee has been advised that the case management initiatives instituted at the Phoenix Regional Office have reduced by approximately two-thirds the number of telephone calls received from claimants, thus freeing staff for case development. Has a similar reduction in telephone traffic been identified at other regional offices which have implemented case management?

Answer: We assume the information about the regional office is based on a conversation with one of the coaches from the Phoenix Regional Office during a congressional or GAO staff visit. That estimate was derived from anecdotal information obtained from the case management teams, based on their experience in taking phone calls from veterans. VBA does not capture data, except for a random sample conducted by two of our regional offices, on the reason why a veteran or beneficiary called the Veteran Service Center. Based on the FYTD sample of calls received at one of our sampling sites, less than 20 percent of the calls received through March 2001 involved the status of a pending claim. The remaining calls covered a wide gamut of questions and issues involving benefits that VBA, VHA, NCA, and other state and federal organizations provide.

While it is not possible to precisely isolate the impact of any one initiative, VBA has been able to reduce the number of calls received by the Veteran Service Center employees as a result of several initiatives that have been undertaken in the last three years. In FY 1999, VBA answered 12 million calls to its general 1-800-827-1000 number which is answered by Veteran Service Representatives (VSR) in the Veteran Service Centers. An additional 27 percent received a busy signal. In FY 2000, 9 million calls were answered by a VSR and only 3 percent received a busy signal. This represents a 25 percent reduction in the number of calls that a VSR was required to answer, thus freeing up more of their time to process claims.

While we believe the proactive steps involved in keeping veterans informed about the status of their claim have helped reduce call volumes, there are several other initiatives that contributed to the reduction. These initiatives included the National Automated Response System (NARS), the establishment of a national toll free education number (1-888-GI Bill 1), and toll free numbers for the Regional Loan Centers and Loan Guaranty Eligibility Centers. Several additional enhancements to NARS, currently in the development and implementation stages, will further decrease the number of calls that are routed to VSRs. In addition, VBA plans to put its State and Other Veteran Benefits Information System on the Internet so that veterans can directly access information about veteran benefits that other organizations provide.

Question 32: Please describe how VA plans to continue partnerships with union representatives in light of the recent Executive Order rescinding the partnership requirement?

Answer: VA will continue to support partnerships with union representatives. Most of VA's collective bargaining agreements have partnership articles under which partnerships arrangements have been formed. The Executive Order did not abrogate any collective bargaining agreements that were in effect on the date of the order.

Question 33: Is VBA expected to request funding for technological or other initiatives to improve claims processing in FY 2002 in addition to increased staffing requirements? Please describe the initiatives which will be undertaken and the expected results.

Answer: Yes. Hiring people is one of the many solutions VBA is pursuing to address claims processing performance. Technological improvements play a key role in enabling performance improvements, as well as training, internal reviews, organizational structure and changed business processes.

The $133.5 million requested increase over the FY 2001 enacted budget authority level will provide for an additional 890 FTE and $89.4 million in increased payroll. This increase includes 701 FTE to counter the expected increased workload from the recently enacted Duty to Assist legislation and new regulations regarding diabetes. New legislation impacting the Education program requires 193 FTE to projected workload increases. Additional FTE for C&P initiatives, e.g., CAPER (10 FTE) Overseas Benefits Delivery at Discharge (12 FTE), and SIPA (80 FTE) are also funded. Decreases in Information Technology FTE and Loan Guaranty FTE associated with the proposed legislation eliminating the Vendee Loan Program partially offset these increases.

The increased request will also provide for continued and new investments in technology, including Benefits Payment Replacement System (VETSNET Migration), Training and Performance Support Systems (TPSS), Virtual VA, Security and Infrastructure Protection (SIPO), Configuration Management, Operational Data Store, WINRS, EDI/EFT, and the *One VA* Telephone Access. Information technology (IT) investments are requested only after they have passed a rigorous review from the Department's Capital Investment Board. VBA ensures solid IT investments that will deliver fully automated systems that are secure and provide the access and ease of use that will ultimately produce the kind of accuracy, timeliness, and customer satisfaction VBA strives to achieve. However, there will be no spending on new IT initiatives until a comprehensive, integrated IT Enterprise Architecture has been adopted.
The increase over the FY 2001 enacted level will mitigate the performance setbacks we will encounter in claims processing and is a first step to achieving the Department's goal of processing rating-related original claims in 100 days by March 2003.

Question 34: Please provide a list of all proposed regulations which were submitted to the Office of Management and Budget prior to January 21, 2001, but which had not been issued in final form as of that date. Please provide a status report on all such regulations.

Answer: On January 31, 2001, the Department of Veterans Affairs withdrew from review by the Office of Information and Regulatory Affairs, Office of Management and Budget, the following regulatory actions:

Veterans Benefits Administration

2900-AJ51 (Final Rule)	Revised Criteria for Monetary Allowance for an Individual Born with Spina Bifida Whose Biological Father or Mother is a Vietnam Veteran

Published in Federal Register on 3/6/01 at 66 FR 13435

2900-AJ52 (Final Rule)	Exclusions from Income

Resubmitted to OMB 2/20/01

2900-AJ55 (Final Rule)	Certification of Evidence for Proof of Service

Published in Federal Register on 4/18/01 at 66 FR 19857

2900-AJ82 (Proposed Rule)	Evidence of Permanent and Total Disability

Resubmitted to OMB on 4/13/01

2900-AJ96 (Proposed Rule)	Presumptive Service Connection for Hepatitis C Infection

Pending in VA

2900-AJ99 (Final Rule)	Review of Benefit Claims Decisions

Published in Federal Register on 5/2/01 at 66 FR 21871

2900-AK07 (Final Rule)	Signature by Mark

Published in Federal Register on 4/6/01 at 66 FR 18194

2900-AK25 (Proposed Rule)	Written and Oral Information or Statement Affecting Entitlement to Benefits

Published in Federal Register on 4/20/01 at 66 FR 20220

2900-AK64 (Proposed Rule)	Diseases Specific to Radiation-Exposed Veterans

Resubmitted to OMB 3/20/01

Veterans Health Administration

2900-AJ20 (Proposed Rule)	Medical Care and Treatment for Which VA Will Not Seek Reimbursement

Resubmitted to OMB on 2/22/01

2900-AK01 (Proposed Rule)	Compensated Work Therapy/Transitional Residences Program

Published in Federal Register on 3/6/01 at 66 FR 13461

2900-AK08 (Proposed Rule)	Payment of Reimbursement for Emergency Treatment Furnished at Non-VA Facilities

Resubmitted to OMB on 4/10/01

2900-AK53 (Final Rule)	Provision of Hospital and Outpatient Care to Veterans

Resubmitted to OMB on 5/1/01

2900-AK55 (Final Rule)	Medical Benefits Package

Resubmitted to OMB 2/20/01

Acquisition

2900-AI71 (Final Rule)	VA Acquisition Regulation: Simplified Acquisition Procedures for Health-Care Resources

Resubmitted to OMB on 2/20/01

Board of Veterans Appeals

2900-AK61 (Final Rule)	Appeals Regulations: Title for Members of the Board of Veterans' Appeals—Rescission

Published in Federal Register on 3/6/01 at 66 FR 13437

2900-AK62 (Proposed Rule)	Appeal Regulations: Title of Members of the Board of Veterans' Appeals

Published in Federal Register on 3/6/01 at 66 FR 13463

General Counsel

2900-AH98 (Final Rule)	Release of Information from Department of Veterans Affairs Records

Pending VA

Question 35: If VBA does not receive supplemental funding in fiscal year 2001 to address the caseload of 481,857 claims pending at regional offices as of March 9, 2001, please describe what actions VBA will need to take to address the backlog without diminishing the quality of the decisions made.

Answer: VBA is already taking action to stem the recent increase in pending claims. These steps include the establishment of SDN Resource Centers, implementation of a centralized training program, and additional hiring during the current fiscal year.

The SDN Resource Centers are discussed in the answer to question 11. Deployment of a centralized training program began in March of this year. The program was developed to provide 12 weeks of comprehensive and compressed training to newly hired Rating Veterans Service Representatives (RVSRs) and Veterans Service Representatives (VSRs). The strategy allows for the simultaneous training of up to 250 employees at seven locations across the country: Philadelphia, Baltimore, St. Louis, St. Paul, St. Petersburg, San Diego, and Houston. This will maximize the talent of a limited number of technical matter experts who are proficient in Instructional Systems Design training techniques. The program will also minimize the impact to local stations in training this many employees by achieving more efficient economies of scale. The goal will be to train over 800 newly hired or promoted employees by the end of the fiscal year.

These steps are aimed at increasing our productive capacity; however, funding for these initiatives must be redirected from FY 2001 program initiatives in the absence of supplemental funding. Many of these program initiatives are aimed at improving our data systems and streamlining our business process, which are projected to have a long-term positive impact on service delivery. The challenge will be to increase output while providing quality service to veterans and their families.

Congressman Howard P. (Buck) McKeon

Question 1: Mr. Secretary, as you know, the Veterans Millennium Health Care and Benefits Act ended the State Home Grant Program and proposed to replace it with a more efficient system. Last March, the VA was to have completed the promulgation process for the new rules for the program, but to the best of my knowledge the rules have yet to be completed. Could you give me a status report of where we are with this program and the rules?

Answer: The Veterans Millennium Health Care and Benefits Act (Public Law 106-117) required VA to revise the State Home Construction Grant regulations. The revised methodology used to prioritize projects for grant award reflects the intent of the Act, The extensive revision to the regulations has taken longer than expected. However, the revision reflects guidance that will have a positive impact on the program and our stakeholders. The revised regulations are being reviewed for final concurrence and VA is pleased to say that they will be in place for the FY 2002 Priority List and funding cycle. VA expects the program to continue to grow. Program improvements and additional staffing are helping us to aggressively address future program needs.

Question 2: Mr. Secretary, in my district, the City of Lancaster is the next in line on the State's priority list for funding for a State Home. However, the delay in the rules promulgation has led some to question whether the Federal funding will exist for new home grant applicants. Can you clarify this situation and provide me with some insight into this matter?

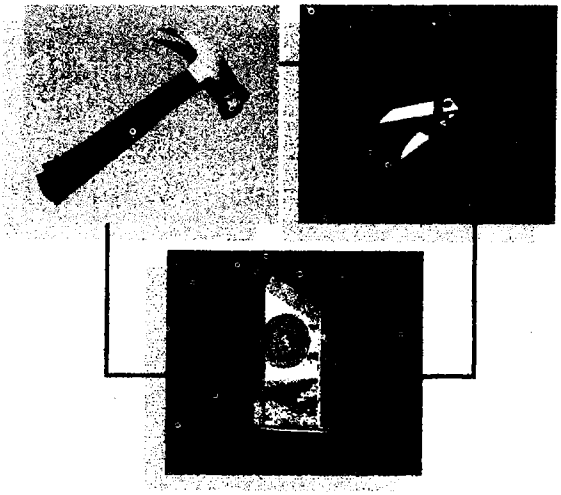
VA has identified Southern California as an area with a severe shortage of skilled nursing and domiciliary beds for veterans. The City of Lancaster has donated a 23-acre parcel of land, which is to be used for the 400-bed Lancaster Veterans Home. Within the 60-mile service area of this site, there are over 300,000 veterans over the age of 60 who are eligible for admission to the home. This home is very important to my constituents and myself, and I hope to see construction begin soon. But as you know, the project cannot begin without proper funding, from both the State and Federal Governments.

Answer: The extensive revision to the State Home Construction Grant regulations has taken longer than expected. VA is reviewing the revised regulations and they will be in place for the FY 2002 Priority List and funding cycle. After August 15, 2001, VA will be reviewing the Lancaster Veterans Home project (FAI 06-042), along with all applications submitted prior to that date for placement on the FY 2002 Priority List. If the State authorizes the project and provides the State's matching funds, the Lancaster project will receive priority in accordance with the new regulations.

Attachment to Congressman Evan's Question 15b

1999 ANNUAL REPORT OF QUALITY AWARDS & BEST PRACTICES

A Compendium of the 1999 Winners of the Hammer, Scissors, and Carey Awards



OFFICE OF POLICY AND PLANNING

DAS for Planning and Evaluation

Management Improvement Service

JULY 2000

Department of Veterans Affairs

Memorandum

Date: JUL 2 0 2000

From: Co-Chairs of VA's National Quality Council

Subj: National Quality Council Report on Quality Awards and Best Practices

To: Administration Heads, Assistant Secretaries, Other Key Officials, and All Field Facility Directors

1. On behalf of the National Quality Council (NQC), it is with great pleasure that we forward to you the first annual report of the Department of Veterans Affairs' Quality Awards and Best Practices. This report identifies all recipients of the Hammer, Scissors, and Carey Awards that were presented in 1999. The report also highlights a number of key success stories for the Department in the areas of quality and management improvement. The objective of this compendium is to provide your offices with a guide to best practices being used to improve quality and enhance performance at the Department of Veterans Affairs.

2. The report is being published under the joint auspices of the Office of Policy and Planning, and the National Quality Council. Staff of the Management Improvement Service compiled material for the report with significant input from the three Administrations, VACO Staff Offices, and local representatives of VA's Council of the American Federation of Government Employees.

3. Electronic access to this information will be provided through the Virtual Learning Center of the Special Projects Office of the Veterans Health Administration.

4. We hope that you will find this report interesting and informative, and a tool to identify best practices that your organization can use to support your quality and performance improvement initiatives. Please contact Ms. Carstine Thompson on (202) 273-5071, if you have any comments or questions.

Gary A. Steinberg Alma L. Lee

Attachment

VA FORM MAR 1989 2105

TABLE OF CONTENTS

I. INTRODUCTION

When the Vice President of the United States introduced the Hammer Award Program in 1993, the Department of Veterans Affairs began reshaping all phases of its operations by streamlining obsolete processes and regulations and forming partnerships that changed the way VA does business. VA has been recognized as being a leader in the areas of quality and management improvement; in fact, the first Hammer Award was given to the VA New York Regional Office in March of 1994 for "Self Directed Work Teams." Over the past 6 years, VA has won over 150 Hammer Awards by implementing measures that reduced cost, improved processes, and resulted in enhanced service to veterans. The establishment of the Deputy Secretary's Scissors Award Program in March 1995 enhanced this effort and complemented the Vice President's Hammer Award Program.

The Deputy Secretary of VA established the Scissors Award to recognize employees who were responsible for common sense initiatives that streamlined operations and saved money. By the end of 1999, over 300 Scissors Awards were presented to VA facilities.

Both the Hammer and the Scissors Quality Programs recognize groups that cut red tape, streamline operations and processes, improve veterans' services, empower employees, and create a more efficient and focused government for the U.S. taxpayers. The major difference between these two programs is scope. The Hammer Awards generally are reserved for broad, far-reaching, and/or "cutting edge" innovations. Scissors Awards are presented for initiatives that, while innovative, veteran focused, and cost cutting, are narrower in scope. It should be noted that since the initiation of the Scissors program, a number of applications were recommended for both a Hammer and a Scissors Award.

Prior to the establishment of the Hammer and Scissors Programs, VA established the Secretary's Robert W. Carey Quality Award for organizational excellence. This prestigious award, which is based on the Malcom Baldrige Award criteria, was established in 1992 to recognize organizations that have excelled in quality achievement. It provides a model against which organizations can assess their quality transformation efforts, organizational effectiveness, and performance in delivering service and satisfying customers.

This report lists the 26 Hammer Awards and the 50 Scissors Awards that were presented to VA staff in calendar year 1999. It also highlights the accomplishments of the 1999 Carey Trophy winner, the Category winners, and the Achievement winner.

We congratulate and applaud all Quality Award Winners for their achievements and encourage them to continue to work to improve operations and procedures within their facilities.

II. HAMMER AND SCISSORS AWARDS PRESENTED IN 1999

Nomination No.	Team Name	Award	Presentation Date
99-000	*President's Welfare to Work Initiative, VACO, Washington, DC (95 employees received recognition for their efforts)	H	9/22/99
99-625	*Central Plains Network University Implementation Team at Central Plains Health Network (14), Lincoln, NE	S	9/14/99
99-623	Regional Loan Center Loan Production Section Team at St. Paul, MN VARO	S	8/19/99
99-622	Cook/Chill Implementation Team at Mountain Home, TN VAMC	S	9/2/99
99-618	*Claims & Risk Management Team at VACO Washington, DC - VHA	S	9/2/99
99-617	*Reclaimed Water Partnership Team at Bushnell, FL NCA	H/S	12/13/99
99-616	Environmental Management Service Team at Richmond, VA VAMC	S	9/13/99
99-614	Annual Refresher Information Security Training Team at Prescott, AZ	S	11/2/99
99-612	Agent Cashier (TQI) Team at H Cleveland, OVARO	S	9/14/99
99-609	Provision of Dental Treatment to S Veterans Under Minnesota State Soldiers Assistance Program at St. Cloud, MN VAMC	S	9/2/99
99-608	*Virtual Learning Center Design Team at Washington, DC VAMC	S	10/1/99
99-606	Christmas Store Team - Voluntary Service Activity Secton at Chillicothe, OH VAMC	S	7/14/99

*** Represents Best Practices - See pages 9-17**

H = Hammers, S = Scissors, and H/S = Hammer and Scissors

Nomination No.	Team Name	Award	Presentation Date
99-604	Prosthetics & Sensory Aids Team Section Support Roseburg, OR VA Health Care System at Roseburg Medical Center	S	9/29/99
99-602	Meals on Wheels Team - Harry S. Truman Memorial Veterans' Hospital, Columbia, MO VAMC	S	8/5/99
99-601	OPT OE/RR Lab Order PI Team at Fargo, ND VAM&ROC	S	9/1/99
99-600	*VA Community Based Outreach Clinic (CBOC)for Homeless Veterans & Mobile Assistance &Shelter for the Homeless (MASH) Partnership At VA Southern Nevada Healthcare System, Las Vegas NV	S	9/3/99
99-599	*Multidisciplinary Telemedicine Team, at Tampa FL VAMC	H	10/14/99
99-596	VA Heartland Network Video Technology Team at Kansas City, MO VAMC	S	10/27/99
99-595	Therapeutic work Programs at Cleveland, OH VAMC	S	3/10/99
99-594	*Veterans First Team at Cleveland, OH VARO	H	6/9/99
99-593	*VA/Bureau of Prisons Incarcerated Veterans Matching Team at Washington, DC VBA	H	5/12/99
98-592	*Detroit VA Medical Center Team at Detroit, MI VAMC. Same nomination as Electronic Medical Evidence Direct Access Project Team at SSA	H S	5/10/99 6/28/99

Nomination No.	Team Name	Award	Presentation Date
99-591	Tucson VAMC & Naval Mobile Construction at Tucson, AZ VAMC	H/S	7/24/99
98-590	*Incarcerated Veterans Identification Team at Huntington, WV RO	H	5/19/99
98-586	Pathology and Laboratory Service Team at Hines, Ill VAMC	S	11/10/99
98-581	The Perceptions Team at Buffalo, NY VAMC	S	12/16/99
98-580	*Tuscaloosa VA Vocational Rehabilitation Program at Tuscaloosa, AL VAMC	S	8/3/99
99-579	*Highway 1/VBA Project Team at Washington, DC VACO, VBA	H	4/9/99
98-577	Voluntary Improvement Program Team at Buffalo, NY VAMC	S	4/29/99
98-576	Altamont Fair Planning Committee at Albany, NY VAMC	S	4/28/99
98-575	*Subsistence Prime Vendor Management Team at Washington, DC VACO	H/S	4/21/99
98-574	*VA Cares Team at Togus, ME VAM&ROC	H	6/8/99
98-573	19th Star Partnership Team at Indianapolis, IN VARO	H/S	7/28/99
98-570	*PreSet Burial Operation Team at Riverside National Cemetery, Riverside, CA	S	7/1/99
98-569	*Telephone Management Group Team at Philadelphia, PA RO	H/S	4/30/99

Nomination No.	Team Name	Award	Presentation Date
98-568	Pharmacy Benefits Management Team, VISN 10, Cincinnati, OH	H/S	4/28/99
98-567	Biomedical Engineering Resource Pool Team, Veteran Integrated Service Network (VISN 3), Bronx, NY	S	9/24/99
98-566	*Telecommunications Project Team at New Orleans VBA/VAMC, New Orleans, LA	H/S	6/28/99
98-563	Marketing and Public Affairs Team at Syracuse, NY VAMC	S	4/7/99
98-560	VHA Headquarters Podiatry Team at Cleveland, Oh VAMC	H/S	3/10/99
98-559	Elective Surgery Admission Performance Improvement Team at Portland, OR VAMC	S	4/7/99
98-558	Radiology Report Turn-Around Time Around Time Improvement at Leavenworth, KS VAMC	H/S	4/5/99
98-555	*Information Center Team at St. Paul, MN RO&IC	H/S	4/2/99
98-552	Pulmonary and Critical Care Team at Buffalo, NY VAMC	S	4/29/99
98-551	*Blanket Purchase Agreements Team at Hampton, VAMC	S	4/9/99
98-539	Nutrition and Food Service Team at Lebanon, PA VAMC	S	1/26/99
98-538	Medical Record Review Team at Lebanon, PA VAMC	S	1/26/99

Nomination No.	Team Name	Award	Presentation Date
98-534	Real Property Team at Honolulu, Hawaii VAM&ROC	S	9/20/99
98-532	*Homeless Assistance Team at Honolulu VAM&ROC	S	9/20/99
98-517	*Asset & Enterprise (Golf Courses) Development Service Team at Office of Facilities Management, VACO, VHA (Includes 97-402 and 97-431)	H/S	5/11/99
98-511	*Health Care for Homeless Veterans Program at Atlanta, GA VAM Syracuse, NY VAMC	H H/S	9/29/99 2/22/99
97-447	*VA's Consolidated Mail-Out Pharmacies (Field)at Bedford, MA, Washington, DC & West LA, CA, Dallas, TX, Hines, IL, Leavenworth, KS, Murfreesboro, TN, & Charleston, SC	H/S	4/17/99
97-438	Urology Clinic Staff Team at Washington, DC VAMC	H	4/14/99
97-424	Acute & Intensive Medical Care Team at Grand Island Division of VA Greater Nebraska Health Care System, Grand Island, NE VAMC	H/S	4/2/99
97-382	*Veterans Village of Tampa Bay and Orlando, Florida at Tampa, FL VAMC	H/S	2/19/99
97-377	Audiology Productivity Process at Syracuse, NY VAMC	H/S	2/22/99
97-338	Urology Clinic Customer Service/Quality Care Focus Team at Washington VAMC VHA	S	4/14/99
96-242	Long Term Care Process Improvement Team at Leavenworth, KS VAMC	S	3/10/99

III. SELECTED BEST PRACTICES - 1999
Hammer Awards

The following best practices were selected by the Hammer and Scissors staff in order to give the reader good examples of innovations and initiatives that have had the greatest impact on service to Veterans. Hopefully, other facilities will use these success stories to improve service.

- **President's Welfare to Work Initiative (99-000) - 9/22/99: Washington, DC - VACO**

The VA's goal of 800 hires was far exceeded with the hiring of 1,391 recipients under this initiative. Effecting more than 160 VA field activities and Headquarters, this outcome is an example of VA's commitment to the overall success of the President's initiative on Welfare to Work. AFGE Local #17 is the labor partner at VA Central Office.

- **Reclaimed Water Partnership (99-617) - 12/13/99: Bushnell, FL - NCA**

By entering into a 4-way partnership, the Bushnell Cemetery piped reclaimed water from the prison water treatment plant for irrigation purposes at the cemetery. This innovative partnership was truly a "win/win" solution. The cemetery gained the water it needed in an economic and efficient manner. The prison gained a solution for disposing of its excess reclaimed water. The community gained protection for its natural water source, and the veteran community gained the assurance that their cemetery would continue to be maintained as a National shrine.

- **Multidisciplinary Telemedicine (99-599) - 10/14/99: Tampa, FL - VAMC**

By utilizing a television camera attached to a microscope, the Tampa/Orlando team provided frozen section coverage at a remote outpatient clinic that does not have or need a pathologist. Since implementation, the accuracy of the television readings has been 100 percent. Cost savings of $120,000 yearly and improved customer service in remote VA Hospitals are direct results of the team efforts. The labor partner in this endeavor is AFGE Local #0547.

- **Veterans First (99-594) - 6/9/99: Cleveland, OH - VARO**

A partnership between VA, two federal agencies and one state agency in Ohio led to the development of a program that provides seamless job placement services for disabled veterans. The program's success rate involved the placement of 148 veterans in FY 1998 and the number more than doubled to 370 placements in FY 1998.

- **Bureau of Prisons Incarcerated Veterans Matching (99-593) - 5/12/99: Washington, DC - VACO**

The process to identify inmates that are receiving VA benefits has been reinvented. The VA, working in partnership with the Bureau of Prisons, can now electronically identify veterans incarcerated in the Federal Prison System. This new process provides the basis for reducing or suspending payments, as provided by law. Overpayment amounts established against a veteran's account since the adjustment can now be initiated more timely than in the past.

- **Highway 1/VBA (99-579) - 4/9/99: Washington, DC - VACO**

This is a partnership with an industry team to streamline and eliminate non-value added paper handling which improved service to veterans and VBS' capacity to adjudicate disability claims in a more timely manner. Veterans who telephone to learn the status of their claims now receive immediate answers to their questions, significantly improving the quality of their experience with the VBA. Savings over $10 million per year in office space will be realized when the huge local file banks are removed from the regional offices.

- **Subsistence Prime Vendor (98-575) - 4/21/99: Washington, DC - VACO.**

The new prime vendor program, which is a direct vendor delivery system, has streamlined operations for Acquisition & Materiel Management, Nutrition and Food Service, and Fiscal/Financial Management Services at VA facilities. Changes in the procurement process resulted in personnel reductions for all three of these services. This initiative has reduced distribution costs, while at the same time improved customer satisfaction with product selection at competitive prices and better service. Millions of dollars have been generated in cost avoidance for recurring initial cost benefits related to personnel reductions and reduced procurement transactions while providing a model framework for product standardization and national contracts.

- **VA Cares (98-574) - 6/8/99: Togus, ME - VAM&ROC**

The VA Cares Team at Togus has successfully reinvented the way to electronically deliver ratings and award letters to all Veterans Service Organizations who serve as Powers of Attorney for veterans. The process began as a joint effort between empowered VA employees and the Disabled American Veterans organization at the Togus facility. As a result of this reinvention, veterans are now able to call their VSO immediately upon receipt of a rating or letter from Togus. Response time for inquiries has also been shortened because the VSO has already received electronic copies of the same correspondence and are aware of the VA decision.

- **Telephone Management (98-569) - 4/30/99: Philadelphia, PA - RO**

During a 6-month time period, the Telephone Management Team saved over $11,000 by increasing the number of toll free telephone lines into the Department of Veterans Affairs Regional Office at Philadelphia. They also decreased the number of local telephone lines, dynamically arranging customer service agent work schedules according to peak telephone call periods, and filtered non-benefits related calls. By modifying the process of managing telephone interview activity, they successfully reduced the number of blocked and abandoned calls. AFGE Local #940 was an instrumental labor partner.

- **Telecommunications (98-566) - 6/28/99: New Orleans, LA - VBA/VAMC**

A joint venture was formed to combine services to one telephone system, save telecommunication dollars, and improve customer service. Prior to this project, the VA Regional Offices telephone system would not allow the transfer of calls between the different facilities. This joint venture saved VBA thousands of dollars by eliminating the purchase of a new telephone system for approximately $375,000 or the upgrade of an existing system for $150,000. The joint venture is an excellent example of the "One VA" concept. The labor partner involved in this initiative was AFGE Local #2062.

- **Information Center (98-555) – 4/2/99: St. Paul, MN - RO&IC**

To address the issue of blocked calls, the Information Center Team proposed a pilot project to provide telecommunications support for 13 states in the Midwest that resulted in increased access to veterans and other beneficiaries who rely on VA to provide information about benefits and services via the telephone. In FY 1995, 81% of call attempts to VA Regional Offices resulted in the call being blocked.

- **Asset & Enterprise - Golf Courses - (98-517) - 5/11/99: Development Service Team, Office of Facilities, Washington, DC; St. Cloud, MN- VAMC**

This creative strategy for reducing maintenance and operational costs of VA golf courses has enabled VA financially and operationally to get back to basics: the business of caring for American's veterans. The need for government funding of the management and operation of 22 VA golf courses was eliminated. While the golf courses were worthwhile to patient care and rehabilitation, the courses were costing VA almost a million dollars a year to operate and maintain.

- **Asset & Enterprise - Golf Courses - (98-517) - 5/11/99: Development Service Team, Office of Facilities, Washington, DC; St. Cloud, MN - VAMC (Continued)**

By using innovative Enhance-Use leasing agreements, this team ensured that patients still have access to most of the courses but VA no longer pays for operation and maintenance. The estimated savings are almost $1 million annually.

- **Health Care for Homeless Veterans (98-511) - 9/29/99: Atlanta, GA - VAMC**

Through case management by the Homeless Program staff, veterans are involved in a continuum of care as they progress towards independent community living. Recognized for reinventing treatment of homeless veterans in the Atlanta area, this team implemented a practical, comprehensive approach combining substance abuse treatment and sober housing with immediate vocational placements.

The program moves homeless veterans off the street and into therapeutic work as part of the rehabilitation process. There are more than 100 veterans on work sites at the VAMC and other federal agencies in the metropolitan Atlanta area. In any single year, the VA pays out more than $1 million to formerly homeless veterans who are in therapeutic employment. Reduced welfare payments, fewer cases in criminal justice system, and other social cost-avoidance savings are realized by the community as veterans move toward becoming productive. Additionally, agencies recognize a savings of $600,000 in personnel dollars. The ultimate goal is that any veteran rescued from the street never returns to the street.

- **Consolidated Mail-Out Pharmacies - CMOPs (97-447): - 4/17/99, Bedford, MA VAMC and 5 other sites**

Prior to establishing the current centralized mail-out pharmacy sites, veterans had to wait up to 20 days before their new or refilled prescriptions would reach their homes. Six facilitates were recognized for moving an outdated manual process out of the hospital and into a high tech state-of-the-art process to serve veterans with accuracy and convenience. These facilities are: Bedford, MA; Dallas, TA; Hines, IL; Leavenworth, KS; Murfreesboro, TN; and West Los Angeles, CA.

VA's CMOPs have increased productivity from 20,000 prescriptions per year per staff person to over 50,000 today. The cost of filling each prescription has decreased from $2 to 80 cents, which translates into annual savings of over $25 million.

- **Veterans Village (97-382) - 2/19/99: Tampa Bay and Orlando Florida, Tampa FL - VAMC**

These two facilities have fulfilled the ideal of the National Performance Review in making a government that costs less and works better. The team is recognized for an ongoing partnership of governmental, business, community agencies and stakeholders to care for and treat homeless veterans. This transitional housing program is a vital component of the continuum of care available to homeless veterans. With assistance from this program, homeless veterans have become independent and productive citizens. The graduates of the program led the nation in their average annual income. The partnership present in Tampa is unique, and the Orlando site was opened without outside funding by an administration that believed in doing what was right, not what was easy. AFGE Local #0547 is the labor partner at this facility.

III. SELECTED BEST PRACTICES - 1999
Scissors Awards

- **Central Plains Network University (99-625) - 9/14/99: Health Care System Greater Nebraska, Lincoln, NE**

For designing an innovative education model to integrate education and training efforts across Network 14. The University provides a cost-efficient structure that facilitates an integrated approach to assessing, planning, developing, coordinating and delivering network-wide education to all levels of employees.

- **Claims & Risk Management (99-618) - 9/2/99: Washington, DC - VHA**

By working closely with users, this team developed and implemented a new, innovative scheduling methodology for VA major construction projects. Based on documented evaluation information, this re-engineered process saves time, money and personnel. Benefits from this effort include the monthly project status reporting turnaround time from 10 days to one day; elimination of $108,000 in mainframe computer processing cost and; elimination of the printing of more than 100,000 pages of reports monthly.

- **Virtual Learning Center (99-608) - 10/1/99: Washington, DC - VAMC**

The Virtual Learning Center is a ***ONE VA***, VA-wide initiative that any VA employee may use to share their innovations with throughout the Department. This sharing of knowledge results in saving resources otherwise expended on reinventing solutions which already existed at other VA facilities, but for which there was no systematic mechanism for sharing. To date there are over 370 innovations and patient safety lessons that have been shared. The labor partner at this facility is AFGE Local #2798.

- **Community Based Outreach Clinic (CBOC) for Homeless Veterans (99-600) - 9/3/99: VA Southern Nevada Healthcare System, Las Vegas, NV**

The VA Southern Nevada Health Care System joined forces with the Mobile Assistance Shelter for the Homeless (MASH) to reinvent the level and method of services that had been traditionally provided to homeless veterans in Southern Nevada. This facility was one of the first to support and participate in one of the country's newest approaches – a community-based, one-stop crisis intervention center for individuals who are "at risk" of being homeless or who are already homeless. The CBOC was able to reduce the emotional and physical fatigue of the homeless wandering all over the city to seek various types of assistance. Any homeless veteran in the Las Vegas area can come to MASH for assistance.

- **Patient Travel Lounge (98-581) - 12/16/99: New York, NY - VAMC**

The Patient Travel Lounge is an excellent example of a great customer-driven initiative as it is a direct result of a patient observation. This lounge, established to ensure the comfort and well being of veterans waiting for special transportation home as well as to assist the travel office in monitoring wait times, is unique in that it celebrates how special the veteran population is to the Department. Patients utilizing the Travel Lounge have increased to a current average of 55 to 60 per day. Patients are happy and a number of veteran service organizations have adopted the travel lounge to provide funding for enhancements.

- **Vocational Rehabilitation (98-580) - 8/3/99: Tuscaloosa, AL - VAMC**

The quality of life for veterans was enhanced by helping them improve their skills and ability for employment. The Transitional Work Program, a component of the overall Vocational Rehabilitation Program, provides opportunities for veterans to re-enter the work force through training and transitional skills that prepare them for community employment. Veterans are placed in selected work sites within the medical center, as part of their treatment program. Participants are paid for their work while they develop the necessary skills to compete in the workforce. During FY 98, twenty-nine veterans were transitioned from this program to employment within the community.

- **PreSet Burial Operation (98-570) - 7/1/99: Riverside National Cemetery, Riverside, CA - NCA**

Preset burial crypts were used to transform the conventional burial operation at Riverside National Cemetery to a creative approach to save land space. This process allows gravesites to be placed closer together which would increase the number of available gravesites per acre. Operational efficiencies were achieved in maintaining burial areas. An important aspect of this reinvention is that it affects the larger veteran population. The use of preset burial crypts allows Riverside Cemetery the ability to double the years of available service to veterans and their dependents.

- **Information Center (98-555) - 4/2/99: St. Paul, MN – RO&IC**

To address the issue of blocked calls, the Information Center Team proposed a pilot project to provide telecommunications support for 13 states in the Midwest that resulted in increased access to veterans and other beneficiaries who rely on VA to provide information about benefits and services via the telephone. In FY 1995, 81% of call attempts to VA Regional Offices resulted in the call being blocked.

- **Information Center (98-55) - 4/2/99: St. Paul, MN – RO&IC (Continued)**

In the 13-state region comprising VBA's Central Area, the blocked call rate averaged 27%, or approximately 605,000 of the Area's annual call attempts. By redirecting traffic to the Information Center, service to members of the public has been improved. Effective results were accomplished in partnership with AFGE Local #1969.

- **Blanket Purchase Agreement (98-551) - 9/20/99: Hampton, VA - VAMC**

This team reinvented Blanket Purchase Agreements and improved the quality of service by vendors while obtaining noteworthy savings for the federal government. Hampton VAMC and the Department of Defense teamed together and expanded their initiative that provided more cost efficient, high quality laboratory reference testing services for three VAMCs and six DoD medical treatment facilities. Blanket Purchase Agreements have resulted in over $1 million in FY 98 as well as equipment upgrades to the laboratories increasing capabilities, making them more efficient and saving money for the government. The team's actions have also made more efficient use of VA/DOD resources.

- **Marketing and Public Affairs (98-563) - 4/7/99: Syracuse, NY - VAMC**

Syracuse VAMC created a sense of partnership among the medical centers within the Network by sharing their marketing experience and media expertise. They developed an innovative approach to more efficiently educate veterans on eligibility issues as well as increase enrollment in VA healthcare. Instead of traveling to one central site to enroll for healthcare, VA goes to the veterans' hometowns. As a result, approximately 12,000 new applications have been processed, over 7,000 new veterans have been scheduled and seen for appointments, and identification cards have been issued. The increase in new veterans for Syracuse has enabled Network 2 to dramatically reduce cost per patient and increase market share.

- **Homeless Assistance (98-532) - 9/20/99: Honolulu, HI - VAM&ROC**

An enormous amount of time has been devoted to improving customer service to homeless veterans by the Veterans Service Center. The team's work ethic and vision made it possible to improve customer service to homeless veterans beyond providing basic outreach. Many homeless veterans do not visit the VA, therefore benefits and services for which they are entitled are not utilized.

- **Homeless Assistance (98-532) - 9/20/99: Honolulu, HI - VAM&ROC (Continued)**

Several new customer services for homeless veterans were established by the Veterans Service Center that include donated meal gift certificates, personal hygiene products, and clothing. These services directly contribute to improving VA's image to the homeless veterans as well as improve their accessibility to VA's benefits and services.

- **Urology Clinic Customer Service (97-438) - 4/14/99: Washington, DC - VAMC**

By reengineering their approach to prostate cancer screening, the Urology Clinic Team at the Washington, DC, VA Medical Center has met a critical customer need, significantly shortened waiting times and quite probably saved lives. By examining and streamlining processes top to bottom, veterans referred for prostate cancer screening today are scheduled for the procedure within one to two week time period versus having to wait several months. This reduction in waiting time provides enormous comfort to patients facing the possibility of prostate cancer and has eliminated any clinically significant delay in making a diagnosis.

IV SECRETARY'S ROBERT W. CAREY QUALITY AWARD

The Secretary of Veterans Affairs Robert W. Carey Quality Award is an annual award that recognizes Department organizations that have excelled in quality achievement. The Award follows the Malcolm Baldrige National Quality Award and the President's Quality Award criteria. It provides a model against which organizations can assess their quality transformation efforts, organizational effectiveness, and performance in delivering service and satisfying customers.

The Award is dedicated to the memory of the late Robert W. Carey, who as Director of the Veterans Affairs Regional Office and Insurance Center, in Philadelphia, PA, was recognized as a "Quality Leader" and a champion for excellence in the Federal Govemment.

Since the inception of the program in September 1992, the Department has recognized over 40 facilities as winners in different categories.

A. CAREY AWARD WINNERS - 1999

TROPHY WINNER

Grand Junction VA Medical Center
Grand Junction, CO

CATEGORY WINNERS

National Cemeteries Category
Florida National Cemetery Complex
Bushnell, FL

Health Care Category
Ann Arbor VA Healthcare System
Ann Arbor, MI

Benefits Services Category
St. Paul VA Regional Office
St. Paul, MN

ACHIEVEMENT WINNER

Manchester VA Regional Office
Manchester, NH

B. BEST PRACTICES - CAREY AWARD

Trophy Winner

The **Grand Junction VA Medical Center in Colorado**, a VISN 19 (Veterans Integrated Service Network) facility, serves the needs of veterans living in a 50,000 square miles area of Western Colorado and Eastern Utah characterized by extreme weather conditions and lack of public transportation.

Grand Junction VAMC's award winning creative approach to providing primary care was pioneered in 1988 and still serves as a model for VA hospitals across the country. The facility utilizes primary care teams to form a "virtual circle of care" around each veteran patient. In this way the VAMC has been recognized as a leader in customer service standards and customer satisfaction. ***Best practices include***: National Disabled Veterans Winter Sports Clinic; Patient Education Process Action Team which includes a veteran as a member; the Ergonomics/Healthy Back Program; Evening Clinic Pilot; anonymous E-mail suggestion program; and a successful and innovative Volunteer Program. Of particular note is the National Disabled Veterans Winter Sports Clinic, now in it's 14th year that has dramatically changed the lives of thousands of disabled veterans. In this program, they experience freedom and ability through the challenge of self-discovery promoted at the Clinic. Last year the VAMC lead its VISN in JCAHO scores and in national performance measures.

On the verge of the new millennium, the staff of the Grand Junction VA Medical Center vows to remain a thriving health care system for the Western Slope by ***Serving Those Who Served...With Excellence!***

Contact:

Kurt W. Schlegelmilch, M.D.
Director
VA Medical Center
Department of Veterans Affairs
2121 North Avenue
Grand Junction, CO 81501
Telephone: 970-242-0731 x2270

Laurel A. Stieferman
Chief, Clinical Support Service
970-242-0731 x2261

B. BEST PRACTICES - CAREY AWARD (Continued)

National Cemeteries Category Winner

Florida National Cemetery Complex, Bushnell, Florida, a Southern Area organization, is the winner of the National Cemetery Category. The complex comprises three separate cemeteries all committed to providing the best service to veterans and their families with dignity, honor, and respect. The team at the complex has produced a strategic business plan that is linked to the goals of the Departmental Strategic Plan. Strategies were identified to ensure continual service through increases in available burial space and burial options, maintenance as a national shrine, and continual development of the workforce. Measures and milestones are built into the plan to assure success. ***Innovative practices*** introduced include: partnership with state and local authorities to produce new sources of irrigation which resulted in the approval for the Vice President's Hammer Award; development of special tools; and use of radio frequency to broadcast information to cemetery visitors in their cars.

Contact:

Mr. Ronald R. Pemberton, Director
Florida National Cemetery Complex
Department of Veterans Affairs
6502 SW 102nd Avenue
Bushnell, FL 33513

Diane M. Polacek
Staff Assistant
Telephone: 352-793-7740

Health Care Category Winner

The VA Ann Arbor Healthcare System of Michigan, a VISN 11 facility, is the winner of the Health Care Category. ***Five strengths that set this institution apart*** include cardiac care, specialty care, research, financial stability, and ease of access to care. Patient care delivery has been reengineered to a patient-focused model. Teams to improve productivity and efficiency reorganized work processes in Administrative Services. An illustration of this is the creation of unit maintenance provider positions on inpatient care teams to utilize engineering and housekeeping talents early in their improvement process. Another initiative is the implementation of a case cart system that allows central supply to assemble case carts by type of surgery. A filmless radiology environment enables clinicians to read reports from anywhere in the facility that eliminates the need for hard copy x-rays and storage requirements while curtailing the potential for missing film.

Contact:

Mr. James W. Roseborough
Director, VA Medical Center
Ann Arbor VA Healthcare System
2215 Fuller Road
Ann Arbor, MI 48105
Telephone: 734-767-5458

Diane M. Stahle
Performance Measurement Coord.
734-769-7357

B. BEST PRACTICES - CAREY AWARD (Continued)

Benefits Services Category Winner

The St. Paul VA Regional Office in Minnesota is the winner of the Benefits Services Category. This facility, which operates as part of SDN 6 (Service Delivery Network), adopted quality management principles in 1990. They moved through the strategic planning process, employed the balanced scorecard approach, and have emphasized quality customer services. **Innovations introduced in the delivery of services to over 112,000 veterans and their families include** the consolidation of loan processing and servicing for an area that includes nine states. St. Paul Regional Loan Center works with local homeless providers to lease eight VA-owned properties for use by veterans. The Information Center has provided customer service to over 600,000 callers who would have otherwise received busy signals. One feature of the facility is a post decision review team that offers veterans a point of contact to discuss their case. The team's "1-800-Call-George" initiative provides an opportunity to resolve disagreements and increase veterans' confidence in the processing of their claims. The facility has received five of the Vice President's Hammer Awards and three VA Scissors Awards. **AFGE Local #1969 has been a consistent partner in advancing the VA mission at this facility.**

Contacts:

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VA Regional Office and Insurance Center
Bishop Henry Whipple Federal Building
1 Federal Drive, Fort Snelling
St. Paul, MN 55111
Telephone: 612-970-5200

Bonnie D. Lacki
Management Analyst
612-970-5205

Achievement Winner

The Manchester VA Regional Office is the winner of the Achievement Award. The office provides benefits to the state's 135,000 veterans and their families; and the Regional Office Director serves as team representative for the VBA Service Delivery Network (SDN 1) that administers benefits for 1.6 million veterans in New York and 1.4 million in New England. ***The facility was among the first*** to implement a partnership council between labor and management, which fostered employee empowerment, continuous improvement, and quality training. This office was the first Regional Loan Center. It served as the prototype for eight other centers nationally. Manchester was the recipient of the Vice President's Hammer Award for improving relations locally among the Veterans Benefit Administration's business lines and laying the groundwork for Business Process Reengineering.

Contact:

Mr. Edward J. Hubbard, Director
Department of Veterans Affairs - VARO
275 Chestnut Street
Manchester, NH 03101
Telephone: 603-666-7901

Louise M. Davis
603-666-7515

A. CRITERIA FOR HAMMER AWARDS

The Vice President's Hammer Award is reserved for teams of pioneers who create an innovative and unique process or program to make government work better and achieve results Americans care about. The Award recognizes accomplishments that are not repetitive of other awards or do not show only plans for future accomplishments. Hammer Awards go to teams who have shown large impacts on customer service, bottom-line results, streamlining government , saving money and exemplary achievements in government problem-solving. Nominations should reflects effective and creative examples of government at its best.

The Hammer Award is a tool to spur as much reinvention as possible across the front lines of government. Since 1994, over 1,200 teams have won the Vice President's Hammer award for starting and spreading reinvention. These teams, along with many others, always look for ways to make government work better, cost less, and get results Americans care about. It's part of their daily routine. Congratulations to those teams for their outstanding efforts in making this happen.

1) The Hammer Award recognizes team not individuals.
2) The team must include a federal component; state, local, and private/nongovernment entities can receive the award only in partnership with a federal agency.
3) Nominations must reflect real accomplishments (plan does not qualify for an award) and innovation in reinventing government.
4) Nominations must show real innovation in at least one of the following areas of reinvention:

    - Putting customers first
    - Empowering employees
    - Cutting red tape
    - Cutting back to basics (Stop doing things not in core mission)
    - Achieving results Americans care about

5) Nominations are strengthened if they show the following:

    - Bottom line savings or cost avoidance
    - Strong partnership (interagency, intergovernmental, private, nonprofit, or others)

6) Nominations must be written in plain language.

Nominations are denied if they do not meet the above criteria, or cause concerns by the agency, department, of the Office of the Vice President.

For more information, contact Sandra Eubanks Brown (202) 694-0040, sandra.brown@npr.gov; or. Leslie Schwager (202) 694-0107, leslie.schwager@npr.gov, at the National Partnership for Reinventing Government.

Additional Hammer Award Criteria

- Real Reinvention/Innovation (Mandatory)
  - Putting customers first
  - Empowering employees
  - Cutting red tape
  - Cutting back to basics (stop doing things not in core mission)
  - Achieving results Americans care about
- Real Accomplishments (Mandatory)
- Written in Plain Language (Mandatory)
- Best Practices (Strengthens)
- Bottom line savings/Cost Avoidance (Strengthens)
- Strong Partnership (Strengthens)

B. VA SCISSORS AWARD GUIDELINES

In the spirit of cutting red tape, the nomination process is simple and requires only one level of review and approval in order to be submitted for the Deputy Secretary's review.

A nomination may be submitted at any time during the year.

The nomination must be based on an initiative that was implemented within approximately the preceding 12 months. The intent of this time frame is to keep the Scissors Award focused on current practices, improvements and successes.

The justification should be short and to the point.

The justification must show clearly what the initiative is and how it improved service to veterans or other customers.

The initiative must have a proven record of effectiveness and have achieved its goal(s). Include all measurable outcomes, costs and time savings.

The nomination must be based on an implemented initiative and not just a good idea.

If the nomination is for a team or organizational effort, attach a list of the team members. Include managers only if they actively participated in the team effort.

Although not essential, we would like to know how you came up with the new initiative; e.g., from another facility, another federal or state agency, a veterans service organization, private industry, from something you read, or was the initiative an original bright idea from a member of your facility.

Nominations that cross-organizational lines and demonstrate cooperative efforts are encouraged.

There is no limit on the number of applications that can be submitted for either an individual or an organization or team as long as it is new.

Applications will be judged on their creativity, originality, value to veterans and their families, enhanced customer service, common sense implementation, appropriateness and transferability to other organizations.

VA SCISSORS AWARD NOMINATION

Mail your nomination to: Department of Veterans Affairs
Scissors Award Program (008B4)
810 Vermont Avenue, NW
Washington, DC 20420
or
Fax to: (202) 273-5991
E-mail to "Scissors Nominations: (MS Mail Address)

Questions? Call us at (202) 273-5071/5038

Nominee (Name of Team or Individual): _____
VA Facility Name and Address: _____
_____
_____

Name and Title of Nominating Supervisor: _____
Signature: _____
Telephone Number: _____ Date Initiative Implemented: _____
Fax Number _____

Describe an innovative initiative or act that has cut through red tape, streamlined operations and improved customer service. Show the date the initiative was implemented. Describe the outcome of the new procedure in terms of cost savings, improved timeliness, reduced paperwork or better service.

Please attach a short, one half page, plain English summary that would tell us why your initiative is a success (emphasize results and cost savings). This summary will be used to publicize your story to others if the team or individual is selected for the award.

C. CRITERIA – Carey Award

2000 Categories/Items		Point	Values
1	Leadership		**125**
	1.1 Organizational Leadership	90	
	1.2 Organization Responsibility and Citizenship	35	
2	Strategic Planning		**95**
	2.1 Strategy Development	45	
	2.2 Strategy Deployment	50	
3	Customer Focus		**95**
	3.1 Customer and Market Knowledge	45	
	3.2 Customer Satisfaction and Relationships	50	
4	Information and Analysis		**95**
	4.1 Measurement of Organizational Performance	45	
	4.2 Analysis of Organization Performance	50	
5	Human Resource Focus		**95**
	5.1 Work Systems	35	
	5.2 Employee Education, Training, and Development	30	
	5.3 Employee Well-Being and Satisfaction	30	
6	Process Management		**95**
	6.1 Product and Service Processes	50	
	6.2 Support Processes	20	
	6.3 Supplier and Partnering Processes	25	
7	Business Results		**400**
	7.1 Customer Focused Results	125	
	7.2 Financial Performance Results	50	
	7.3 Human Resource Results	75	
	7.4 Supplier and Partner Results	75	
	7.5 Organizational Effectiveness Results	75	
	Total Points		**1000**

The Programs Performance Excellence Criteria
The Performance Excellence Criteria are closely aligned with the Malcolm Baldrige National Quality Award Criteria (MBNQA), with several modifications to reflect the government environment.

VI. REPORT SUMMARY

This report identifies the 26 Hammer Awards, 50 Scissors Awards, and the Carey Awards that were presented in 1999. The intent is for the reader to scan the listings, find descriptions of interest, and then contact winning facilities for a detailed description of the best practices that were developed. Contact the Management Improvement Service, if additional information is desired. It is anticipated that during the year 2000, a database of all Quality Awards and Best Practices will be placed on the web and made accessible to all VA employees.

The Management Improvement Service gives special thanks and recognition to the Scissors and Hammer Awards panel and other organizations within the Department who have worked hard to support the efforts of this office. Without their commitment and dedication, these awards would not have been possible. We also recognize the effective input from labor organizations and other stakeholders on these initiatives. Through their efforts and continued support, we were able to effectively communicate and foster the idea that partnership does exist and is a significant asset to VA's mission, as many of these Scissors and Hammer Awards demonstrate. Special appreciation is also extended to Clara Martin and Gwen Young for their efforts in encoding the information relating to all Hammer and Scissors Awards that were presented at the Department of Veterans Affairs. Terrence Graham and Mark Whitney are recognized for setting up the database that was used to compile this information. A note of appreciation is given to Noel Quander and Melvin Daley for their continuing efforts to support the quality awards programs.

We also want to recognize the contributions made by VA's National Quality Council (NQC) for sponsoring this report and obtaining input from many of the VA locals of the American Federation of Government Employees (AFGE). All of the NQC representatives were particularly helpful on the initial draft version of the report.

Carstine Thompson

Martin Reiss

Management Improvement Service
(202) 273-5071/ 5131


Department of
Veterans Affairs

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