

# FISCAL YEAR 1998 DEPARTMENT OF VETERANS AFFAIRS BUDGET

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## HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

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FEBRUARY 13 AND FEBRUARY 27, 1997

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# FISCAL YEAR 1998 DEPARTMENT OF VETERANS AFFAIRS BUDGET

THURSDAY, FEBRUARY 13, 1997

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

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

Present: Representatives Stump, Bilirakis, Everett, Buyer, Quinn, Stearns, Moran, Cooksey, Chenoweth, LaHood, Evans, Kennedy, Filner, Gutierrez, Bishop, Clyburn, Brown, Doyle, Mascara, Peterson, Reyes, and Snyder.

## OPENING STATEMENT OF CHAIRMAN BOB STUMP

The CHAIRMAN. The meeting will please come to order.

I'd like to welcome all those that are appearing today to testify before this committee. For the first time in recent memory, we will hear testimony concerning the budgets of the American Battle Monument's Commission and the Arlington National Cemetery.

Our first panel is headed by our Secretary of Veterans Affairs, Jesse Brown, and we're looking forward to his statement.

The CHAIRMAN. However, Mr. Secretary, I must tell you I am very concerned about your health care budget proposals. The administration request assumes that Congress will enact legislation this year to allow VA to keep all the fees and health insurance collections it presently deposits in the Treasury.

It also assumes that Congress will enact Medicare subvention legislation which will produce over a billion dollars in the future years, the next 5 years. Additionally, this budget is based on an assumption that VA will lower its cost per patient by 30 percent over the next 5 years.

This committee will pursue Medicare subvention and retaining insurance collections as additions to our appropriated dollars, as we have done in the past. But let me remind you that the last time we tried to pass a third party collections proposal, I believe the veterans themselves came up and objected.

Now, maybe they're more uniform this time, and I hope so. But what concerns me is what happens, and I'll get to this later, if we don't pass this legislation by some means. Then we're going to be about \$590 million short in health care, and I don't know how we can overcome that.

I think it's unprecedented for VA health care spending to be conditioned on the passage of such legislation. Mr. Secretary, I'm also

concerned about the veterans going to school under the Montgomery GI Bill. The GI bill has probably been the most important Federal legislation passed in the 20th century.

It has done more to create a post World War II middle class than any other law passed by Congress. Unfortunately, it appears that the budget increases nearly every other education program while ignoring the GI bill. And we are determined to raise this issue in our budget deliberations this year.

Mr. Secretary, I'd also like to mention two other programs: the Cemetery System and the Benefits Administration. National Cemetery Director, Jerry Bowen, recently visited Arizona and our National Memorial Cemetery in Arizona and the Post Cemetery at Fort Huachuca.

Now, our cemetery's the tenth busiest cemetery in this country and I want to thank him for taking the time to come to see these cemeteries and also express my appreciation to you for recognizing the needs of Arizona's only open national cemetery in this year's budget.

Mr. Secretary, you've begun the process of selecting a new Under Secretary for Benefits, and I hope you'll try to find someone who can do for the Veterans Benefits Administration what Dr. Kizer is doing for the health care system.

It will take someone who is willing to bring innovative ideas to the difficult task of improving timeliness and the quality of claims processing, and I hope you find such a person.

I would now like to recognize the ranking member, Mr. Evans, for his statement.

[The prepared statement of Chairman Stump appears on p. 97.]

#### **OPENING STATEMENT OF HON. LANE EVANS**

Mr. EVANS. Thank you, Mr. Chairman.

I believe that the fiscal year 1998 budget proposed last week for the Department of Veterans Affairs is a pretty good starting point. It provides a foundation on which to construct a budget to meet the needs of our veterans.

For example, I commend the President and the Secretary for recommending VA retain all insurance and other third party reimbursements that the VA collects. VA retention of these funds to provide veterans' health care is a proposition this committee has long supported.

We should give this proposal full consideration. Our job is to make a fair and informed decision when the details of this proposal are made available.

On the other hand, I am disappointed that a budget that correctly emphasizes expanding educational opportunities for our citizens does not include an increase in the VA educational benefits. The strength of our Nation's economy and national security depend on and will benefit directly from improving education.

It is clear to me, however, that the young men and women who earn their GI bill benefits through honorable military service should be among the first to benefit from the President's commitment to improving the quality and availability of education in our country.

As Americans, we value our national honor and deeply respect our national commitments. If we do not keep America's promise to "care for him who shall have borne this battle and for his widow and for his orphan," our integrity as a Nation is undermined.

It will be our task and our responsibility to ensure that the budget we in Congress adopt provides the resources the VA needs to achieve excellent health care to veterans in a timely manner. The budget must provide VA the tools it needs to process claims quickly and accurately.

The budget must be sufficient to ensure that vocational rehabilitation opportunities we provide for our disabled veterans are second to none. The budget must ensure specialized services for blinded veterans and those with spinal cord problems continue to be among the finest in the world.

In short, the budget must be one that keeps America's promise to our veterans and their families. I look forward to working closely with you, Mr. Chairman, to achieve that goal.

[The prepared statement of Congressman Evans appears on p. 101.]

The CHAIRMAN. Thank you, Mr. Evans.

Mr. Secretary, let me take a second to remind those that are not familiar with that little green light, and I'm sure you are, that—and we have requested that if possible, we—if you could keep your remarks to 10 minutes.

Of course, as always, your entire statement will be printed in the record. And those statements of anyone testifying will be printed fully in the record.

The members will be recognized by seniority, those first that were here as the gavel went down, alternating from side to side. And those that came in after the gavel, of course, regardless of seniority, will be recognized after the members that were here before then.

Mr. Secretary, let me once again welcome you; and the floor is yours, sir.

#### **STATEMENT OF HON. JESSE BROWN, SECRETARY OF VETERANS AFFAIRS**

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

Mr. Chairman, thank you for allowing me to present the President's 1998 budget request for the Department of Veterans Affairs. I see there were several changes in the committee since I was here last year, and I would like to congratulate Congressman Evans on becoming the ranking Democrat.

I also would like to congratulate the new leaders of the subcommittees, Congressmen Everett, which I will be seeing, I guess, in a week or two; Congressmen Quinn, Stearns, Gutierrez, Filner, and Bishop.

Finally, I am glad to see all of the new members. We look forward to working with all of you.

Mr. Chairman, we are requesting \$17.6 billion for medical care, \$19.7 billion for compensation and pension payments, \$818 million for VBA, \$84 million for national cemeteries, \$234 million for research, \$79.5 million for major construction, and \$166.3 million for minor construction.

The details on the total of \$41.1 billion and 210,625 employees for VA programs are contained in my written testimony.

I think this is a good budget because it will allow VA to continue providing quality care and services to our veterans and their families. The President's proposal is innovative and historic. It builds on our progress and makes changes needed to operate within budget realities.

These changes and eligibility reform offer VA a great opportunity to expand and improve health care services, attract new revenue streams, and provide value to taxpayers. Our proposal includes some new tools to keep the system alive.

I am pleased to report that VA will expand and improve health care delivery in 1998 without any appropriated increase above the 1997 enacted level for medical care. This is unprecedented for our system.

Mr. Chairman, we have been very proactive in changing the way we do business. And if we are to continue, we need the help of Congress. Critical to this so-called baseline strategy is our proposed legislation to retain all third party collections.

Retaining MCCR collections will require an offset of \$1.9 billion dollars. The OBRA extenders that we are proposing provide savings of \$3.4 billion, which means \$1.5 billion for deficit reduction.

It is also our goal to collect Medicare reimbursement for higher income, non-service connected veterans who choose VA health care. This will require legislation authorizing the VA Medicare demonstration. Passage of our legislation package will permit us to accomplish the following:

By the year 2002, we expect to reduce the per patient cost of health care by 30 percent, increase the number of veterans served by 20 percent, and fund 10 percent of VA's health care budget from non-appropriated revenues.

These three goals are mutually dependent. We cannot accomplish any one of them alone. Without enactment of these legislative proposals, a straight line appropriation in 1998 would force the VA to deny care to 105,000 veterans and eliminate 6,600 health care positions.

By the year 2002, we would have denied care to half a million veterans. However, under our proposal, we would provide care to half a million more veterans; treat 3.1 million unique patients, an increase of 135,000 over 1997; provide 890 inpatient episodes of care and 33.2 million outpatient visits.

Mr. Chairman, we have worked hard on this proposal. And while it is different, if we are to accomplish our goals, we must increase the number of veterans that we serve. And we must be able to collect and retain the MCCR revenues.

We should no longer send this money to the Treasury. We should be allowed to use it to treat sick veterans.

Mr. Chairman, this concludes my statement, and I look forward to working with you and the committee members to honor the commitment we have made to our veterans and their families. I will now be happy to respond to your questions.

[The prepared statement of Secretary Brown appears on p. 118.]

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

I just have one brief question. And that is, what happens if the VA's plan for collecting these insurance monies or for us passing that bill—what happens if we don't pass that bill by the time the fiscal year starts? We're going to end up \$591 million short.

And would it be your intention to maybe ask for a supplemental or just what are we going to do?

Secretary BROWN. Well, the bottom line is that we have to have that money. What we have tried to do is look within the fiscal realities that we are dealing with. No longer are we going to enjoy the days of yesteryear when we were able to get a billion dollars each and every year.

That's not going to happen. So we have to look forward to the future to try to figure out a way that we can continue to make our services available to our veterans. And in order to do that, that's one of the reasons why we came up with the particular approach that I described.

If that money is not there, then obviously we are going to have to rely on the good will of the Congress to come to our aid. The bottom line is that we must have that revenue. And I'm particularly concerned about the \$600 million.

I would like to see the legislative proposal that we submitted granted because we have been working for it a long time. But certainly if it is not, I would like to see the money replaced through the appropriation process.

And with one caveat to that, I might say, Mr. Chairman. I certainly would hope that the money won't come from other veterans within our appropriation category. I just don't believe that it is fair to take money from one group to fund another group.

The CHAIRMAN. Mr. Secretary, I'm sure this committee agrees with you on that last point. And as you know, we've gone on record for many years favoring the collection and retention of these, along with these insurance funds, along with Medicare subvention. That may be a little harder.

And I realize it does not have probably any impact on the first year's budget, but in the out years it does.

Thank you very much, Mr. Secretary.

Secretary BROWN. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Evans.

Mr. EVANS. Mr. Secretary, you indicate that we're talking about \$600 million next year in third party reimbursements, but that's less collection expenses. What amount would be left after collection expenses are taken into account?

Secretary BROWN. The net effect for medical care would be \$468 million. But the reason why I talk about the \$600 million, and I'm excited about that, because this legislation allows for us to keep all third party reimbursement. And we pay for the collective efforts out of total revenue.

We plan on reducing that. We spend now about \$125 million to collect about a half a billion dollars. I think that's too much. We are right now in the process of developing a business plan that will allow us to reduce our expense ratio, and I plan on using the difference to invest in additional health care for our veterans.

Mr. EVANS. Well, the other side of the equation, how can we be assured that the VA won't be forced to reduce discretionary spend-

ing to offset third party collections that it receives? I mean, if we're totally successful on this, won't there be pressure on us essentially to see discretionary spending in the VA drop by that amount?

Secretary BROWN. Well, in our budget—again, I would have to throw myself at the mercy and the good will of our congressional process. In our budget, we call for straight lining appropriations at the 1995 level—1997 level; with the caveat, of course, that we be able to maintain third party reimbursements and also hopefully an expansion of Medicare subvention.

And if we interfere with that process, then the objectives that we have described—that I described in my opening statement will be severely compromised.

Mr. EVANS. So your fall back contingency plan is to come back to us if we don't achieve our third party collection goals?

Secretary BROWN. Yes, sir. You're the ones with deep pockets.

Mr. EVANS. Besides the actual health care problems that we're facing, how are the needs of homeless veterans, women veterans, and minority veterans better met by the VA under the proposed budget than they are today?

Secretary BROWN. Well, we have continued to maintain that these are high priorities within the VA. Over the last 4 years, our requests for additional appropriations for, let us say, homeless veterans—there are 250,000 that we have out on the street each and every night with no place to call home.

And we like to say that they do have a home, and it is called America—has increased about 100 percent. And we continue to invest. We continue to try innovative things. We are forging a close relationship with the private sector because many of them are doing different tasks and we want to try to discover what is the right combination.

So we would want to duplicate that. That effort will continue. Through the support of this committee and the Congress, we have offices that are mandated by Congress to respond to the needs of our women veterans and our minority veterans.

And I'm very happy that we have been out on the forefront, particularly with this issue involving sexual harassment. We are in the process, if we have not already, mailed a letter to every one of our female veterans inviting them to contact us if any of these tragic events happened to them.

And we'll provide a full array of services to help them get on with their life.

Mr. EVANS. All right; thank you, Mr. Secretary.

The CHAIRMAN. Thank you, Mr. Secretary, if you'd like to introduce those at the table, your assistant secretaries, department heads, please feel free to do that at this time for the record. We'd be glad to have that.

Secretary BROWN. Yes, Mr. Chairman; I didn't do so initially because I didn't want it to count against my 5 minutes. [Laughter.]

The CHAIRMAN. Mr. Secretary, we gave you 10 minutes today. I thought somebody told you that.

Secretary BROWN. We have our General Counsel, Mary Lou Keener; our Acting Under Secretary for Benefits, Steve Lemons; our Assistant Secretary for Management, Mark Catlett; Tom

Garthwaite, our Deputy Under Secretary for Health; and Jerry Bowen, our Director of National Cemetery System.

The CHAIRMAN. Thank you. We want you to know Dr. Garthwaite did a good job the other day testifying before our hearing on Persian Gulf Illnesses.

Secretary BROWN. Thank you.

The CHAIRMAN. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Mr. Secretary and members of the staff on the panel there, welcome.

Mr. Secretary, has CBO scored your portion of the budget yet?

Secretary BROWN. No, I think we—we're still waiting on the CBO numbers. Yes, we're still waiting on their analysis.

Mr. BILIRAKIS. What are you anticipating?

Mr. CATLETT. Mr. Bilirakis, we don't directly deal with CBO on this. It's an OMB issue. But we don't expect any significant changes because these proposals are the same that have been considered before.

Both the extenders, the extension of the savings proposals that are already in law for our benefits programs, and our MCCR proposals, for which the level of collections in our proposal has already been achieved, should not be a problem.

So we don't anticipate any major differences on those proposals.

Mr. BILIRAKIS. Well, you know, I just wish—and I commend the Chairman for holding this hearing. It certainly is timely. But I think we all would be a heck of a lot more comfortable if we had the CBO figures. But we don't have, so we can't do much about that.

But I know that in the past, the CBO has always scored, for instance, Medicare subvention proposals as costing Medicare a significant amount of money. And really, the only thing that we've been concerned with has been the DOD retirees, the DOD subvention, not the—all the veterans' subvention.

So your goal—you know, I don't think we should take the tack of throwing stones at the administration or at the administration's budget because it's a partisan thing to do or anything of that nature.

I know that the bottom line for all of us, of course, is veterans and taking care of our veterans. And I know how you feel about that, Mr. Secretary. And I can't really believe—I mean, you've done a good job sitting there and basically telling us the party line, if you will, the administration line; but I can't believe that it comes from your heart.

And I'm not asking for a response to that from you because it—you're throwing the whole onus basically on the Congress. Is the Congress going to pass these pieces of—these conditional legislation that you're referring to?

You know, we have big Medicare problems. And you know that as well as everybody else here. And now we're talking about taking more out of the Medicare fund that would ordinarily go into Medicare. We're talking about taking it and switching it over into the VA.

And that's going to be a tough nut to crack insofar as the Congress is concerned. The third party payor—I've always thought that

we should—that money should inure to the benefit of the VA, not go to the general revenue fund.

But we also have the budget to cope with now. And there's that certain amount that is a part of—that's contemplated in the budget. So now we're talking about taking that out of the budget; and that's not a sure thing, I don't think. Hopefully that will be an easier nut to crack than Medicare.

So you've considered how the Medicare program will fund your subvention proposal—you've taken all that into consideration in the process here?

Secretary BROWN. Yes. And Mr. Bilirakis, let me just say for the record too that you and I have known each other for a long, long time. And you described my commitment, and I could just take your words and just turn them right back because they certainly apply to you.

You have a strong veterans record historically, and I thank you for that.

We thought a long time. And quite frankly, we are somewhat confused about this concept that allowing VA to charge the Medicare account for services rendered would somehow reduce the Medicare Trust Fund. From our standpoint, that is simply not true.

First of all, we are only saying that it would only require reimbursement from high—from people that are currently locked out of the system. That's our so-called category C's, which is our high income, non-service connected veterans.

They are already using their Medicare. They're using it in the private sector. So we are simply saying, give them an additional option. If they're spending, let's say, \$4,000 a year in the private sector for care, we're simply saying let VA be on that list.

And so it theoretically is good government because we provide care generally at a lower rate than the private sector. So it will be, I think, a value that accrues to the taxpayer.

Mr. BILIRAKIS. Well, but you refer to the private sector. I'm talking about Medicare dollars which are now a part of the Medicare budget or the Medicare pot, if you will.

And now—and those dollars—if that particular veteran is not using Medicare now and is using the VA instead, then those dollars are there still for the benefit of that Medicare pot. But now you're taking and switching them from there over to the VA.

Secretary BROWN. No, no. What we are saying—we only want reimbursements for the people that are locked out of the VA. They can't get into the VA today. They simply—there is no one that we will request reimbursement for that's currently receiving care from the VA.

Mr. BILIRAKIS. Well, but there are people, sir—there are people, sir, who would be able to get the benefit from the VA who qualify under the eligibility rules who still currently might use Medicare or currently use third party—

Secretary BROWN. And they would not be billed. They would not be billed. Our whole philosophy and approach to this was not to request reimbursement for people that already had access to VA care. So therefore, you don't end up giving folks dual entitlement here.

For those that we already are taking care of, we will not bill Medicare. We would only bill Medicare for those who do not have entitlement or access to the VA currently.

So in that respect, it shouldn't cost, theoretically, Medicare one additional dime.

Mr. BILIRAKIS. I'm not sure—you know, I may have a misunderstanding, but I'm not sure that we have a meeting of the minds on it. My time is up, but it's something that we'll be continuing to talk about.

Secretary BROWN. Thank you.

Mr. BILIRAKIS. Thanks, Mr. Chairman.

The CHAIRMAN. Mr. Secretary, we're certainly going to need your help in getting this through the Ways and Means Committee.

Secretary BROWN. Well, we're going to work hard.

The CHAIRMAN. The gentleman from Pennsylvania, Mr. Mascara.

Mr. MASCARA. Thank you, Mr. Chairman.

Mr. Secretary, welcome.

Secretary BROWN. Thank you.

#### OPENING STATEMENT OF HON. FRANK MASCARA

Mr. MASCARA. These are not ordinary times. I'm sure we all agree to that. And many of us have the propensity to deal in smoke and mirrors as it relates to fiscal policies.

And I'm not suggesting that you're doing that, but I'm—as an accountant in my former life, I'm having some problems. On page two, there's a paragraph there, and I'll cite the area that I have some concerns about.

“Our budget request commits us to reduce the per patient cost for health care by 30 percent, increase the number of veterans served by 20 percent, and fund 10 percent of the VA health care budget from non-appropriated revenues by the year 2002.”

First of all, do you have any figures on what the reduction in costs would be by reducing those costs of 30 percent that you're talking about? The reduction—what would the reduction be? And what would be the increase in the cost for the 20 percent more that you're serving?

And where do you expect the non-appropriated revenues to come from?

Secretary BROWN. Okay, I'm going to ask Dr. Garthwaite to respond.

But before I do, let me just simply say—as I mentioned in my opening statement, each one of the three items that you described is dependent on each other; and we can't achieve the goal without having all three of them in the process.

And the basic concept is this: it is almost like computers. You know, when computers first came out, they were very, very high. But the more and more we produce, the prices drop. And that's because, as you know as an accountant, we're able to spread the capital costs across.

The more people involved, the less you can charge because you're spreading your capital costs across the basis. And so, that's basically the approach we're taking when we talk about increasing our veteran population by about 20 percent. And in that process, we're

going to end up actually decreasing the per patient cost by about 30 percent.

Let me ask Dr. Garthwaite to give us a better explanation.

Dr. GARTHWAITE. We have a multitude of things that we can do to decrease the cost in medical care. As the Secretary pointed out, we have a significant number of fixed costs. And currently, those costs are distributed over a smaller number of patients.

With more patients, the cost per patient goes down. Currently, because of the limited revenue streams that we get from appropriations, we have to treat the sickest patients. By bringing in some patients who aren't as sick, we not only reduce current average costs but avoid future costs. It's been shown that if you ignore health care problems and treat them at their latest stages, you spend a lot more money. We think we can decrease overall health care costs. In addition, we've taken on totally transforming the VA system.

As was mentioned by the Chairman, under Dr. Kizer's leadership and with the great cooperation of our 190,000 people in the system, we've been able to dramatically reduce the cost for care. As an example, in VISN 3 in New York, we've already reduced \$130 million in costs and been able to turn that into four new Community Based Clinics and improve the quality of care.

Based on Gallup Poll survey data, New York veterans are more satisfied. We've been able to change the way we think about providing care. Part of that is moving from inpatient to outpatient care. Part of it is being smarter about the way we buy drugs and services. Part of it is a national nursing home contract that gives us more choice and better rates.

So we have a myriad of things that we think will continue to ratchet down the costs, especially if we bring in some patients who aren't as sick.

In terms of the other revenue streams, we think it's critical that we introduce into the system a new variable, and that is incentive and risk. Not risk for the veteran; but in a sense, risk for the health care providers. And we believe that that is a powerful motivator.

All our people are very excited about where we're going. Most of our people, I can't say all. In a time of change, you can't say all. But I would say the bulk of individuals we talked to, as they get to know our agenda for change and become more comfortable with the change process, have been very excited about where the VA is going and the momentum that we're building.

And I think that we have a real great opportunity to use that to our advantage as well.

Mr. MASCARA. Well, that's fine. I'm still interested in knowing what kind of numbers you have assigned to each of those categories. You say you're going to serve 20 percent more and you're going to have an increase in the number of veterans that you're going to serve.

And you're saying all of that will be absorbed by the fact that you have more people going through the system and you're going to service those people with the same staffing pattern?

Secretary BROWN. No, it's going to be better. We are now moving—just 2 years ago—and the Chairman mentioned Dr. Kizer. Dr.

Kizer is just simply brilliant not only as a physician, but also as an organizer, and an administrator.

And we are now moving from where we were just 2 years ago when you would walk into our facility and before they would touch you, they ask you questions like are you service connected; or is that a non-service connected disability? Now we're moving toward primary health care.

And because of your help, we're going to be able to treat the individual. Once they're enrolled, they can come in and get care for anything as long as there is a medical need. So that's the kind of care we're moving towards. So it's not going to be the same.

Mr. MASCARA. My time has run out, but Mr. Secretary and Dr. Garthwaite, if somehow you could get to me and tell me how you're going to reduce the per patient cost and how much that 30 percent reduction means to you in your overall budget. We have percentages. We have no numbers.

Dr. GARTHWAITE. We have a spreadsheet we can get to you.

Mr. MASCARA. Thank you, Mr. Chairman.

[The information follows:]

**30% Reduced Price; 20% More Veterans Served; 10% less Reliance on Appropriations**  
 Major Policy Goals in the FY 1998 Medical Care Request

	1997 Base	Fiscal Year				
		1998	1999	2000	2001	2002
<b>30% Reduced Price</b>						
Current Service Unit Costs	\$5,846	\$6,068	\$6,296	\$6,537	\$6,765	\$7,030
% Increase over FY 1997 base		3.8%	7.7%	11.8%	15.7%	20.3%
% Decrease in Unit Cost		-5.6%	-12.0%	-18.0%	-24.0%	-30.0%
Net % Decrease after Inflation		-1.8%	-4.3%	-6.2%	-8.3%	-9.7%
Requested Unit Cost		\$5,742	\$5,595	\$5,485	\$5,362	\$5,277

**20% More Veterans Served**

Current Svc. Baseline Patients	2,937,000	2,937,000	2,937,000	2,937,000	2,937,000	2,937,000
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**Requested Increase Afforded by:**

Appropriation, MCCR & Sharing	134,914	233,965	315,460	408,657	481,877
Medicare		995	36,980	61,263	105,523
Net Increase in Patients	134,914	234,960	352,440	469,920	587,400
% Increase over FY 1997 base	4.6%	8.0%	12.0%	16.0%	20.0%

**Requested Unique Patient level**

	3,071,914	3,171,960	3,289,440	3,406,920	3,524,400
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**30% Reduced Price; 20% More Veterans Served; 10% less Reliance on Appropriations**

**Major Policy Goals in the FY 1998 Medical Care Request (Continued)**

(Dollars in thousands)

	1997 Base	Fiscal Year				
		1998	1999	2000	2001	2002
<b>10% Less Reliance on Appropriations</b>						
MCCR Gross Collections		\$590,918	\$669,503	\$749,397	\$824,749	\$902,913
Sharing & Other Reimbursements	\$75,000	78,000	103,000	128,000	153,000	178,000
C&P Exam Reimbursements		68,000	68,000	68,000	68,000	68,000
Medicare Collections		-	5,564	202,842	328,506	556,807
<b>Total Non-Appropriated \$'s</b>	<b>\$75,000</b>	<b>\$736,918</b>	<b>\$846,067</b>	<b>\$1,148,239</b>	<b>\$1,374,255</b>	<b>\$1,705,720</b>
<b>Total Requested Obligations</b>	<b>\$17,169,660</b>	<b>\$17,776,977</b>	<b>\$17,886,126</b>	<b>\$18,188,298</b>	<b>\$18,414,314</b>	<b>\$18,745,779</b>
<b>(Appropriation Portion)</b>	<b>(\$17,013,447)</b>	<b>(\$16,958,846)</b>	<b>(\$16,958,846)</b>	<b>(\$16,958,846)</b>	<b>(\$16,958,846)</b>	<b>(\$16,958,846)</b>
<b>% Non-Appropriation \$'s to Total</b>	<b>0.4%</b>	<b>4.1%</b>	<b>4.7%</b>	<b>6.3%</b>	<b>7.5%</b>	<b>9.1%</b>

The CHAIRMAN. Thank you, sir.  
The Chairman of our Oversight Committee, Mr. Everett.

#### OPENING STATEMENT OF HON. TERRY EVERETT

Mr. EVERETT. Thank you, Mr. Chairman.

Mr. Secretary, it's certainly good to see you, and I do look forward to your visit to Montgomery. I hope you have some time to go by Selma. I think you know both Alabama and Selma are very proud of the distinguished service that you've given to this country over the years.

Having said that,—

[Laughter.]

Mr. EVERETT (continuing). I also share some serious concerns about this budget. This budget, in all honesty, appears to me to be a budget that has built in shortfalls in the out years. And those are pretty obviously recognized. I recognize them right off the bat.

As an example, the 1998 budget indicates that the MCCR collections jump from \$557 million in 1996 to \$903 million in 2002. Considering the fact that that indicates almost an 80 percent increase in your collections, how do you explain that you're going to be able to do that?

I don't want to see a situation develop where we recognize and know that there are shortfalls there, and yet the administration comes back and says well, the Congress wouldn't give us more money when they built the shortfalls into the budget to start with.

Secretary BROWN. Well, one of good things that's come out of this whole process, and obviously I personally have not necessarily agreed with the end result; but what has come out of it is a desire—not a desire. It's a situation which has forced us to look for every opportunity of efficiency.

And let me just—and you mentioned the MCCR. Now, when we look at that—and I mentioned as one example that we—that I gave. It cost us \$125 million to collect \$500 million—\$545 million or so a year.

And that's with no incentive. No incentive whatsoever. None. So there are two things right there that we can look at. Number one, I don't want to spend \$125 million to collect that. The private sector probably is doing it much cheaper, which we are looking at.

We are looking at bringing that cost down. I'm looking at somewhere around, quite frankly, about \$50 million—\$50 to \$75 million to collect that money. That's one thing. So we will take the difference and just add it to that number.

Another thing is this. The VA—we've got a kind of a crazy system in—when a bill comes in, we could just—no matter what the cost is, we charge a flat rate, \$150. We are moving away from that. We are going to look at what our actual cost is.

And I think that that's going to have a significant impact on the amount of revenues that are generated. So those are some of the things that—the reason why we are very confident that we can achieve the goals that are contained in the budget proposal.

Mr. EVERETT. Well, I think rather than pursuing that topic, the Oversight Committee will have additional hearings on this, and we look forward to discussing it with you.

Let me switch just a minute. The veteran population continues to age, as you know, rapidly. Yet this year, the administration is again requesting a decrease in funding for the State Extended Care Grants Program. I think that's not working in favor of the veterans.

Secretary BROWN. Well, let me tell you, you're absolutely right. I don't disagree with you on that. I think that's one of our most efficient programs in terms of our cost efficiency that accrued to the Federal Government or to the Federal taxpayer.

But I have a real major problem. I only have so much money. And so we had to prioritize what was important to the veterans and their families. I would have liked to have, for instance, a straight line increase on each and every account. I would—it hurt me to my heart that I had to reduce research.

You know, so there are many things that I would have liked to have done. But looking at the fiscal realities of it, it just was not enough resources to do what I wanted to do. So we had to make the best judgement that we could.

Mr. EVERETT. I appreciate your concern about reducing research also in light of the Persian Gulf situation that we're currently facing.

Mr. Secretary, as always, I enjoy our conversations. They're always interesting, and I do look forward to seeing you in Montgomery.

Thank you, Mr. Chairman.

Secretary BROWN. Mr. Everett, on the issue of Persian Gulf, I do want you to know in our research there's certain things that we fenced off, and Persian Gulf research would be protected. It will certainly not suffer.

I'm sure that it will probably continue to grow as a larger percentage of any research dollars that are available.

Mr. EVERETT. Mr. Secretary, I'm pleased and I know the committee is pleased, to hear that. Thank you.

The CHAIRMAN. The gentleman from Texas, Mr. Reyes, is recognized.

#### OPENING STATEMENT OF HON. SELVESTER REYES

Mr. REYES. Thank you, Mr. Chairman.

Mr. Secretary, it is always a pleasure to see you, and I too appreciate all the work—the hard work that you do on behalf of our veterans. I have just a couple of questions.

The first one I have is, from the district that I represent, there are a number of unique issues that come up with minority veterans. And specifically, well, as an example, the development of diabetes and things like that.

Are there specific programs that the VA is engaged in to address those unique issues as they pertain to minority veterans?

Secretary BROWN. Yes, sir. Because of the support of this committee and the Congress in general, we have a minority veterans' program under the direction of Willie Hensley, who happens to be a retired colonel. He is doing an outstanding job at recognizing the unique needs of minority veterans and developing close relationships with various components of our Department to try to find resolutions.

So he is doing a great job on that side, and Joan Furey is doing a great job on the women veterans side to address those kinds of concerns.

Mr. REYES. Thank you. Just switching—because I'll tell you, there is a large segment of the minority veteran population that lives along the border, specifically down in the Rio Grande Valley, where accessibility to VA health care is—use the word impractical since they have to travel over 200 miles to the closest facility.

And I notice in the budget that you were forced to take a 543 FTE cut. And it's mentioned that this will be offset by streamlining and restructuring and doing other things that will make the Department much more effective.

In lights of the needs that we specifically have in those Minority populated areas, is it practical—and I believe we understand the situation you're in; but is it practical to take a 543 FTE cut, with areas that are under served like that?

Secretary BROWN. Sir, the 543 cut that you refer to is VBA. That's our Veterans Benefits Administration. So it has nothing to do with health care. But with respect to health care, what we're doing is really much more exciting.

We're going to have some cuts in health care that we are proposing. I think we're proposing in the 1998 budget about a 1,700 FTE reduction. But what's exciting is, the savings that are being generated. One example is our inpatient bed census is going down and our outpatient episodes are going up, which represent a tremendous savings.

We are taking that money and we are reinvesting it in access. We're developing—we're going to have hundreds of new Community Based Clinics all around the country so veterans will be able to go and get their primary health care.

That's going to be very cheap, very cost effective because we can just come to, say, Dr. Bishop and say Dr. Bishop, you, for all intents and purposes, will be a VA community based clinic. We're going to send all of our patients to you. You will take care of them.

If they need sophisticated tests, then you will send them to a VA hospital. Of if they need hospitalization, they'll go to a VA hospital. If there's an emergency nature, we'll have a sharing arrangement already established with the local facilities.

So these are the kinds of things that we—what's in our plan to allow us to increase the number of veterans we treat by 20 percent—that we are describing in this particular budget. So we think it's really good news in the long run; but we have to keep the package together, or otherwise it falls apart.

Mr. REYES. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. The gentleman from Arkansas, Dr. Snyder, is recognized.

#### OPENING STATEMENT OF HON. VIC SNYDER

Dr. SNYDER. Thank you, Mr. Chairman. I'm sorry I had to step outside.

I wanted to go back to Congressman Mascara's concern about the—what I call government by base ten number system; you know, 30 percent and 20 percent and 10 percent. Because it seems like, as time goes by, if instead of, you know, that 10 percent, it

turns out to be a 3 percent, and a 30 percent turns out to be an 18.7 percent, and a 20 percent turns—we don't pass it, or whatever; you know, something happens, and suddenly you're billions and billions of dollars behind.

So I would be interested in seeing the written evaluation too of how you came at those numbers. Tell me, when you look at your per patient cost over the last decade, what has your—do you know off hand what your per patient cost has done?

Secretary BROWN. Yes, it's about—

Dr. SNYDER. Has it been going up like everything else has?

Secretary BROWN. Yes. It's about 43—the average across the country is about \$4,300. One of the things that we're doing is we're looking at pulling—well, that's the average. We're looking on the positive side of the average where some of the facilities are as high as 40 percent—40 percent higher.

So we're forcing them to come closer in line, making adjustments for things like higher labor costs, special treatment modalities, education, research, and that type of thing. So we're squeezing that.

Dr. SNYDER. What has your cost done the last 5, 10 years? Has that—

Dr. GARTHWAITE. In constant dollars, it's been going down.

Dr. SNYDER. It has been going down?

Dr. GARTHWAITE. Constant dollars, yes.

Dr. SNYDER. So do you know in what—are we talking one or two percent a year, or—

Dr. GARTHWAITE. Yes, about that range.

Dr. SNYDER. Okay, so you're anticipating—so a 30 percent reduction over 5 years, you're looking to increase what you're doing now by 20 percent or so or—I guess that's not a fair way of looking at it.

Have you had any independent folks look at your numbers that have been kind of involved in the delivery of medical care in terms of coming—helping—giving you a truth check on these numbers? And are they—or are they just going to be kind of numerical goals like all these lofty things we're going to accomplish by the year 2000 and the year 2001 we're going to—

Dr. GARTHWAITE. We have had significant outside input, especially at the network level. Several of the networks have contracted with the Meidcal Advisory Board, others have used Ernst & Young.

Dr. SNYDER. Did you have any of your consultants that you looked at or talked to or people you brought in, kind of the minority side of things, that said no way are you going to make these goals; why are you even throwing these out there?

Dr. GARTHWAITE. Not that I'm aware of.

Dr. SNYDER. Okay.

Dr. GARTHWAITE. I think it's been reviewed by many people in different places, and we've just gotten the network plans in.

Dr. SNYDER. I won't ask any further questions. But I would like to see the break down. I'm interested in what Congressman Mascara was, was 2 percent percent related to what, and was 2.7 percent—how we got to a total of 30 and 20 and 10.

Dr. GARTHWAITE. We agree with you that these are stretch goals. But we also believe that the best organizations in the world set stretch goals and stretch targets to achieve the best.

Dr. SNYDER. Thank you. Appreciate that.

The CHAIRMAN. The ranking member on the Benefits Subcommittee, Mr. Filner.

#### OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for welcoming us back. We are pleased to see you again and very glad you are continuing to serve as Secretary of Veterans Affairs. You have maintained excellent communication with the veterans of San Diego and across the country. You are doing an incredible job, and we thank you.

To quote Mr. Everett, “. . . having said that . . .”, we know the budget pressures you work under. Nonetheless, many of us are disappointed in some aspects of the proposed VA budget for fiscal year 1998, as I know you are. I am particularly disappointed in the veterans’ education programs funding. Obviously the Montgomery GI Bill benefits have not kept up with the ever-rising costs of higher education—which creates significant pressures for our veteran students. To highlight that issue, I am introducing a bill, and I invite all the members of our Committee to join me, which would provide a 10 percent increase in Montgomery GI Bill benefits. I believe this is the minimum level of increase we should be talking about.

My bill would also increase education benefits provided for the children and surviving spouses of those who die while on active duty or are permanently and totally disabled as a result of their military service. The benefits paid under this program haven’t been increased for 7 years—and the costs of education have soared during these years.

I want to help you out with this issue, and I hope my bill will at least spotlight the needs that are there. With your fabled ability to get what the VA needs from the President, I was surprised, the budget didn’t include increases in veterans’ education programs. Given the President’s emphasis on education in his State of the Union address, and your long commitment to providing meaningful education assistance to veterans, I’m surprised the benefits paid under the Montgomery GI Bill and other education programs administered by the VA were not increased.

I hope you can build on that with the President in further budget considerations—and that you can point out to him that he left out one very important group when developing his education improvements. So, I look forward to working with you to accomplish what I know is our shared goal.

Secretary BROWN. With respect to your comment about the increase in the educational benefits to include Chapter 35, I would only ask that any increase not come from another veterans’ program. Let us look somewhere else for that adjustment.

I don’t want to get into a situation that we’re taking from widows and sick veterans to fund an educational adjustment. And likewise, in the opposite direction, I wouldn’t want to take from people that are receiving education benefits to do the same thing.

And so I would like to see new money come into the process. And with respect to asking the—

Mr. FILNER. So moved.

Secretary BROWN (continuing). With the President to consider a new emphasis in his educational agenda, next time I see him, I'm certainly going to bring that to his attention.

Mr. FILNER. Thank you. I understand and share your concerns about taking from one VA program to give to another. We have other concerns with the budget and, as we discuss them, I hope we can somehow find additional resources. I think you know that whether it's the transition assistance program, the benefits programs, or the health care programs, we want to do more in all these areas. As you know, you have a lot of allies on this Committee, and we all want to help you in every way possible. We look forward to working closely with you.

Thank you, Mr. Chairman.

The CHAIRMAN. The Chair recognizes the ranking member on the Health Subcommittee, Mr. Gutierrez.

#### OPENING STATEMENT OF HON. LUIS GUTIERREZ

Mr. GUTIERREZ. Thank you, Mr. Chairman.

Chairman Stump and ranking member Evans and Mr. Secretary, all of your staff, I'm happy that we're here to discuss the fiscal year 1998 budget for the Department of Veterans Affairs.

As we all know, the process of change and reform at the DVA has picked up speed dramatically during the past year. Nowhere is this more evident than in President Clinton's budget request for fiscal year 1998.

It seems to me that while overall, funding has not decreased from the 1997 level, the already scarce resources available to the VA will be allocated in a different manner than in years past. A number of service networks will face significant shortfalls this year and may be forced to consolidate and eliminate some services in their regions.

The ramifications of the new VA resource allocation framework will be profound. In my review of VISN 12 based around Chicago area, we will lose approximately \$57 million. VISN 1 in Boston will lose \$52 million, and VISN 3 in the Bronx will lose \$148 million.

The question the members of this committee must ask, and we are certainly seeking your answer, is how will these cuts affect veterans? Now, I'm not quite sure how we're going to take a reduction in 30 percent of care costs for patients and offer 20 percent more to veterans and have 10 percent more overall VA health care funds to do that with.

It sounds remarkable, and I hope that the VA can obviously achieve this goal. However, in Chicago and in many areas facing similar reduction, will the VA be able to provide more care with so few resources? This committee must find answers to these important questions with you, Mr. Secretary.

It's our obligation in this committee to guarantee that veterans throughout our Nation receive the best care available and that VA restructuring does not take from some veterans, as you have suggested will not happen earlier.

I am sure that this is not the intended goal. But I think it's something that we really need to examine very, very, very closely. As the ranking member on the subcommittee on health, I intend

to pursue this issue vigorously in conjunction with Chairman Stearns, obviously.

I look forward to working on that issue with him and with you, Mr. Secretary.

Let me just ask one question because I know it's been asked before here this morning, but maybe I could just get a little more clarity. The notion veterans will be better served through more efficiency while VA employment is reduced has been a premise in many past VA budget proposals.

Why is this year's version, the so-called 30-20-10 Health Care Plan, more likely to succeed than failed past similar proposals, reduce patient care costs by 30 percent reduction, offer health care to 20 percent more veterans, obtain 10 percent of VA health care funds from sources other than appropriations?

The 30-20-10 Health Care Plan has been called a gamble. What do you feel, Mr. Secretary, are the odds for its success; and what is the future of the VA health care system if the gamble fails?

Secretary BROWN. Well, thank you so very much for those observations. Let me just respond.

With respect to VISA 12, the 1997 reduction that we are targeted at is about \$8 million. The number that you use is—I think it's a 3 year total. And to give you an idea of what we hope to achieve when we assign these target reductions, the hospitals there, Lakeside, Westside, and Hines, are all very closely related.

In fact, Westside and Lakeside is about 6 miles from each other. And as a result, we asked ourselves some basic questions. Why should we have two separate personnel departments? We only need one. We asked ourselves why do we need two separate directors, assistant directors, and assistants to the assistant directors?

We only need one. So those are the kinds of things that we use to force the region to become more efficient. So that's a reflection of what we see in these numbers.

Now, with respect to why do you think that we're going to—why do we think we're going to be successful, I can only tell you that certainly any business plan, there is risk involved. But we have a lot of smart people working at the VA, and the history shows us that we're moving in the right direction.

For instance, already we have cut about 7 percent and increased patient load about 5 percent. So it's moving in the direction that we have to move in if we are going to survive. I personally don't want to be on the ship, let alone leading the ship as captain of the ship, if—to start closing down—wholesale closing down hospitals.

So in order to keep this system alive so that it can be there to take care of our World War II veterans that I'm really concerned about, our career war veterans that I'm concerned about, little less our Vietnam—because they're still pretty young and they can make adjustments.

But I'm really worried about World War II and Korean War veterans. I want to make sure that system is there so that it can respond to their needs when they do not have the capacity to respond to their individual needs. They can't go out and get another job that has lifetime health care.

So in order to do that, I've got to look at the entire system to make sure that we maximize the resources that have been made

available to us by the American tax people through our democratic processes and so that we can honor the commitment that we made to them. And that is our only goal.

If we fail, we revisit this each and every year. And since we have so many friends here in Congress, I know they are not going to let the ship sink.

Mr. GUTIERREZ. Mr. Secretary, thank you for being here with us this morning. Look forward to meeting with you with the Illinois delegation. I know I talked to Senator Durbin. He gave me a call. We look forward in a kind of Washington, DC setting to talk to you and get some answers about what's happening in our own visit.

I'm sure that you'll probably get a call from the Massachusetts delegation now to meet with them and the other delegations. But knowing that you meet with everybody, I look forward to that meeting so we can start getting some answers and working with you.

Thank you so much.

Secretary BROWN. Thank you, sir.

Mr. GUTIERREZ. We're always proud you're from Chicago.

Secretary BROWN. Thank you so very much, sir.

The CHAIRMAN. The Chairman of our Benefits Subcommittee, Mr. Quinn, is recognized.

#### OPENING STATEMENT OF HON. JACK QUINN

Mr. QUINN. Thank you, Mr. Chairman.

And Mr. Secretary and your team, welcome back. We've seen a lot of each other these last couple of days, and I want to thank you for your interest and your sharing of information.

Mr. Gutierrez makes a good point about your willingness to share information. Those of us in the New York delegation met with you and your staff yesterday. A follow up meeting in my office right after that with some of your staff was very, very helpful.

And one of the things that I said at our meeting yesterday with the New York delegation might be worth repeating today. And it was, I think, a mild criticism, but one that also is a pat on the back. I would suggest to all of our members that the Secretary and his staff are doing some great things out there.

You explained to the New York delegation some of those cost savings and how you're actually seeing more veterans at a cheaper price. Mr. Snyder—Dr. Snyder has left. When you talk about that \$4,300 per patient number, that is going to go down a little bit; and you're actually seeing more veterans.

It sounds impossible, but it's actually happening because of some things that you and your staff are doing. The problem is, it's one of the best kept secrets around. And I'll tell you, for one, the New York delegation learned a great deal yesterday, as will the Chicago and Massachusetts and others.

And I would only encourage you, as I did yesterday—maybe in some strong terms yesterday—but suggest to you that you ought to tell that story. And that those of us on this committee need to hear it, and that's our responsibility to go out and hear that as well.

Communication is a two way street. But it will help us answer those questions. And I appreciate you doing that yesterday. Those numbers, in our vision up in New York and other places, we still

have to work on. But don't keep it a secret. You know it. Let this committee know it so we can let other parts of the country.

And most importantly, so we can let our veterans know back in our districts. And we can prepare them for some changes. We can also tell them the good news when we sometimes have to deliver some bad news too.

So that went very, very well, and I think a lot of what's been talked about earlier this morning heads in that direction.

Some specific questions. Dr. Garthwaite, you mentioned yesterday and again today that theoretically some of these numbers are going to go from 30 and 20 and 10, and you talked about being able to get to 10 percent of non-appropriated funds in the year 2002.

All of that Medicare subvention and these things are new. Let me ask a general question only. Sometimes we need to walk before we run. Have we given any thought to some test sites for some of these new ideas, some of these new plans, before we do it all at once?

And that might be helpful to see how it works in some areas before we change the whole system.

Secretary BROWN. Mr. Quinn, that is exactly what the proposed legislation would accomplish. It's a test project. It's not—it does not—at least the proposal does not request that we implement the program. It's simply to test it to see if it will work. Quite frankly, to answer the questions that you just asked.

Mr. QUINN. You talk about 10 percent of non-appropriated funds by the year 2000 or 2002. How much right now are you using of non-appropriated funds?

Mr. CATLETT. Less than one percent. Less than a half a percent actually. It's only \$75 million in this year.

Dr. GARTHWAITE. If you would include MCCR which now goes into the Treasury, it would be up to about 4 percent. So the 10 percent goal included what we're already billing, plus our CHAMPUS and other things.

Mr. QUINN. Okay.

Dr. GARTHWAITE. So we do have pilots in CHAMPUS, and we're working with the Tricare providers to provide some care to DOD beneficiaries. And we've had pilots with CHAMPUS for quite a long time.

We briefed Ways and Means yesterday on our proposal for Medicare, and we're trying to work with them to provide assurances both that we will not make a run on the Trust Fund, which is a concern; and in addition, to make sure that we provide adequate data to demonstrate that we're cost effective and efficient in delivering that care.

So we have proposed two specific pilots.

Mr. QUINN. Well, that's absolutely heading in the right direction then for 2002. And I think Dr. Snyder has some excellent observations in that area.

Dr. Lemons, I talked to Ms. Moffit yesterday. Mr. Filner and I are going to be working—it's great to have you all here. There's so many questions, the 5 minute rule doesn't allow enough time. I just want to let you know that we'll be looking forward to working with you to maybe streamline the compensation claims processing system a little.

Just an observation, not a question. And then finally, as time runs out here, again to pick up on something Mr. Filner said, in terms of education money and the President's thrust generally for education and the treatment of the Montgomery Bill here and your response about new money, I don't think we should forget that the President of the United States is a player in this discussion—a big player.

And I think that when you say you're going to mention some of this to him, I think we can get more formal than that. I think that maybe we can help you as members on both sides of the aisle of this committee to get the President's attention to get some new money for the Montgomery GI Bill.

I mean, we don't receive the budget, do our little things in absence of the President. This is budget. It's your budget. It's his budget. It's going to be our budget, the budget for the veterans of this country. We shouldn't discuss, we shouldn't argue and compromise without the administration being involved.

So I would encourage you to do that. I would encourage our chairman to include this committee in our efforts to get the President to pay attention to this as well.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, sir.

The gentleman from Indiana, Mr. Buyer, is recognized.

#### OPENING STATEMENT OF HON. STEVE BUYER

Mr. BUYER. Thank you, Mr. Chairman.

Mr. Secretary, I'm trying to go through the numbers play here. I think you can conclude by—from all the members here that we have some skepticism. I guess it's a skepticism because of over the years, we've had administrations where the Republican even come here and they give expectations that aren't fulfilled.

And we're also seeing that now. And the numbers are extremely important. So, you know, I have a responsibility on the National Security Committee. I've got—in my subcommittee over there, I've got the whole military health delivery system, so I understand when terms get thrown around.

You know, we've got \$4,800 cost per beneficiary in the Medicare system. You threw out that you have \$4,300 cost per beneficiary. I've seen many about the private systems around \$2,000. The military health delivery system is around \$1,600.

It's very easy for us on this whole Medicare subvention issue to sell it with regard to the retired military retirees because if—you know, bringing them in to the military health delivery systems when it's at the \$1,600 cost per beneficiary as opposed to paying out \$4,800 makes good business sense.

I'm uncomfortable though when you come here and say but ours is less than what we're paying out in Medicare. I'd like to know from you specifically when you calculate your figure, your \$4,300, does it include your capital costs, capital improvements, your personnel and the benefits?

Secretary BROWN. Yes. The answer—the answer to that is yes.

But before you—before I make another statement, let me back up just a little bit to say that the \$4,300, sir, is an average. We have

within that some of our facilities as far down—I remember a number like \$2,200.

And we have to keep in mind that it's not fair to compare the military with the VA because the military, they're young, they're healthy, they have a mix of women who are healthy, they have young folks, children. And in our delivery of—

Mr. BUYER. Time out. I'm not comparing. I just threw out that we do have different type of systems out there at relatively different costs.

Secretary BROWN. Oh, okay.

Mr. BUYER. I understand about the military health delivery system.

Secretary BROWN. Okay.

Mr. BUYER. What I want to try to get at so I can understand the numbers—I'm going to yield to my friend over here, if you'd like to. You're on the right path. I'm not an accountant. It's the numbers—it's the numbers that don't lie. It's the numbers that are very real.

That's what we have to deal with. I think you are on the right path, and I want to yield to you because you ran out of your time. If you want to explore it further, I'd yield to the gentleman from Pennsylvania.

Secretary BROWN. We're going to get you what you want.

Mr. BUYER. Well, no; I want him to—see, I don't want him to let you off the hook that easily. [Laughter.]

Because the accountant over here knows the numbers, and I think he still has some questions.

Mr. MASCARA. Well, first of all, Mr. Secretary, I don't mean to be contentious. I did take the time last night to review the material that was supplied to me, your complete statement. And those matters jumped out at me.

I have another question about modeling. What type of modeling did you do to arrive at the 30-20-10 calculation? Did you use some model, or was—did you pick that out of the air, or did you use some past statistics that you might have had?

Dr. GARTHWAITE. I think the easiest answer is that Dr. Kizer is in Chile and we don't have his ability to get into his mind. As I said, those are stretch goals. But I think there's some realism to them.

There are a lot of assumptions, models are based on assumptions. You can have any number of models. We believe that it's critical for us to bring in some additional patients to allow us to spread our fixed costs, which we can't get rid of unless we start closing hospitals, and start down a very steep slope for closure of the VA system.

We need to have the kind of patient base that justifies keeping all those fixed costs in place, and provide care effectively and efficiently and give the taxpayer good value for their money, that's what this is all about.

So the answer to your question is we use models to project; but in a sense, these are stretch goals that really are to stimulate our creativity.

Mr. MASCARA. And one last question. If, in future years, you cannot collect Medicare—and I think your response, Mr. Secretary,

was we'll come back for more appropriations. If the 30-20-10 doesn't work out, do you have a contingency plan? Where are you going to go?

Secretary BROWN. Well, one good thing about that. This process is reviewed each and every year, so we have a—kind of like a built in tracking and evaluation process that will let us know where we are at all times. So it's not as if we're going to be bush whacked and all of a sudden we find that we are not going to be able to achieve our goals.

So we think we have a real handle on that. We don't expect anything, whether it's positive or negative, to just all of a sudden come up on us one day. We will know what's going on each and every day, and we'll be able to make appropriate requests.

Mr. BUYER. Mr. Mascara, can I reclaim my time?

Mr. Chairman, you know, we're being asked here to make a very serious gamble on some assumptions out there that I think needs to be scrubbed through CBO. I think there's some members—all of us here are really a little uncomfortable at the moment. But I wanted to share that with you.

Thank you, Mr. Chairman.

The CHAIRMAN. The Chairman of our Health Subcommittee, Mr. Stearns, is recognized.

#### OPENING STATEMENT OF HON. CLIFF STEARNS

Mr. STEARNS. Good morning and thank you, Mr. Chairman.

And good morning, Mr. Secretary.

Secretary BROWN. Good morning.

Mr. STEARNS. I have a great deal of respect for you. Last year I asked you to sort of a difficult question about the Clinton administration's budget for veterans, and you took the unusual step of saying that you thought it wasn't high enough and big enough.

So after that, I've sort of notched you up very high in my estimation, so I sort of feel that you're—usually you come up here straightforward and speak right to the point and are working very hard for veterans.

With that in mind, I wanted to talk to you a little bit about the Medical Care Cost Recovery Program. Just for members here, I'd like to just give its mission—it is to maximize the recovery of funds due VA for the provisions of health care services to veterans, dependents, and others using the VA system.

I have a couple of questions. And if you would indulge me perhaps just with a short answer, if you could. Maybe yes or no would be helpful. And this is both for my benefit as a new chairman of the health subcommittee and also for our staff so we can better understand this area.

Isn't it true that you lack a methodology to accurately estimate the collection of potential VA MCCR program?

Secretary BROWN. Yes.

Mr. STEARNS. Okay. Since you project that VA will continue to shift more and more care away from high cost inpatient stays to low cost outpatient care, isn't it quite possible that that will adversely affect your third party collections?

Secretary BROWN. No.

Mr. STEARNS. Okay. In that regard, are you aware that VA must generate about 20 outpatient bills to get the same recovery of a single inpatient bill?

Secretary BROWN. Well, ask that—make the statement again.

Mr. STEARNS. Are you aware that the VA must generate about 20 outpatient bills to get the same recovery of a single inpatient bill?

Secretary BROWN. Yes.

Mr. STEARNS. Okay. Since more and more people are joining HMO's—we see it everywhere—which do not cover care provided outside that HMO, isn't it possible, quite possible, that these HMO's will adversely affect your third party collections, make it more difficult?

Secretary BROWN. No.

Mr. STEARNS. Let me let you elaborate on that. [Laughter.]

Secretary BROWN. But you said yes and no. [Laughter.]

The reason why I said no to that is because we believe that there is inherent within our collection process a lot of potential. I think before you came in, I mentioned, for instance, on an outpatient basis—I think it's an outpatient where we just charge a flat \$150.

Now, we could have actually performed \$3,000 worth of work, and we bill the insurance company \$150. So what we're looking at is that we are going to have to develop a collection process that actually reflect the value in which we provide to the veteran.

And so within that, I think that there is a tremendous amount—and that's one of the reasons why I'm willing to take this risk. I'm willing to take this risk because I think that we are not getting the kind of returns on the services that we provide simply because we don't have the sophistication and mechanism to identify what it is and ask for it.

So that's the reason why I made those statements, even though they seem a little bit odd.

Mr. STEARNS. Okay. Isn't it true that the VA in recent years has applied more stringent eligibility criteria and no longer provides treatment to many of its former higher income patients who are the patients with the highest level of insurance coverage?

Secretary BROWN. Yes.

Mr. STEARNS. Okay. Absent authority to recover from Medicare and given higher income veterans' low treatment priority, isn't it possible—in fact, quite possible—that that trend will continue and adversely affect third party collections?

Secretary BROWN. Will you say that again?

Mr. STEARNS. Absent the authority to recover from Medicare and given higher income veterans' low treatment priority, isn't it quite possible that that trend will continue and ultimately adversely affect the third party collections on which you're making your assumption?

Secretary BROWN. No.

Mr. STEARNS. Mr. Chairman, whenever he says something that I don't agree with, I'm going to let him explain. [Laughter.]

Secretary BROWN. Your time is out. [Laughter.]

When you say—the way it is right now, very few people understand that we only basically treat two categories of veterans, and

they are our service connected veterans and our low income veterans. Everyone else is locked out of the system.

Although there are a few facilities that are treating the people that you described, higher income veterans. I guess about what, one or two percent? Two percent in the whole country. So that's basically nothing.

So what we want to do is to create an environment that—where all of these thousands and maybe millions of higher income veterans—and now, when I talk about higher income, sir, I'm talking about an individual that makes \$21,000 a year or \$22,000 a year.

We want to create an environment so that they can come to the VA and get their care, and they pay for it with their insurance payments or they pay for it with their Medicare entitlement.

Mr. STEARNS. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. The Chair is pleased to recognize the newest member of our committee, the gentleman from Illinois, Mr. LaHood.

#### OPENING STATEMENT OF HON. RAY LAHOOD

Mr. LAHOOD. Thank you, Mr. Chairman.

Mr. Secretary, I want to raise a parochial issue with you, and I don't expect you to know the answer; but I would appreciate it if you or your staff could get back to me. I met with the—I'm from Illinois, and I represent a district right in the middle of the state.

Peoria is my home town. We have a very fine VA clinic there and the people there do a marvelous job. My district adjoins Mr. Evans' district, and I look forward to working with him on veterans' issues.

I met with a group of people from the University of Illinois yesterday. There's a study going on by GAO to look at the relationship between the University of Illinois Medical School and the hospitals in Chicago, primarily in Mr. Gutierrez's district and Mr. Davis's district.

The people at the University of Illinois have a great deal of heartburn about the way that they're being treated by your regional staff. Before the study is complete, they are beginning to cut off some services, some relationships, and they have asked our delegation to send you a letter to see if you would intercede so that the relationships that have been established can continue until the GAO study is complete.

So I'm going to raise that issue with you. You will anticipate a letter from our delegation outlining these concerns, and I hope that you will be able to respond to us at least to the extent of persuading your staff at the regional office to wait until the study is done before they begin to discontinue relationships that have been developed.

The University of Illinois is providing good medical care and they have a relationship with Hines and a couple of these other facilities, including Lakeside and Westside. So if you can indulge us with at least reading our letter and listening to our concerns and then persuading your regional people that we ought to wait until the study is complete before they discontinue some of these relationships, I would appreciate it.

And I know that Congressman Davis and Congressman Gutierrez and certainly others in that part of the state would be very grateful to you.

Thank you very much.

Secretary BROWN. Thank you.

The CHAIRMAN. The ranking member on the Oversight Committee, Mr. Bishop, is recognized.

#### OPENING STATEMENT OF HON. SANFORD BISHOP

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

As the ranking member of the investigations of oversight, I look forward to working with Mr. Everett whose district adjoins me just across the Chatahoochie River in the State of Alabama to looking into a lot of the areas of VA administration which concern our veterans populations.

But I want to first associate myself with all of the very laudatory remarks that have been made about you and your advocacy—and effective advocacy, I might add—for veterans. I know that the people in Georgia are very appreciative of the work that you and the VA has done and the efforts that you have made to lift up the needs and the concerns of veterans.

But as has been said, however, we are still concerned as we listen to the administration's proposals in this budget about how you will actually be able to do more with less. It almost seems as if you're going to perform magic.

Certainly you've come forth with some creative and some very innovative approaches to delivering veterans' health care services, and you've streamlined some of the programs and the services. And I'm very, very pleased that you're going to have monitoring each year.

But I'm still concerned, as is Mr. Gutierrez and Mr. Mascara, about things such as how, with the projected budget, we're going to continue to reduce pending compensation claims with less resources to do that.

How are we going to really—how are you going to know that you're going to provide more benefits for our veterans when, for example, there's a decrease of \$6 million in the level of funding for grants for state homes which provide a number of services for our elderly veterans?

These concerns are nagging for us, and we're just concerned as to how you're going to be able to perform magic.

Can you kind of address that? I've heard the proposals, and there is some skepticism; and certainly we wish you success. God knows we want success because it means a better service for our veterans.

Can you just sort of address that? And I have one other question. I'll ask it quickly. And it relates to the co-location of VA and DOD facilities for surveying veterans who are not very, very close to VA facilities.

For example, Mr. Everett and I represent areas of Alabama and Georgia in the Southwest portion and the middle portion of Georgia that requires veterans to travel a great distance in order to get even primary health care service from a VA facility.

Secretary BROWN. Yes; thank you, Mr. Bishop.

I would like to—before I respond to your questions, to thank you for the strong advocacy that you have historically shown on behalf of our veterans and their families. You not only represent the veterans of Georgia very, very well; but also through your role in this committee, you have shown great honor to the veterans all across our Nation.

With respect to your last question, we are right now looking at a number of projects. Number one, we have a couple of joint ventures where we are actively working with DOD and providing care using sharing resources to take care of the folks that are on active duty and also veterans and active duty personnel.

That's actually physically happening in New Mexico and—where else? Nellis is one. And so—and in fact, any new project which we don't expect to have any place—would be something we'd have to look at that concept because it is a good concept.

Mr. BISHOP. That's a little bit far from Georgia though.

Secretary BROWN. I know, but I was just talking about concept, that we are actually—that we are applying it. We also, as Dr. Garthwaite mentioned, we have a project where we are looking at allowing people who are retired from the military to use their CHAMPUS entitlement to come to the VA and we provide care to them.

I mean, this is very, very important as we downsize and as hospitals close and various retirement communities. So the issues that you raised, we are looking at; and I will get back with you to see if we actually have any projects or any community based clinics that we plan on opening up in your area across the river and Mr. Everett's area.

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

We have recently approved the development of a new community based outpatient clinic in Dothan, AL. We anticipate this access point to be functioning by May, 1997. The Atlanta Network is completing proposals for two new community based outpatient clinics to be located in Macon and Albany, GA. These proposals will start the approval process in the Veterans Health Administration within the next few weeks. Opening these three new access points will decrease the travel time to less than an hour for veterans to receive primary care.

The Central Alabama Veterans Health Care System is also in the process of increasing the number of primary care providers at the existing Columbus, GA community based clinic. The goal is to improve timeliness and effectiveness of care at this very busy outpatient clinic.

With respect to the two areas that are programs that you talked about, health care—how we're going to provide more with less—basically we have to do that in order to, as has already been stated, be able to spread our capital costs.

If we don't do that, then the next alternative is we have to close it down. If we—the bottom line is that we have a hospital today where—a system where we had about—just about 10 years ago, we had about 90,000 authorized beds. I think now there's about 50,000 that we have, and they continue to go down.

But what doesn't continue to decrease at the same rate as our bed census, is the capital costs. We still have to pay the air condition costs, we have to pay the heating costs, we have to pay the physicians and so forth. So in order to be able to spread that cost

out, we have to open the system up to more veterans in order to remain efficient.

So that's really what we're being forced to do as opposed to starting to close down facilities. And we're doing that and paying for it by actually looking for opportunities to save. One that was mentioned here today is lowering our inpatient census and increasing our outpatient census.

That's a tremendous savings. Another one, as Mr. Gutierrez was talking about, has to do with eliminating duplications. We are asking ourselves some critical questions in areas to include the private sector. Why do we need two MRI's? If the private sector has one, we should use it.

If we have it, they can use ours and pay us. So those are the kinds of savings that we're looking for in order to be able to pay for the expansion of service; and at the same time, reducing the per patient costs.

And another important factor that we don't give a lot of credence to and something Dr. Garthwaite said, and that is when we attract healthier people into the system, we theoretically get paid for those healthier people and don't end up having to pay out as much.

So those are the kinds of things and those are the advantages we get shrinking the system and opening it up.

On the adjudication side, here we have a wonderful opportunity to use the advantages of modern technology. We haven't done as good as we would have liked to, and Mr. Everett knows a lot about that. But we now I think clearly are on track, and we feel very comfortable with the estimates that we have made and projected out to the year 2002.

Mr. BISHOP. Thank you, Mr. Secretary. I think my time has expired.

The CHAIRMAN. I thank the gentleman.

The gentleman from Minnesota, Mr. Peterson, is recognized.

Mr. PETERSON. Thank you, Mr. Chairman.

#### OPENING STATEMENT OF HON. COLLIN PETERSON

Mr. Secretary, from the veterans of Minnesota, we very much appreciate your leadership and your willingness to come out and visit with us, not only the veterans but our good VA stuff out there.

Mr. BROWN. Thank you.

Mr. PETERSON. Glad to listen to your testimony this morning. I'm kind of the new kid on the block here. I'm trying to get up to speed on what is going on and trying to digest all of this. I think I somewhat grasp what you're trying to do, and I think agree with where you're trying to go here.

I think, from what I can tell, you are trying to become part of the mix. If there's going to be choices for HMOs, or all of those other things, you'd like the VA to be a choice that people can select kind of on a level playing field. That's where you're trying to get.

Mr. BROWN. And get paid for it.

Mr. PETERSON. Right. Yes, and get paid for it. So that's where you're trying to get, and I think that is the right direction and is probably the only way you're going to be able to make this work.

You know, last year our group, Blue Dog Democrats, did our own budget and we did some things a little bit different. One of the

things we had in our budget last year was we had subvention, which nobody else had. We didn't get a lot of credit for it, but, you know, we found a way to pay for it, and so forth. So I think that there are ways that this stuff could be done.

I guess my question is: you have taken some action, you've got some pilot programs to try to move in that direction. But isn't a lot of what you need to do dependent on us changing legislation to allow you to do this?

Mr. BROWN. Absolutely. Without your support, our whole concept falls apart, and the only thing that would keep it afloat is that you replace the dollars that we requested hopefully from sources outside our category, or that we requested in our budget.

Mr. PETERSON. But even if we replace the dollars, if you can't make the fundamental reforms, you're going to have big problems.

Mr. BROWN. Absolutely.

Mr. PETERSON. I mean, it's the same thing when we went through this Medicare debate last year. I mean, you know, the issue in Medicare is not the amount of dollars. The issue is we need fundamental reform in the Medicare system to put choice into that system, so that people that are accessing it can make choices and let the market work.

And I think that's what we need to do in the VA is we need to give you the ability to get into the marketplace and compete. And right now, you've got too much bureaucracy. You've got too much law locking you, so you can't do what needs to be done. And, you know, so I guess what I'm getting at, is the legislation that you need, is it drafted? Where is it? Is that—maybe it's in here and I haven't read it yet.

Mr. BROWN. Mary Lou.

Ms. KEENER. I can respond to that, Congressman Peterson. The Medicare subvention bill has gone back to Congress in the same form that it was in last year. As far as we know, the legislation that we need is up there. Now we need your help.

Mr. PETERSON. And to some extent, it's the Authorizing Committee that has to make some of these changes. Some of it probably has to be dealt with in Appropriations, I assume. Some of it probably has to be dealt with in the Budget Reconciliation. Okay. So I'm just trying to get a handle on where this all is.

We are going to be, as I say, finalizing our budget for this year, and so I will do what I can to try to get some of this stuff into what we're doing on our side, and hopefully we can all work together and give you the tools to do what you need to do, you know? Because I think you're on the right track. You're heading in the right direction.

And I very much commend you for stepping up and providing leadership and thinking this through, because there is just too much bureaucracy in the system now. We've got to cut out the underbrush.

Mr. BROWN. Mr. Peterson, I just wanted to say before the meeting is adjourned that I'm really delighted that you're on this committee. I've followed your career for a long time, and having the opportunity to have worked with you and the veterans in Minnesota, I know that we really have a champion that is going to look out for us. And I'm so glad that you—

Mr. PETERSON. We want you to get back up to Minnesota, but we won't invite you this month. It's 10 below there this morning.

Mr. BROWN. Thank you so much for that.

Mr. PETERSON. And we 15-foot snow drifts at the VA hospital in St. Cloud there, so you probably—unless you bring your skis, you know, it—

[Laughter.]

Mr. PETERSON (continuing). But we'll bring you up there when the weather is nice.

Mr. BROWN. Okay.

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

Thank you, Mr. Chairman.

The CHAIRMAN. Yes. Mr. Peterson, Mr. Evans and I signed a letter to both Secretary Brown and the Secretary of HHS asking them to address the concerns of the Ways and Means Committee before it got up here, and hopefully we can get into that, because it is going to be a problem.

We testified last year on behalf of this Medicare subvention, but neither our committee, nor the Armed Services Committee, were successful.

The gentleman from Pennsylvania, Mr. Doyle, is recognized.

Mr. PETERSON. Mr. Chairman, I just would say that we did have subvention in the Blue Dog budget, so when it comes up this year, if we can keep it in there, why don't you all look at that and maybe you can support the Blue Dog budget and we'll get—

[Laughter.]

The CHAIRMAN. The gentleman from Pennsylvania, Mr. Doyle.

#### OPENING STATEMENT OF HON. MIKE DOYLE

Mr. DOYLE. Thank you, Mr. Chairman. And I'll try to be brief. I have a statement which I'd like to submit for the record.

Mr. Secretary, welcome back. We're glad you're here and hope you stay with us 4 more years, and the veterans in Pittsburgh, PA, are glad that you're back at the helm.

Let me just first reiterate a concern that I think my colleague, Mr. Mascara, has and several members of this committee have. And, you know, we look at this budget, and at the end of 5 years we're going to treat more patients with fewer staff, with the same budget resources that we have today.

And it sort of reminds me of a line from a movie that's popular right now—you know, "show me the money." We're sort of concerned that you don't put yourself into a box. I mean, I think this is a worthy thing you're trying, and I've learned a new word today—stretch goals. We get to learn a lot of new buzz words up here on the Hill, and that's the new one today—stretch goals.

And I want to say that, while expressing concerns, we don't want to—I don't want you to misinterpret it that we're saying this is never going to work and don't try it. We're saying go ahead and try it, but, you know, when you put out these stretch goals, let's not get ourselves into a box 5 years from now that we can't get out of, because we are in an era of dwindling resources.

And when we get to the outyears of this balanced budget agreement that we're all cruising down, this glide path, you know, all of the stuff hits the fan in the outyears—you know, fifth, sixth, sev-

enth year. I'd hate to see us be put in a situation where veterans are put at risk because we weren't able to meet some of these rather ambitious goals. And that's just a concern.

But I have a question that hasn't been touched on today that I'd like to get your reaction to. You know, with the new VISN initiative that is taking place, we're giving VISN directors all over this country a great deal of latitude to run their VISNs and to achieve some efficiencies. And I think that's good.

I had a conversation with a VISN director who told me that he doesn't think veterans should even be in the service care delivery business, that his vision for VISN would be to see us—there wouldn't be any more veterans hospitals, that veterans would become a health care plan, just like the many other private health care plans out there in the private sector. And that sort of struck me; I was very concerned at that statement.

I wonder, do you share a vision, or do you see coming down the road where some day there won't be any more veterans hospitals, and that this Veterans Administration is going to become another health care plan?

[The prepared statement of Congressman Doyle appears on p. 115.]

Mr. BROWN. I'm not going to ask you for the VISN director's name. [Laughter.]

But he's—

Mr. DOYLE. And I'll gladly give it to you in private.

Mr. BROWN. I'm afraid what I might do with it, so I'm not going to ask you.

He or she certainly does not share our view. We believe that the VA is very, very important to our society. We recognize that it is costly, but that is part of the continuation of the cost of war. And the only reason why I would even support the VA going out of business is because we've run out of veterans.

And quite frankly, philosophically, I hope that one day that we won't have a need for veterans, that we won't have a need to place our young folks—our best and our brightest—at risk. And as a result, we won't have a need to have VA hospitals to respond to the hazards associated with military service.

So that's my statement on that. And as long as we are placing our young people at risk, we've got to have an institution that responds to their needs when they come home, because you've got to realize this here, sir. Most people don't realize that many of the problems that our young folks have when they come home are really unique problems.

You just take the question of Persian Gulf. If all 700,000 of those young folks were sick, it would not be in the private sector's best interest to invest millions and millions in research to find a solution, because they could never recoup their investment. There's not enough—the market share is just not there.

But at the same time, because they did what we asked them to do, we have a responsibility to make that investment. And that is a good example on why we must continue to protect the VA, that we make it efficient but continue to let it thrive and exist and respond to the needs of our citizen soldiers.

Mr. DOYLE. Mr. Secretary, I knew that was the answer you were going to give, but I think it's important that we say that, that people understand that we serve a population—veterans hospitals—that is different from the general population in many aspects. And I hope we don't ever go down that path of thinking that we can just become another health care plan, that veterans hospitals will always be around.

We don't want to abandon the principle either that we fully fund veterans programs during this appropriations process. And I want you to set goals, and I want you to look for efficiencies, but let's not put ourselves in a position 3 or 4 years from now where, because of the way we're going budget-wise, that we put veterans at risk.

I look forward to continuing working with you.

Thank you, Mr. Chairman and Mr. Secretary.

Mr. BROWN. Thank you, sir.

The CHAIRMAN. The gentleman from Massachusetts, Mr. Kennedy.

#### OPENING STATEMENT OF HON. JOE KENNEDY

Mr. KENNEDY. Thank you, Mr. Chairman.

Mr. Secretary, welcome, and welcome to the members of your staff.

Mr. BROWN. Thank you.

Mr. KENNEDY. Mr. Secretary, a couple of sort of concerns. I had an opportunity to meet with Dr. Fitzgerald up in Massachusetts a month or so ago, and we had a meeting about his VISN plans. And obviously, seeing such large cuts in the budget up in that part of the country, I think just raises some questions in terms of not only whether or not there is sort of equitable cuts going on in terms of our region versus some of the other regions of the country. And at some point, maybe we could have a little more definitive get together on that issue.

But there was also I think a series of concerns that came up in our discussion, and so I want to make clear that I'd like to come back and get together, maybe in your office or something like that, where we can go over some of the comparisons.

Obviously, you're going to need to go and make reductions in terms of duplicity and that type of thing, and nobody wants to see you waste money. On the other hand, I think we want to have a sense that there's a balance in terms of the various regions, so that any particular region isn't being singled out for cuts well above other parts of the country.

So I'd like to be able to come back to you on that.

Mr. BROWN. Yes, sir.

Mr. KENNEDY. I think it also raises some of the questions about the concerns once those cuts become more public, as to how the veterans groups that depend on certain facilities have come to utilize certain services, and the like, are going to be able to have input in terms of their own convenience and the kinds of disruptions that are going to take place.

As you are aware, when we have faced those issues in the past, because in some cases how the VA went about trying to make some of those changes, it has had to pull back. And so I think it's very,

very important that when you go through that change process that it is explained, and that the VSOs and others are brought in, and that the veterans that actually use particular facilities, that that's going to change dramatically or give an opportunity to get their input. And I wonder whether or not you have a comment about how that is going to go.

I also have another question, so I'd like to—if you can make it reasonably brief, I'd like to come back to you.

Mr. BROWN. First of all, Mr. Kennedy, I basically do nothing without running it by the VSOs. I take a position; I don't want members of Congress, and I don't want our VSOs to read about an initiative that we have in the paper. So they are part of the process.

Mr. KENNEDY. That's the local, as well as the nationals.

Mr. BROWN. Well, I'm talking about the local—I mean, the national now. But with respect to the local part of the implementation, we have left it up to the VISN directors. And we have made it very, very clear that in order for any change to take place, they are going to have to include an implementation plan where members of Congress, their staff at least, and VSOs are at the table.

If you're telling me that that has not happened in VISN 1, then I certainly will look into that because that should have been part of the process.

Mr. KENNEDY. I didn't mean to imply that it has. I don't think it has as yet, Mr. Secretary. I don't think that would be—you know, I think they're still in the formulation plan in terms of where they're headed, you know, with their reorganization. What I'm trying to suggest to you is that I have seen very clearly when the VA had determined that it was in their interest to close certain clinics and change around how people were going to move.

And they topped that on—they said they checked with folks. But, I mean, believe me, they hadn't checked with tens of thousands of veterans that had come to use those facilities. And, you know, I've seen the whole thing just blow up in the VA's face.

So I wasn't specifically being critical of Dr. Fitzgerald and what his plan was. It's very hard for me, as a layperson, sitting there listening to a guy tell me how much duplicity exists in the system, and therefore he's going to close this, that, and the other thing, and he's going to save you a whole stack of money, and then be able to make some assessment as to how that's going to actually affect a lot of the veterans groups.

But I think that if there is a very important issue here in terms of making certain that local input—I don't think that just saying that they—that leaving it up to the local VISN director to say, "I hope you're going to check with the local folks to make sure it's okay," I think it's got to probably go much deeper than that.

Mr. BROWN. Mr. Kennedy, I think we even have a checklist that we mandated them to use that we said before you do anything, and particularly on closing and anything controversial, they have to come to us. In fact, in one case, we started putting veterans out of hospitals in your state, and Boston, and we found out about it. And he didn't check with us, and when I went there at Senator Kerry's invitation, we reversed that.

So we have a checklist that says that these are some of the things that you have to do before you make any major changes. And on that checklist is to make sure that you have all interested parties at the table before it happens.

Mr. KENNEDY. Maybe you could submit that checklist for the record, Mr. Secretary.

Mr. BROWN. Sure. We'd be happy to.

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

The attached memorandum from the Under Secretary for Health provided guidance concerning required reviews for Program Restructuring efforts at the VISN level. Also, the attached checklist guides facilities that are integrating management and functions.

**Department of  
Veterans Affairs**

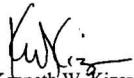
**Memorandum**

Date: SEP 27 1996  
 From: Under Secretary for Health (10)  
 Subj: Program Restructuring, Stakeholder Involvement and Headquarters Notification  
 To: Headquarters Chief Officers  
 Chief Consultants  
 Chief Network Officer  
 Network Directors  
 Facility Directors

1. Considerable concern from several sectors has arisen recently regarding proposed and actual facility restructuring of clinical programs - especially regarding proposed changes to designated special emphasis programs (SEPs) such as spinal cord injury and prosthetics. Specific concerns have been raised about a perceived lack of timely stakeholder and employee involvement in planning such changes and a perceived lack of review by VA Headquarters (VAHQ) chief consultants. Further, a number of facilities have pursued program or service closures of various types (e.g., nursing home care units, dialysis units and in-patient substance abuse treatment units) without providing VAHQ with advance notice.
2. By way of this communication, I am reminding you that any proposal for restructuring clinical services, and especially the SEPs, must involve stakeholders and employees and be reviewed by the program chief consultants early on and as needed throughout the process. Further, VAHQ must be notified in advance of any proposed program or service closure. This notification should be with sufficient lead time that HQ concerns and questions can be addressed. At a minimum, VAHQ should receive such notice ten (10) working days before any definitive action is planned to be taken.
3. It is my hope to avoid having to require VAHQ approval of facility or network structural reorganizations.
4. I will also take this occasion to remind you that in developing any restructuring proposal a number of issues or questions must be clearly addressed. At a minimum, these include the following:
  - a. What are general and specific goals that are to be achieved by the restructuring?

- b. What are the specific outcome measures that will be tracked, and what is the process for monitoring those measures that will be used to determine if the goals are being achieved?
- c. How will the identity and functioning of national programs (e.g., spinal cord injury, blind rehabilitation and prosthetics) be maintained if the restructuring occurs, and especially, how will standardized processes or procedures to provide service and the uniformity of services be ensured?
- d. How will a continuum of care be assured?
- e. How will quality of care be monitored and maintained or improved?
- f. Who will provide medical and administrative leadership and oversight for the program if it is restructured? How will adequate medical input to program decision-making be assured?
- g. Who will have actual program "ownership" and responsibility, and how will program and provider accountability be assured if the program is reorganized?
- h. How will patient satisfaction and customer service be monitored and maintained or improved?
- i. How will program costs be evaluated and monitored?

5. The importance of being able to clearly answer the above questions cannot be over emphasized. Likewise, the need for full and open discussion with stakeholder groups and employees is of paramount importance.

  
Kenneth W. Kizer, M.D., M.P.H.

**INTEGRATION CHECKLIST**

ITEM	STATUS	RESPONSIBLE PARTIES	COMPLETION DATE	COMMENTS
<b><i>I. Pre-Integration Activities</i></b>				
A. Notification of Headquarters				
B. Survey of the general environment to determine the feasibility of integration				
C. Develop Communication Plan: Begin discussions of integration of activities with service chiefs - develop a SWOT's analysis				
D. Begin gathering baseline data				
E. Visit local integrated facilities (profit and NFP)				
F. Involve Labor Management/Partnership Council				
G. Involvement of the Stakeholders, i.e., congressional representatives, medical school affiliations, educational affiliations				
H. Write integration proposal				
<b><i>II. Initial Integration Phase</i></b>				
A. Establish an Integration Coordinator				
B. Submit integration proposal for approval (Fact Sheet)				
C. Announcement of your integration to include, staff, media, congressional representatives, and VSO's				
D. Name your new System				
E. Establish Management Structure				
F. Development Partnership Council (if necessary)				
G. Development Leadership Council or Governing Board				
H. Develop transportation system between divisions				

INTEGRATION CHECKLIST

ITEM	STATUS	RESPONSIBLE PARTIES	COMPLETION DATE	COMMENTS
I. Brainstorm with staff to identify areas of concern to address				
J. Set up working groups for integration teams				
<b>III. Working Towards Functional Integration</b>				
The following are very labor intensive but essential components in the integration				
A. Integration of Organizational Charts				
B. Integration of Policies and Procedures				
C. Establishment of a Communication Link				
D. Constant viability				
E. Integration of Data Base				
F. One committee structure with representative from all divisions				
G. Development of one set of Medical Staff By-Laws				
H. Development of a Mission, Vision and Value Statement for the System				
I. Establish an evaluation methodology for the integration				
J. Develop an integration time line				
K. Develop a Strategic/Business Plan, to include but not limited to:				
1. Identify duplicate functions				
2. Eliminate/minimize unnecessary duplication				
3. Identify specific programs/functions by locations				
4. Develop plan for a full continuum of care				
L. Work toward continuum of care				
M. Evaluation of integration				

Mr. KENNEDY. I also—we didn't get to the whole issue of eligibility reform, which I wanted to come to. But maybe we'll have a chance to catch up on that.

There was some confusion, I must say, Mr. Secretary, in the VISN director's mind about what was intended by this committee in terms of our eligibility reform. And I think it's well worthwhile exploring that at a further date.

But I do think that it's just very important that we get some very, very, you know, important input from the local community in terms of how veterans are going to view these kinds of changes. And I'm concerned that that's not, in fact—that that might not, in fact, go on. So I look forward to the list and to working with you.

Mr. BROWN. Thank you. And I agree with you.

Mr. KENNEDY. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

The gentlelady from Florida is recognized.

#### OPENING STATEMENT OF HON. CORRINE BROWN

Ms. BROWN. Thank you, Mr. Chairman. Thank you for holding this important hearing today. I've been on this committee for 5 years, and one of the highlights always is when the Secretary comes to this committee. He is a champion and an advocate for the brave men and women who have served this country.

I think I'm supposed to also thank you, because each year you come we talk about Florida, and we talk about the formula for Florida. And I understand that we just put a new program into play yesterday, and can you explain a little bit about the program? I understand that at last that the funds will be following the veterans. For example, the Minnesota veterans today is in Florida. So they're being serviced in Florida, and so we're going to get some reimbursement in Florida. Could you explain that a little bit?

Mr. BROWN. Congresswoman Brown, I love you, but you sure put me in an awkward situation with that question. [Laughter.]

Yes, we are now in the process—and we have already—for two reasons. Number one, simply because it is the right thing to do; but in addition to that, as a direct result of mandate of law, we have initiated a program where we are making sure that the funds follow the veterans. And so that has something to do with what Mr. Kennedy was talking about, where we are looking at average costs and forcing those that deviate, for no apparent reason, far from the average to get more in line. And we are taking those dollars and putting them in areas where veterans are moving to.

Out of this whole process, in our 22 regions there are 16 winners. And, of course, Florida is a big winner in that process.

Ms. BROWN. Thank you.

Mr. BROWN. And there are six losers. But we don't like to think of the losers as actually losers. It's allowing them to become more efficient, and we are giving them the incentives to do so.

Ms. BROWN. I just want to thank you, Mr. Secretary. I mean, you know the strain that we have experienced in Florida over the 5 years that I've been here and before. I guess one other question that I always have to ask is: what has happened to the central Florida veterans with Brevard Hospital? And I saw that the President didn't include it in his budget, and so where are we?

Mr. BROWN. Well, as you can tell, Ms. Brown is in there fighting for our veterans. When I first met her, she was mad at me about a clinic and came to my office and just ran me up one wall and down the other. So I'm really glad that I've been able to respond to some of your concerns, because your concerns were clearly valid.

With respect to Brevard, as you know, we are under mandate of law to have a study, and at this particular time we have not—I have not received the study results. But as soon as I do, I will make sure that you get a copy of it and then we can talk about what is our next course of action.

Ms. BROWN. Thank you, and welcome back.

Mr. BROWN. Thank you so much, ma'am.

The CHAIRMAN. Thank you, Ms. Brown.

The gentleman from Louisiana, Dr. Cooksey, is recognized.

#### OPENING STATEMENT OF HON. JOHN COOKSEY

Dr. COOKSEY. Thank you, Mr. Chairman.

We are glad to have you here, Mr. Secretary.

Mr. BROWN. Thank you, sir.

Dr. COOKSEY. As a freshman Congressman, I'm spending a lot of time running between various meetings. But as a veteran, and as a physician, I appreciate your coming here.

I have gone to the trouble to visit my veterans hospital, and I think the people there are doing a good job, and they are moving in the right direction and moving from the system that all of the hospitals were in, the ones that I worked in as a physician, to the changes that are more cost efficient but yet put quality as the criteria, quality of care above cost of care. I think that's still important.

I would add that I have used all of the veterans services. After I got out of the Air Force, during the Vietnam period, I did use my GI bill. Much to the chagrin of my opponents in my race, I have not had to use your cemetery services. [Laughter.]

Mr. BROWN. If you did, I would have been the first one out of here. [Laughter.]

Dr. COOKSEY. But anyway, as a physician, I am trying to find solutions to problems, as opposed to my colleagues in the legal profession who are trying to find fault. And we are here to help you. I am here to help you, and I think that we can all work together and do a lot of the right things.

I personally, quite frankly, had some major problems with your budgetary assumptions. In fact, we were looking it over between 7:30 and 8:00 this morning, and I understand from my staff person that those questions were asked and answered, and you've touched on them again. So I'll keep my fingers crossed and hope that it does work this year.

Mr. BROWN. Thank you.

Dr. COOKSEY. If not, we'll see you next year.

Mr. BROWN. Thank you.

Dr. COOKSEY. Thank you, Mr. Secretary.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Secretary, I believe Mr. Evans has another question to follow up.

Mr. EVANS. Actually, I wanted to direct it to the General Counsel.

I understand that there have been a number of requests for extensions before the Court of Veterans Appeals by the so-called Group VII, the group that represents the VA before the court. Is this true? And has that been caused by a lack of funding for Group VII?

Ms. KEENER. I'm not aware of the numbers on that, Congressman. I can get them for you and let you know. I am not aware that a decrease in funding has caused an increase in those numbers, but I can tell you that a decrease in the GOE funding has caused us to look at, the loss of approximately 35 attorneys in 1998. Several of whom will come from Group VII.

I have two groups in particular that I am very concerned about staffing levels, and one of those is Group VII. As the 1998 budget is currently projected, we anticipate that it is not going to get better. It is going to get worse.

Mr. EVANS. Okay. If you could submit the numbers of extensions—

Ms. KEENER. Yes, sir.

[The information follows:]

2/24/97

**RESPONSE TO QUESTION  
FROM  
REPRESENTATIVE LANE EVANS  
RE  
EXTENSIONS SOUGHT IN COURT OF VETERANS APPEALS**

**I. BACKGROUND**

A. The Secretary of Veterans Affairs, as the appellee or respondent in every case brought before the Court of Veterans Appeals (CVA or Court), is represented by the General Counsel, pursuant to 38 U.S.C. § 7263(a). The Appellate Litigation Group, Professional Staff Group VII (PSG VII), handles the CVA caseload for the General Counsel.

B. Under the CVA's Rules of Practice and Procedure, the Secretary has a number of sequential filing obligations in every case. For example, pursuant to Rule 4(c), a copy of the decision of the Board of Veterans' Appeals (BVA or Board) on appeal to the Court must be filed and served upon the appellant within 30 days of the issuance of the Court's Notice of Docketing. The Designation of the Record on Appeal (DOR) is due 60 days after docketing, Rule 10(a). The Transmission of the Record on Appeal (TOR) is due within 30 days after appellant's due-date for filing a counter designation of, or statement accepting the DOR, under Rule 11(a)(2). Appellant's brief comes due within 30 days after the Clerk of the Court gives notice that the TOR has been filed, Rule 31(a). The Secretary's Brief is due within 30 days after the appellant's brief is filed and served, under Rule 31(a). Miscellaneous other deadlines are imposed by orders of the Court.

C. If a party is unable to meet a Court-imposed due-date, a motion for an extension of time is filed, under Rules 26(b) and 27(a), asking the Court to extend the deadline. It must show good cause for the requested extension. The following statistics reflect extension motions filed on behalf of the Secretary.

D. Motions for extensions by the Secretary, listed by calendar year, and by major item due in CVA:

	<u>1994</u>	<u>1995</u>	<u>1996</u>
DOR	258	219	1003
TOR	82	196	367
Brief	<u>1107</u>	<u>1337</u>	<u>1568</u>
Total	1447	1752	2938

The rising numbers reflect the growth in the number of cases appealed from the BVA, the increasing complexity of cases appealed, and a decline in personnel assets which is explained in the following paragraphs.

## II. PSG VII CASELOAD

A. The figures regarding extensions sought by the Secretary reflect that the caseload has been growing steadily over the past four years. The number of cases filed in the Court has increased as follows:

FY 1993	1319
FY 1994	1364
FY 1995	1464
FY 1996	1826
FY 1997	2400 (Projected)

B. The most recent trend shows that, over the past nine months, new CVA cases have been filed at a rate of nearly 200 each month, as follows (figures show new cases and total pending):

May 1996	176	1600
Jun 1996	202	1664
Jul 1996	213	1741
Aug 1996	194	1769
Sep 1996	203	1854
Oct 1996	188	1833
Nov 1996	217	1904
Dec 1996	175	1923
Jan 1997	209	1972

C. PSG VII's caseload is a reflection of the decisional output of the Board of Veterans' Appeals. Although improved BVA procedures have contributed to the increased output, the BVA has experienced significant personnel growth in the past several years. The number of decisions

rendered by the BVA over the past four years shows a steady growth as follows:

FY 1993	26,400
FY 1994	22,045
FY 1995	28,195
FY 1996	33,944
FY 1997	38,000 (Projected)

D. At the current pace, it is anticipated that the CVA will docket 2400 or more cases in FY 1997. BVA statistics indicate that the Board had over 57,000 appeals pending at the start of calendar year 1997. Cases appealed to the CVA are projected to increase in number for the foreseeable future.

E. Another indicator of the growing case backlog is the volume of photocopies prepared by PSG VII for filing in the Court. The increased volume reflects the growth in the size of records on appeal as well as the complexity of issues under consideration. For the last three calendar years, the following number of copies have been produced:

<u>1994</u> - 4,683,008	<u>1995</u> - 4,458,638	<u>1996</u> - 5,096,183
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This reflects a growth of about 34,500 copies per month between 1994 and the end of calendar 1996.

### III. COMPLEXITY OF PSG VII CASELOAD

A. Not only has the raw number of cases increased, but the demands placed upon the attorneys by each case have grown significantly. In the first three years of the Court's existence, PSG VII responded to most cases by filing motions for summary affirmance on the merits. The Court expressed dissatisfaction with that practice, and, since about 1993, full legal briefs are filed in the majority of merits cases.

B. In addition to litigating cases on the merits, PSG VII must deal with Equal Access to Justice Act (EAJA) cases. As a direct fallout of the Federal Courts Administration Act of 1992, EAJA fees were authorized for representation of appellants before the CVA. The involvement of PSG VII attorneys in EAJA cases has siphoned a great deal of their time away from the litigation of merits appeals. EAJA payments require a PSG VII analysis of the application for the legal sufficiency of the claim. The preparation also requires telephonic or in-person conferences to negotiate payment of "reasonable" fees. PSG VII must also prepare the final settlement

memorandum and follow up to ensure the responsible VA Finance official effects prompt payment. The analysis, negotiation, settlement, and payment of these claims has been a significant time drain on the attorney staff -- all of which adds to the increasing incidents of motions for extensions. EAJA fee payments have mushroomed since inception as reflected by the following:

	FY93	FY94	FY95	FY96	Total
Cases Settled	11	69	300	207	576
Amount Paid	\$59,236	\$81,770	\$1,199,235	\$1,402,052	\$2,743,293

C. Since August 1993, the Court has instituted the practice of convening a "Rule 10" conference in every case in which a dispute arises as to the content of the Record on Appeal, and a "Rule 33" conference in every case in which the appellant has a representative. Such prehearing conferences require PSG VII counsel to review the case in preparation for and to participate in the telephonic or in-person conference which involves Court personnel and the appellant and/or the appellant's representative. Each conference, two per merits case, takes at least an hour each of attorney time.

#### IV. PSG VII STAFFING

A. The Appellate Litigation Group is currently staffed with 34 attorneys; an Assistant General Counsel, one Principal Deputy Assistant General Counsel, two Special Assistants (one an attorney, one special assistant for administration), four Deputy Assistant General Counsel, and 25 Appellate Attorneys. However, since 1993, attorney staffing has been reduced, by attrition, by approximately four, and the size and experience level of the paralegal staff has been reduced.

B. Since the start of Fiscal Year 1994, 12 attorneys have departed PSG VII (including two who will be leaving within the next month). Six attorneys joined PSG VII in that time period. The net result is that attorney staffing has declined by four since FY 1994. The average caseload per Appellate Attorney has grown from the 20's to nearly 50 active cases.

C. The average caseload would be much higher, but PSG VII has undertaken initiatives to eliminate cases which present threshold jurisdictional issues. The attorney Special Assistant, with support from the paralegals and one Appellate Attorney, screens all incoming cases and, where it appears there may be grounds to challenge jurisdiction, prepares and

files appropriate motions, declarations, preliminary records, etc. Nearly 600 cases have been identified and handled as jurisdictional issues over the past three years. This obviated the need for the General Counsel to prepare a full record on appeal and to brief those 600 cases for the Court.

D. Similarly, since FY 1994, six paralegals have left PSG VII, and less experienced replacements have been hired. Current staff consists of two experienced paralegals and two inexperienced paralegal students.

Mr. EVANS (continuing). I'd appreciate it.

Mr. Chairman, I also ask unanimous consent that all members that have written questions, that they be allowed to submit those for the record, and the answers to those questions to be a part of the record.

The CHAIRMAN. Without objection.

Mr. Secretary, if you would respond to those as expeditiously as possible, we'll make them part of the record.

Mr. BROWN. Yes, sir.

The CHAIRMAN. We want to thank you for taking the time to be here with us. And I just want you to know that one of the perks and the joys of being the chairman and the ranking member is that we get to sit here through the lunch hour and hear nine more witnesses. [Laughter.]

Thank you, Mr. Secretary.

Mr. BROWN. Thank you, Mr. Chairman.

The CHAIRMAN. If those that are leaving could exit the room as promptly as possible, we'll get to Judge Nebeker here in a minute.

The CHAIRMAN. The meeting will please come to order.

Judge, we appreciate your patience, and we welcome you here this morning. You may proceed in any way you choose.

#### **STATEMENT OF HON. FRANK Q. NEBEKER, CHIEF JUDGE, U.S. COURT OF VETERANS APPEALS**

Judge NEBEKER. Thank you, Mr. Chairman.

I had come prepared to give a brief outline of where the court came from, why it exists, and what it does, because I recognize that there are members of this committee who are new and probably have not heard of the court before. That intention may be misplaced, because it doesn't appear as though there is anyone here who is a novice about the court. That being the case, I will hardly consume but a minute of your time this morning.

On behalf of the court, I state that I have three purposes in being here. The first is to urge the passage of Title II of the legislative proposal, which is still before the committee having been submitted over a year ago. Title I is a totally different matter, but Title II is something that is, I think, quite justified in its purpose. And I would urge that favorable action be undertaken on it as soon as possible.

My second point is, again, to assert and request that the pro bono representation program be separated from the court's budget, and that to that end they ought to be authorized by the Congress as a separate entity. And then we can work out—I hope we can work out, a way by which the court's operating budget does not fund one side of a substantial number of appellants that appear before the court.

The third request that I would make is that based upon our written testimony and the budget that we have submitted, that we could command the support of this committee with a favorable recommendation, respecting our appropriation request for the ensuing year, to the Appropriations Committee.

And with that, I have nothing further to add, other than what, of course, is in my written testimony.

[The prepared statement of Judge Nebeker, with attachments, appears on p. 127.]

The CHAIRMAN. Thank you, Judge, and I apologize for the attendance. Perhaps with your cooperation, we could schedule a meeting later on specifically for the newer members that have not had the benefit of knowing the workings of the court.

Judge NEBEKER. Thank you. I would welcome that opportunity.

The CHAIRMAN. All right, sir. I have one quick question.

Judge NEBEKER. Surely.

The CHAIRMAN. I believe a year or so ago you advocated reducing the associate justices from six to four, and perhaps as late as this month still thought you would do that. Is that still going to be the case?

Judge NEBEKER. Not really, sir. The caseload of the court is driven by the dispositions of the Board of Veterans Appeals. The chairman has reported recently, and perhaps mentioned it to you this morning, the denials of benefits, outright flat denials of benefits, has increased in the last year from some 6,000 plus to some 10,000 plus. That means the caseload in our court will soon be reflective of that increase.

Some of the veterans service organizations, I understand, opposed the downsizing of the court. Some took a more cautious approach of wait and see. Well, they may have been vindicated, because it looks as though our caseload is on the increase. And as you know, we are now but six judges, five associate judges and myself, because of the untimely death of Judge Hart Mankin.

The CHAIRMAN. Thank you, Judge. I think that while we're all interested in saving money, we're probably more interested in expediting these hearings.

I would turn to Mr. Evans for any questions.

Mr. EVANS. Thank you, Mr. Chairman. I think it's a good idea to have another meeting with the Judge, and I'd suggest maybe we do it down at the Court of Veterans Appeals, so members know where it is.

Judge NEBEKER. You would be welcome to come.

Mr. EVANS (continuing). Maybe meet some of the other judges as well.

Judge, some critics have said that the court has become a policymaking body and also lengthened the appellate process. Would you care to comment on those views?

Judge NEBEKER. Well, of course the court is not a policymaking body. The court is a creature of this Congress and the legislation that it passed in 1988. We are an appellate court, independent of the Department of Justice—I'm sorry, the Department of Veterans Affairs. That takes me back a few years, that slip.

Our role is limited. Our scope of review is limited. And our job basically is to see to it that the Board does things in accordance with the statutes and the regulations adopted by the Secretary. And we do find quite a number of instances in which that complex set of regulations has in some aspect been forgotten about, ignored, or misapplied.

And so we are there to correct those papers. That is not, by any objective standard, policymaking. The court fully recognizes policy is made here, and policy is made in the Secretary's office. I am sure

those who are the recipients of reversals or remands deem what we do, from their vantage point, to be making policy. But I think they lack an understanding as to what the purpose of an appellate court is.

Insofar as delay is concerned, I can report that, as an appellate court ought to be, we are about as current as should be. There is delay before the cases are submitted for a decision, and I would be remiss if I didn't bring it to your attention and seek your help in solving the problem. It is not the problem of the court, except that it impacts upon the court's ability to get to the cases faster.

I am referring to the necessity of the general counsel's office, who represents the Secretary before the court, to expeditiously bring those cases to the court by designating the record and then by filing a brief. Group VII, the group of attorneys that represents the Secretary before our court, has been understaffed, has been decimated by illness and a few other things, and it is my understanding has also been hurt with respect to the current appropriations process for this fiscal year, and that they are understaffed, and that morale is a problem.

Now, that does rub off on the court. It may sound as though it's none of the court's business, but it really gets to be if the problem isn't solved. It is not something that the court is in a position to do a thing about.

Thank you, sir.

The CHAIRMAN. Judge, thank you very much. We look forward to working with you. And I apologize again, and next time we'll take better care in scheduling. We will separate the Secretary out from the rest of you that have to testify later. But due to the outstanding attendance we had this morning, we ran a little longer than we anticipated.

Thank you very much.

Judge NEBEKER. Thank you, Mr. Chairman. I look forward to getting together with the members at their convenience.

The CHAIRMAN. Thank you. We'll work that out.

The CHAIRMAN. If the third panel would come up, please—Mr. Taylor, Mr. Herrling, and Mr. Lancaster.

Mr. Secretary, we'll start off with you. Let me properly introduce you. Honorable Preston Taylor, the Assistant Secretary for Veterans' Employment and Training of the U.S. Department of Labor. Your entire statement will be inserted in the record. Any way you wish to summarize, please proceed, and we'll recognize the other two later.

**STATEMENT OF HON. PRESTON M. TAYLOR, JR., ASSISTANT SECRETARY FOR VETERANS' EMPLOYMENT AND TRAINING, U.S. DEPARTMENT OF LABOR; MAJ. GEN. JOHN P. HERRLING, USA (RET.), SECRETARY, AMERICAN BATTLE MONUMENTS COMMISSION; AND HON. H. MARTIN LANCASTER, ASSISTANT SECRETARY OF THE ARMY (CIVIL WORKS)**

**STATEMENT OF HON. PRESTON M. TAYLOR, JR.**

Mr. TAYLOR. Good morning. I appreciate the opportunity to submit for the record the fiscal year 1998 Department of Labor budget request for the Veterans' Employment and Training Service. First,

I want to acknowledge the efforts of this committee and others in Congress who provided the resources that made it possible for VETS and our state partners to continue to meet the needs of our customers in fiscal 1997.

My vision for VETS in 1998, and into the 21st century, is that we continue to evolve into a world-class organization, providing employment, training, and enforcement services to our Nation's veterans. I expect our staff to keep pace with the demands and rewards of putting our customers, veterans, and their prospective employers first. This will give each veteran a chance for real employment security in a rapidly changing world economy.

The agency's 1998 budget request is designed to promote the maximum employment and training opportunities for veterans, particularly those who still suffer from higher-than-average unemployment rates—the disabled, the special disabled, minority, female veterans, young veterans, and recently separated veterans. To better serve veterans, we are streamlining, shifting resources, and making better use of electronic tools.

The quality of jobs available through the state employment service system is improving. Federal contractors—and that means many of the Nation's leading companies—can now place job openings electronically on America's job bank. Many of these are better-paying and career-building jobs. I intend to make sure that DVOPs and LVERs have the knowledge and tools necessary to access these jobs and place our veterans into them.

The only significant increase in our 1998 budget submission is a \$2.5 million request for the homeless veterans reintegration project—an important program reauthorized by Congress last year. These funds will allow us to competitively award 20 grants to help homeless veterans move into unsubsidized employment. VETS is the only government agency directly working to put homeless veterans into jobs.

The bulk of our budget, just over \$157 million, is for grants to our state partners to fund DVOP and LVER positions. We plan to emphasize and protect the LVER program, which supports the direct services to veterans, and functional supervision of priority of services to our state agency partners.

We are working with the state employment security agencies to make sure that the efficiencies generated by this emphasis will enable DVOPs to give more time and attention to those veterans who are not job ready, or when they leave military service and have need for more targeted, intensive assistance.

This emphasis will not adversely affect our services to any of our veteran customers. In fact, it will allow DVOPs to concentrate more of their efforts on case managing, and those disabled veterans who require specifically tailored services to make them job ready.

Our request for JPTA IV(c) is the same as last year, \$7.3 million. These, too, will be competitive grants awarded to state entities through the governors' offices. A small amount of the funds will be used at my discretion for research and demonstration projects.

The \$22.8 million request for administration of the agency will support 254 employees, six fewer than we currently have on board. I intend to reach this staffing level through attrition. Our administrative funds will also support the transition assistance program,

TAP, for about 160,000 separating service members and their spouses.

Finally, \$2 million is requested to continue funding the National Veterans' Training Institute, which provides quality training services to federal and state personnel charged with helping veterans.

This is a tight and responsible budget. I appreciate the opportunity to present its highlights to you and look forward to working closely with the committee on behalf of our Nation's veterans. I'll be glad to answer any questions you may have, sir.

[The prepared statement of Mr. Taylor appears on p. 150.]

The CHAIRMAN. Thank you, Mr. Secretary. I do have one question. What is the effect of not having a separate funding line for the transition assistance program?

Mr. TAYLOR. I have looked at this. I've been in this job now just about 3½ years, and that was one of the first questions I asked when I got here. I recently looked at it again, and I have determined that there is no adverse impact at all. And there really is no advantage to pulling the TAP funds out of the administrative costs and making it a separate line.

The CHAIRMAN. Thank you, Mr. Secretary.

Next we have Major General John P. Herrling, Secretary of the American Battle Monuments Commission. General Herrling?

#### STATEMENT OF MG JOHN P. HERRLING

General HERRLING. Good morning, Mr. Chairman.

On behalf of the chairman of the American Battle Monuments Commission, General Fred Warner, I am pleased to appear before you today.

Let me begin by thanking you, Mr. Chairman, and the members of this committee for the support you have provided to our commission over the years. The special nature of the American Battle Monuments Commission places it in a unique and highly responsible position with the American people. The manner in which we care for our Honored War Dead is, and should remain, a reflection of the high regard in which we as a nation memorialize their service and sacrifices.

As you know, the American Battle Monuments Commission, established by Congress in 1923, is a small, one-of-a-kind agency responsible for commemorating the services of American armed forces, where they have served since April of 1917, through the erection of memorial shrines, monuments, and military burial grounds on foreign soil.

The American Battle Monuments Commission administers, operates, and maintains 24 permanent memorial cemeteries, and 28 monuments, memorials, and markers, in 15 countries around the world. We have eight World War I and 14 World War II cemeteries located in Europe, the Mediterranean, North Africa, and the Philippines. All of these cemeteries are closed to burials. In addition, we are responsible for the American cemeteries in Mexico City and Panama.

Interred in these cemeteries are approximately 31,000 World War I service members, 93,000 from World War II, and 750 from the Mexican War, for a total of approximately 125,000.

Also, we have approximately 5,000 American veterans and others buried in the cemetery in Panama. In addition, we have honored another 94,000 service members on the walls of the missing, dedicated to those who are missing in action and those lost and buried at sea.

The care of these cemeteries and memorials requires a significant annual program of maintenance and repair of facilities, equipment, and grounds. Care and maintenance of these facilities is exceptionally labor intensive. Therefore, personnel costs account for 72 percent of our budget in fiscal year 1998. The remaining 28 percent is required to fund our operations—our engineering maintenance, utilities, horticultural supplies, equipment, and administrative costs. Also, we operate with fixed assets. We do not have the option of closing or consolidating cemeteries or memorials. In light of this, we have increased our efforts to achieve greater efficiency and effectiveness, through automation, in the operation and financial management areas.

In addition to our overseas mission, we have been mandated by the Congress to construct two memorials here in Washington, DC.

On July 27, 1995, President Clinton and President Kim Young Sam of the Republic of Korea dedicated the Korean War Veterans Memorial. Last week, on February 6th, we opened the Korean War Veterans Memorial information kiosk. This kiosk houses the Korean War veterans honor roll, which allows friends and relatives to query a database containing the names and information about those who died during the Korean War. With the opening of the kiosk, the Korean War Veterans Memorial is now complete.

In May of 1993, Congress authorized the American Battle Monuments Commission to build a national World War II Memorial. The Rainbow Pool site on the mall was dedicated on November 11, 1995, by President Clinton. Since that time, a national design competition for the memorial was held, with over 400 preliminary designs submitted. Six finalists were selected for the final stage of the competition. On January 17, 1997, President Clinton announced the winning design for that competition.

In the packet that you and the other members of this committee have been provided is additional information and the renderings of the winning design. As directed by Congress, the project will be funded through private donations. The American Battle Monuments Commission is working closely with the Presidentially-appointed World War II Memorial Advisory Board to raise the funds to build the memorial.

Our greatest challenge, Mr. Chairman, for fiscal year 1998 will be in dealing with aging facilities and equipment. Our cemetery memorials range in age from approximately 50 to 80 years, with the Mexico City cemetery being over 140 years old. The permanent structures and plantings which make these facilities among the most beautiful memorials in the world are aging and require prioritized funding to maintain them at the current standards. In addition, much of our equipment is aging and rapidly reaching the end of its useful life.

In summary, Mr. Chairman, since 1923, the American Battle Monuments Commission's cemeteries and memorials have been held to a high standard in order to reflect America's continuing

commitment to its Honored War Dead, their families, and the U.S. national image. This commission intends to continue to fulfill that sacred trust. Our appropriation request for fiscal year 1998 is \$23,897,000.

Sir, this concludes my statement, and I will be pleased to respond to your questions.

[The prepared statement of General Herrling, with attachment, appears on p. 157.]

The CHAIRMAN. Thank you, General. You mentioned the aging facilities and equipment. Are you sure that your budget request for 1998 properly or adequately covers these? Are you satisfied that it does, or—

General HERRLING. Sir, I am somewhat satisfied, as we have had to carefully prioritize our maintenance requirements. And like most other organizations of the federal government, I have a fairly sizeable deferred maintenance program. With the money I have been given this year, I will be able to make some in-roads into that deferred maintenance program. But it's not all that I would like, or it's not all that the program requires.

The CHAIRMAN. When you made mention of the fact that you could not consolidate or close a national cemetery, would that be of help to you? Or when you say "close," do you mean just lock it up, or just continue on with maintenance and if you have no more burials in that area?

General HERRLING. Sir, all of our World War I and World War II cemeteries are closed to burials, with the exception of those War Dead whose remains may be discovered on old battlefields. What I meant was that we could not close and disinter the remains in one cemetery and move them to another cemetery, thereby reducing the number of cemeteries we are responsible for. Nor could we close the gates and just walk away from one of our cemeteries. Our cemeteries need to be maintained in perpetuity by this country to honor the commitment we have made to the War Dead and their families.

The CHAIRMAN. I didn't mean it for that. I just meant the management. Of course, you do that now, I guess.

General HERRLING. We do.

The CHAIRMAN. Thank you, General.

Mr. Evans, do you have any questions of the General?

Mr. EVANS. No questions, Mr. Chairman. I just look forward to working with all of our friends, and it's particularly good to see Martin Lancaster back with us. He was chairman of the Veterans in Congress Caucus for a period of time.

And we miss you here, Martin, and are glad to see you again.

Mr. LANCASTER. Thank you.

The CHAIRMAN. Okay. We'll listen to the Honorable Martin Lancaster, the Assistant Secretary of the Army. We're pleased to have a colleague here, Martin, and we look forward to your testimony.

#### STATEMENT OF HON. MARTIN LANCASTER

Mr. LANCASTER. Thank you, Mr. Chairman. It is my first opportunity to testify before your committee since you assumed the chairmanship and since Mr. Evans became the ranking member. And I'm looking forward to working with you on Arlington National

Cemetery Soldiers' and Airmen's Home National Cemetery, which come under my jurisdiction.

I appreciate the opportunity to testify today in support of the fiscal year 1998 budget for those cemeteries. The deputy superintendent of Arlington, Mr. Thurman Higginbotham, and my deputy for management and budget, Steve Dola, accompany me and will be available for questions after my testimony.

With your permission, I will summarize my testimony and request that my full statement be submitted for the record at this point.

The request for fiscal year 1998 is \$11,815,000. This amount will finance operations at both Arlington and the Soldiers' and Airmen's Home National Cemeteries. It supports the workforce, will assure adequate maintenance of the buildings and grounds, and will permit the superintendent to acquire necessary supplies and equipment.

Major new construction projects proposed for fiscal year 1998 include replacement of the historic Custis Walk, which is approximately 2,500 feet long and is about 75 percent affected by heaving and cracking which requires visitors to exercise additional care and presents a true safety hazard on the grounds of the cemetery.

Also, access roads at the Columbarium complex will be constructed, which will allow full utilization of the new inurnment courts currently under construction. Additionally, \$200,000 is being applied to further expand contracts that enhance the appearance of the cemetery while implementing government-wide streamlining plans and staff reductions.

Our total personnel strength is declining from 128 authorized in fiscal year 1996, to 121 in 1997, to 117 in fiscal year 1998. However, at the same time, we plan to perform the same work contractually that previously was performed by civil service personnel. And we have directed those contractors to take on additional tasks that need to be accomplished.

Ground maintenance, tree and shrub maintenance, custodial services, guide services, and informational receptionists, and headstone setting, realignment, and cleaning are all major functions now performed by contract personnel.

The \$11,815,000 requested are divided into three programs—operations and maintenance, administration, and construction. The O&M program, totaling \$8,779,000, will provide for the cost of daily operations necessary to support an average of 28 inurnments and interments per day, and for maintenance of approximately 630 acres. This program supports 111 of the cemetery's total 117 full-time permanent positions.

The administration program, \$599,000, provides for essential management and administrative functions, to include staff supervision of Arlington and Soldiers' and Airmen's Home National Cemeteries.

The construction program, \$2,437,000, provides \$1,175,000 to replace the Custis Walk, \$810,000 to construct the Columbarium access roads, and \$350,000 to continue the graveliner program and other minor items.

In fiscal year 1996, there were 3,325 interments and 1,733 inurnments; 3,500 interments and 1,900 inurnments are estimated for both fiscal years 1997 and 1998.

Arlington National Cemetery is the Nation's principal shrine to honor the men and women who served in the armed forces. In addition to the thousands of funerals with military honors held each year, hundreds of other ceremonies are conducted to honor those who rest in the cemetery and those who served.

The 11,286 niche capacity of the Columbarium Phase III currently under construction will bring the total niches in the Columbarium complex to 31,286. Phase I completed in 1984, and Phase II completed in 1991, each provide 10,000 niches. The additional niche capacity was achieved by increasing the square footage or footprint of each of the Phase III courts by 10 percent.

In addition to providing more niches, the larger footprint permits the inclusion of a needed rest room and mechanical storage areas.

That completes my summary, Mr. Chairman, and I will be pleased to answer your questions.

[The prepared statement of Mr. Lancaster appears on p. 191.]

The CHAIRMAN. Thank you. We look forward to working with you on this contracting out. I know when the national director was out in Arizona he expressed some concern as to just how far you could go on some of this contracting out, and we look forward to working with you.

Let me ask you, to your overall land acquisition plan for Arlington, and is there land available to fit the master plan?

Mr. LANCASTER. Well, certainly, the master plan, which has now been presented to the Secretary for his consideration, does envision the acquisition of additional property. Part of the property acquisition is now in the works, in the study process, and that is the 24-acre tract known as section 29, which is across Sherman Drive from the Custis-Lee Mansion.

A study is now underway with the Department of Interior to determine which of the 12 acres identified as the Preservation Zone are appropriate to transfer to us with the 12 additional acres identified as the Interment Zone, coming to us following that study. That study will be sensitive to the historical nature of the site of the mansion and the backdrop that this area provides for that historic structure.

The master plan, which is now before the Secretary, would also envision other acquisitions. But until that is reviewed by the Secretary and released by him, it probably would not be appropriate for us to discuss what those plans are. But very clearly, without additional acquisition of property adjacent to the existing Arlington National Cemetery, at some point the burial space will be exhausted.

We now have sufficient graves to carry us through, I believe, 2025. But with acquisition of Section 29 lands, in the near term, and the potential acquisition of other lands evaluated in the master plan, along with implementation of projects to better utilize existing lands, I believe that would go to 2050. And then, if there is other land available, that would extend the life of the cemetery even farther, but that is not included in the master plan that is before the Secretary for his approval.

The CHAIRMAN. Thank you. Mr. Evans.

Mr. EVANS. No questions, Mr. Chairman. Thank you.

The CHAIRMAN. Gentlemen, thank you, and we apologize again for the attendance. And thank you very much, and your statements will be made a part of the record in their entirety.

The CHAIRMAN. You gentlemen from the Independent Budget, if there is no objection, the Chair would be more than happy to re-schedule your meeting, if it doesn't work too much of an imposition, so that we will have more of the members here. I really would like for them to hear it.

Now, unless I hear some objection, if that meets with your approval, I think we will do that. I can give you a possible—perhaps the latter part of the last week of this month, is that—or if you want to continue on, we're perfectly willing to sit here and—

Mr. GORMAN. Well, Mr. Chairman, I appreciate the offer. I think we will take you up on that, and maybe you can—

The CHAIRMAN. All right, sir.

Mr. GORMAN (continuing). Sit down with staff and try to get a date that's convenient for all of us toward the end of the month?

The CHAIRMAN. If you would contact—work with Carl here, we'll certainly accommodate you. And I apologize and appreciate your doing that.

Mr. GORMAN. Thank you.

The CHAIRMAN. All right, sir.

I think that's all, then, isn't it?

I'd like for the record to show that Chairman Spence was holding a meeting, the National Security Committee meeting, and couldn't be with us today.

[Whereupon, at 11:58 a.m., the committee was adjourned.]



# FISCAL YEAR 1998 DEPARTMENT OF VETERANS AFFAIRS BUDGET

THURSDAY, FEBRUARY 27, 1997

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

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

Present: Representatives Stump, Evans, Smith, Kennedy, Bili-rakis, Gutierrez, Everett, Bishop, Buyer, Quinn, Doyle, Stearns, Peterson, Cooksey, Snyder and Chenoweth.

## OPENING STATEMENT OF CHAIRMAN STUMP

The CHAIRMAN. The meeting will please come to order. I would like to welcome all the witnesses who will be presenting testimony today, and especially those that so graciously agreed to return when we ran out of members last week, and I appreciate that very much.

This, of course, is a follow-on hearing of the February 13 budget, and at that hearing many people asked questions of Secretary Brown that we didn't get around to the rest of them, so he we re-scheduled them for today.

Today we are going to hear from the Honorable Frank Nebeker, Chief Judge of the U.S. Court of Veterans Appeals; the *Independent Budget* Panel, consisting of the Disabled Veterans, Veterans of Foreign Wars and Paralyzed Veterans; as well as American Legion Noncommissioned Officer Association and the Vietnam Veterans Association.

Before we begin with our first witness Judge Nebeker, I would like to recognize Ranking Member Mr. Evans for an opening statement. Lane.

## OPENING STATEMENT OF HON. LANE EVANS

Mr. EVANS. Thank you Mr. Chairman.

I thank all the members coming back to hear Judge Nebeker and the veterans' service organizations about the *Independent Budget*. I think it is very important to have as many members as we possibly can have to hear from the VSOs in particular.

I would be remiss in not mentioning the American Legion. The Legion has performed an invaluable service to this community over the years in providing its perspective on budgetary needs.

We need to look at your views on the budget and your continuing efforts to put veterans first as we consider VA initiatives ranging

from VA health care reform to giving our ailing Persian Gulf veterans the answers they deserve.

I know this will be some of the new members' first exposure to Court of Veterans Appeals. It has been one of my proudest accomplishments to help enact the legislation that created the court, and we are very pleased that Judge Nebeker is able to give us testimony today before these new members.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you Mr. Evans.

Judge, I don't know whether to apologize or not. We rescheduled this mainly for the benefit of the freshman members to hear the workings of the Court of Veterans Appeals, and now, unfortunately, not having any votes today except perhaps one procedure vote and the fact that we have the president of Chile on the Floor at 10 o'clock, we are still short. But we are going to proceed anyway.

I understand you have left a statement for each Member, a fact sheet, and we appreciate that. Your entire statement, of course, will be inserted in the record, and you may proceed at any way you see fit. Judge.

#### **STATEMENT OF HON. FRANK Q. NEBEKER, CHIEF JUDGE, U.S. COURT OF VETERANS APPEALS**

Judge NEBEKER. Thank you, Mr. Chairman. I appreciate the opportunity to acquaint the committee and its staff with the court. I recognize that there are some who may not know much about the court.

First of all, you might legitimately want to know where I come from. I will tell you. I have 45 years of service to the government. I began in 1953 working in the White House. When I passed the bar, I went to the Department of Justice and finally the U.S. Attorney's Office, where I served for 9 years. I was then appointed in 1969 to the DC Court of Appeals. That is the equivalent of a State supreme court. I served there until 1987, when I was appointed to be the director of the Office of Government Ethics in the executive branch. And after the transition to the Bush administration, I was asked if I would take the job I presently hold. They were looking for somebody who could be a chief judge of the brand new court. And now to the court:

It is a new court. Judicial review was not permitted regarding denial of veterans' benefits prior to 1988. The court was apparently in a 10-year to 15-year gestation period during which time there was deliberation here in the Congress as to whether there should be judicial review, and if so, what kind. They finally settled upon, in 1988, the Court of Veterans Appeals, a seven-judge court that can hear appeals from decisions adverse to veterans by the Board of Veterans' Appeals. That is the sole jurisdiction of the court.

Some of our decisions are reviewable in the U.S. Court of Appeals for the Federal Circuit—not all, but some are—where we interpret a statute, the Constitution or regulation of the Veterans Department. We incidentally are batting a thousand in the Supreme Court. We had one case go to the Supreme Court. You probably all heard of it, *Gardner*, and we were affirmed, as was the Federal Circuit, by unanimous decision of the Supreme Court. That

is the only case where there has been certiorari granted to the Federal Circuit through our court.

Now I notice that in your oversight plan there is an indication that the court is viewed as a court in the executive branch. That is not particularly important, but I would like to invite some facts to your attention.

Unlike executive branch agencies, our judges file their financial disclosure statements with the Judicial Conference of the United States. That is by an act of Congress that we do so. Also, by an act of Congress, we are subject to the Code of Judicial Conduct of Judges of the U.S. Courts. In addition to that factor, the disciplinary machinery, ethics and disciplinary machinery, for the judges of our court is an integral part of that which is established in the Judicial Conference of the United States. All that is by statute. So when you look at it, we seem to be pretty much integrated into the judicial branch of government, albeit, that the court was created under Article I as a tribunal inferior to the Supreme Court. That is the language of the pertinent provision in Article I of the Constitution.

As I say, we sit here in the District. As I have informed many members, we have also sat across the country. We have the authority to do so, but we don't exercise that authority very often.

We have a very unique situation within the court, one that the Congress ought to be proud of. It is the wave of the future. Here is an appellate court that can sit single judge, in panels of three, or en banc. It is the single-judge authority that is the wave of the future. It has to be the wave of the future in the State appellate courts because they, likewise, are inundated with frivolous or near frivolous cases.

There are those who would say that the single-judge dispositional authority is devoid of collegiality in the decision-making process. That is simply a misunderstanding on their part. Briefly, here is the way it works: When a case is at issue, it is assigned at random to a single judge. That judge makes the decision whether the case is one that requires an opinion of the court for precedent purposes, or whether it is absolutely controlled by existing statute or decision and the outcome is not debatable. If that decision is made, the opinion is circulated to the rest of the judges. If any judge says, I think it ought to go before a panel, it is pretty well a foregone conclusion that it will go before a panel. So there is collegial input at that stage.

Once the decision is out, the single-judge decision is out, there is the authority under our rule to petition for panel review. That automatically involves two more judges, who then look at the opinion again and look at the record and decide whether to grant panel review. If panel review is denied, the single-judge opinion stands. If it is granted, the single-judge opinion disappears, is vacated, and a new opinion will appear.

There is more collegiality in that kind of a disposition than there is in so many of these busy appellate courts where you have in name three judges on the panel, but in reality a one-judge decision because it is too much for the court to handle.

I have urged throughout the United States to the appellate judges of the country that they seek single-judge authority. It is a

way of conserving judicial resources, and it does not sacrifice the collegiality of the court.

We have one other unique factor on our court. Almost all appellate courts have a central legal staff that helps narrow the issues, and get the record on appeal together where there is a dispute as to what ought to be in the record on appeal. Our central legal staff does that; but they do more. Since we do not have retired judges, as most State courts do, and they use retired judges for alternative dispute resolution called presettlement—or prehearing settlement conferences, where at the appellate level cases are settled out, we have been able to use our central legal staff for that purpose.

There is a wall between them, when they are conducting settlement conferences, and the judges. The judges never learn a thing about what went on in the settlement conference. And, you know, they are settling a lot of cases, which means that there is a disposition that is accomplished often before briefs are even filed. So this process is disposing of the cases where they ought to go back to the Board because of Board error, and these cases don't have to wait in queue to come before the court for disposition.

We continue on the court to have a pretty high pro se, that is represent yourself, rate. Of late it has been 70 percent, a slight decline, but it is still far higher than any other Federal court. Unfortunately, the cases that come before the court for disposition have about a 50 percent error rate requiring remand. That is high. I know they have got a terrible job at the Board level. They have got a lot of cases. But the court's function is to comb those records for error that affects substantial rights. That is what we are doing, and we are finding it in about 50 percent of the cases that come before the court.

I will go back to the single-judge disposition that I mentioned just a moment ago. In those cases by single-judge action that are sent back, there is prejudicial error found. The single-judge technique is not limited to affirming near-frivolous or frivolous appeals. It is used, I would guess, perhaps 40 percent of the time to remand cases because there was error in them.

That concludes my presentation to you on what I am and what the court is. I would be happy to entertain questions.

The CHAIRMAN. Judge, thank you very much, and we appreciate your willingness to appear before this committee.

[The prepared statement of Judge Nebeker, with attachment, appears on p. 201.]

The CHAIRMAN. Mr. Kennedy.

Mr. KENNEDY. Just a very brief question, Mr. Chairman.

Judge, when you were describing the process where a individual that has a case before the single judge that might object to the single-judge ruling, you described a situation where if it is a clear ruling of law, and it would be sort of automatically referred to a four-judge panel or something like that.

Judge NEBEKER. No, three.

Mr. KENNEDY. Three-judge panel.

Would the veteran or the veteran's attorney be able to bring to the attention of that three-judge panel any disagreement that he or she may have, or is that just up to the judges themselves to make that determination?

Judge NEBEKER. No, that is the purpose of a motion for panel review of the single-judge decision, so that they may come in and make the arguments that they want to make to persuade the court that the single-judge decision is in error.

Mr. KENNEDY. I see. Well, it sounds like a reasonable system, Judge.

Judge NEBEKER. It works beautifully.

Mr. KENNEDY. Have you found many of the attorneys objecting to the system that is in place in terms of providing them grounds for dealing with controversial issues? I mean, are you getting a lot of complaints that this system is not working because of the way the system has been set up?

Judge NEBEKER. No. We have received no complaints as such from members of the bar. I understand there is an institutional concern among some veterans' services organizations that the system is not to their liking, and I submit it is because they don't understand how it works. That is why I appreciate the opportunity to lay it on the record here to demonstrate that it does involve collegial reaction.

Mr. KENNEDY. Thank you very much, Your Honor.

And if any of the VSOs do have a particular complaint, I would be happy to talk to them and maybe drop up a note and let you know what their specific concerns are. I am not aware what they are, so if there are some that haven't come to light, I would be happy to try to follow up.

Judge NEBEKER. I appreciate that.

The CHAIRMAN. Judge, let me follow. Is it accurate that the court finds the pro bono system to be of assistance to the courts?

Judge NEBEKER. Yes, not only the court, but I think the veterans do. They are hanging out there with no ability to really take care of themselves before the court. It is an adversarial process all of a sudden, and it helps them as much if not more than it helps the court.

The CHAIRMAN. Is it also accurate to say your budget remains the same except for the pro bono program?

Judge NEBEKER. Yes.

The CHAIRMAN. Thank you, sir. Mr. Stearns.

Mr. STEARNS. Thank you, Chairman. I have a question that is perhaps a little far from your field. Does the fact that this budget we are putting together and its priorities affect you and your Department at all? In other words, do you feel any impact from the budget, veterans' budget?

Judge NEBEKER. You mean the Department of Veterans Affairs budget?

Mr. STEARNS. Yes.

Judge NEBEKER. No, we are totally independent of that. Our budget is submitted to the Office of Management and Budget, but the executive branch has no power to cut it. Fortunately when the court was created, we were given that type of judicial independence, if you will, and that is why I appear to justify the court's budget, because it is not something that is handled through the executive branch.

Mr. STEARNS. Okay, thank you.

The CHAIRMAN. Mr. Gutierrez.

Mr. GUTIERREZ. Thank you very much, Judge, for being with us here this morning. You describe in your written testimony the significant increase in appeal cases seen before your court in the past 2 fiscal years. If you could, would you explain in greater detail why this pattern is occurring and why you believe it will continue as we move toward the end of the century?

Judge NEBEKER. Surely. The caseload in our court is directly driven by the dispositional rate at the Board of Veterans' Appeals. The chairman of the Board has informed us lately that their dispositional denials, outright denials, have gone from 6,000 odd to 10,000. That of necessity means a greater percentage—a greater number will come to our court, although not all 10,000 of them. We have learned that there is not that 100 percent ratio of appeals.

Many of those who have had their claims denied consult with veterans' service organizations or others and learn that there is nothing that they can do, that an appeal would be fruitless. But we still get a number of appeals just because the right of appeal exists, and so we do get an increase whenever the door is opened at the Board level.

Incidentally, sir, it isn't just the complete denial, flat denial, that is appealable. The Board can sometimes award benefits for one thing and deny for another, and then we get that denial, and that is not included in the 10,000.

Mr. GUTIERREZ. Excuse me, Judge. And you believe it is going to continue, that the increase in the—

Judge NEBEKER. Yes, sir.

Mr. GUTIERREZ (continuing). In the number of cases?

Judge NEBEKER. Yes, sir.

Mr. GUTIERREZ. What leads you to believe that there is going to be a continued increase in denial?

Judge NEBEKER. Because the chairman of the Board has been successful within the Department in his endeavor to increase his staff, and they have had marked increases in their capability. This is one of the problems that we are experiencing right now because on the other end of the belt, the Group VII lawyers in the General Counsel's Office that represent the Secretary before our court have not had incremental increases. In fact, they have gone the other way, and it is causing problems.

Mr. GUTIERREZ. So, Judge, they can get more work done, which ultimately leads to more appeals.

Judge NEBEKER. To more appeals for us, that is correct.

Mr. GUTIERREZ. Thank you for being with us here today, Judge. I appreciate it.

The CHAIRMAN. Mr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman.

Judge, you know this is the first term row right here, so I am going to start with the basics here. Could you give me the thumb-nail of what key points you see in this year's budget request that I need to know?

Judge NEBEKER. You mean for the court?

Mr. SNYDER. For the court. It had some points about the pro bono.

Judge NEBEKER. Well, our operating budget is a flat budget, and we are continuing to meet the demands that were imposed a year

ago to cut back on government through the National Performance Review. But we are maintaining a flat budget with no increases except where by law we have to give pay raises. And there is no pay raise for judges. We are not anticipating an entitlement for pay raises there. So our budget is flat.

Mr. SNYDER. Do you want it to be flat?

Judge NEBEKER. We can get by with it, yes.

Mr. SNYDER. I notice you have cut out your annual conferences. Is that a good thing?

Judge NEBEKER. We have. It isn't that expensive a thing. We don't travel. We have them right here at Fort Myer, and it is something that the Article III Federal courts have done as well.

Mr. SNYDER. What, gone to every 2 years?

Judge NEBEKER. Every 2 years, yes. And we have done it because obviously others involved have to spend money, too. The Board puts out a lot of money to come to the conference, and the decision was made that it is good enough to do it every 2 years. It is fun to do it every year, but we don't have to.

Mr. SNYDER. So you are satisfied with the budget being flat?

Judge NEBEKER. I am satisfied with our operating budget this year being flat, yes. The aggregate budget, of course, is not, but I offer no comment on the pro bono's portion of that budget.

Mr. SNYDER. In terms of the amount?

Judge NEBEKER. In terms of the amount.

Mr. SNYDER. Now your statement makes comment about where it ought to be. Would you explain or give me a 30-second summary the point you made in your statement?

Judge NEBEKER. You see, out of our operating budget we are funding a substantial portion of one side of the litigants that appears before the courts. There is a problem of objectivity. There is a problem of appearance that the court is perhaps in a position where it has to sacrifice its own function for the purpose of litigants on one side, and as a result impartiality could be questioned. At least the appearance of it could be questioned. It is for that reason that we would like to see the program, which we support—It is a fine program—We would like to see it authorized and separately funded in some way.

Mr. SNYDER. You made this point last year.

Judge NEBEKER. We did.

Mr. SNYDER. That argument didn't carry today apparently.

Judge NEBEKER. It did not.

Mr. SNYDER. Why was that you think?

Judge NEBEKER. Well, it was not authorized. The program was not authorized, and as I understand it, there is a problem with whose apportionment, the money comes from. We thought it would be a good idea to let it go to the Legal Services Corporation, but that gets it into a totally different appropriations subcommittee, and that is a turf problem, a jurisdictional problem, and I gather it is creating a problem.

Ideally this program, which was a pilot program, ought to be funded privately. I don't oppose it being funded by public funds, but it was a pilot program when we got it started. It is a roaring success, quite frankly. The folks that are working in it have done tremendous work, and they are continuing to do it. And if they can

just in some way be funded beyond the appearance of the court sacrificing over here in order to run a program over here, we would be very happy.

Mr. SNYDER. And then another point in your statement you talk about survivors' benefit change. Am I understanding that right?

Judge NEBEKER. Yes. There is title 2 of this legislative proposal which we submitted last year, the so-called downsizing proposal. Title 1, the downsizing proposal, as Mr. Gutierrez's question points out, we have got an increase in caseload now, so we ought to leave that thing alone. But title 2 deals with bringing the retirement and the annuity system for survivors up to a par with what is in existence elsewhere within the judicial branch of government, the Tax Court, what used to be the Court of Military Appeals, and the Article III Courts. And we urged that that provision, that title, be enacted into law. We understand that veterans' service organizations support that effort.

Mr. SNYDER. Thank you, Judge.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Quinn.

Mr. QUINN. Thank you, Mr. Chairman.

Judge, thank you for being with us today. I want to get back to the pro bono program for a minute that the chairman mentioned before.

Judge NEBEKER. Sure.

Mr. QUINN. You mentioned your positive reaction to that. Do you have any measurement to gauge that positive reaction, that it is working, that it is helpful? Is there anything formal in place that gives you some feedback, or is it just a sense?

Judge NEBEKER. No, there is something rather formal, if you want to call it that. We start out with about 70, 75 percent pro se when they come in the door. By the time they go out, it is down to 50. A lot of that change is as a result of the program.

The other thing that is significant is that the program screens these cases so that these volunteer attorneys are not taking the frivolous cases, they are taking a case that the screeners think has got some merit to it, and their rate of success, i.e., their winning the case before the court, is very high. So those are two factors that I say demonstrate the program is a success.

Mr. QUINN. How about feedback from the veterans themselves?

Judge NEBEKER. We don't get any.

Mr. QUINN. Do you think you need any?

Judge NEBEKER. No, we don't get any accolades, and we don't want any from the litigants that appear before the court. Our job is to decide the case. If they are pleased, they are pleased; if they are not, they are not. That is the way it has to be in the court. You may hear about it.

Mr. QUINN. I agree we hear about it.

The CHAIRMAN. Mr. Bilirakis. No questions. Mr. Buyer.

Mr. BUYER. Judge, as I figure, you make 50 percent happy, somebody.

Judge NEBEKER. Sometimes neither is happy because we rule against the position the Secretary has taken, and he still wins the case, or part of the case.

Mr. BUYER. I don't have any other questions.

The CHAIRMAN. Mr. Cooksey.

Mr. COOKSEY. No questions.

The CHAIRMAN. Mr. Doyle.

Mr. DOYLE. No questions.

The CHAIRMAN. Mr. Evans.

Mr. EVANS. I would like unanimous consent to submit written questions and ask that the answers to those questions and the questions themselves be made part of the record.

The CHAIRMAN. Certainly.

Judge, there may be some questions from staff. If you would respond for the record—or from other members—we would appreciate it.

Judge NEBEKER. We will be happy to do that.

The CHAIRMAN. Thank you very much, sir.

Judge NEBEKER. Thank you for indulging me.

The CHAIRMAN. Our second panel consists of four veterans' service organizations who have prepared the *Independent Budget*.

Gentlemen, we appreciate all the efforts you have put in the preparation of this document and the cooperative spirit which this document represents.

Each witness this morning will be recognized for 5 minutes, and when you are ready, you may proceed in any order that you see fit.

I might say to the new members that the *Independent Budget* is put together by the organizations that you see represented before you, not in conjunction with but in contrast to what the Department asked for. So it is there for our assistance, and it is of great value, I think, in helping the members decide which is the right amount.

**STATEMENTS OF DAVID W. GORMAN, EXECUTIVE DIRECTOR, DISABLED AMERICAN VETERANS; KENNETH A. STEADMAN, EXECUTIVE DIRECTOR, VETERANS OF FOREIGN WARS OF THE UNITED STATES; MICHAEL E. NAYLON, NATIONAL EXECUTIVE DIRECTOR, AMVETS; AND JOHN C. BOLLINGER, DEPUTY EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA**

Mr. GORMAN. Good morning, Mr. Chairman. My name is David Gorman, and I have the honor of being this year's chairman of the Policy Council of the *Independent Budget*. And with your permission and your indulgence, what I would like to do is to introduce each member at the table today and member of the *Independent Budget* and have them proceed with their area of responsibility for putting the document together.

The CHAIRMAN. That will be fine, and their entire statements will be made part of the record.

Mr. GORMAN. On my right-hand side is John Bollinger, the Deputy Executive Director for the Paralyzed Veterans of America; to my far left Mike Naylor, the Executive Director of AMVETS, who will be doing the National Cemetery System portion of the *Independent Budget*; and to my immediate left Ken Steadman, the Executive Director of the VFW, who will be doing the constructive portion of the budget; and I will be doing the benefit section of the *Independent Budget*, Mr. Chairman.

I would like to start with Mr. Bollinger if we could.

The CHAIRMAN. Mr. Bollinger.

**STATEMENT OF JOHN C. BOLLINGER**

Mr. BOLLINGER. Thank you, Mr. Chairman. Good morning to you and members of the committee. I will focus my comments on the medical care portion of the budget.

First of all, let me commend you and many of the members for their remarks a couple weeks ago when this hearing got started. We share your concerns with regard to this budget. We see the administration's budget as a gamble. It is a gamble that is going to result in some actions taken that will directly affect the very real health care needs of veterans.

When all is said and done, the administration's budget in appropriated dollars is \$55 million less than it is this year. When you take those kinds of budget cuts, project them to the year 2002, and coming at a time when the VA is going to be treating an increasingly elderly population you have a real problem. It is going to come at a time when already scarce resources are going to be moved from the Northeast to the South and the Southwest. It is going to come at a time when more veterans are going to use the system.

The increase that the administration is talking about is, we think, a big risk. The increase relies on legislative proposals to make up for the reduction in appropriated dollars, legislative proposals that are not sufficiently tested, proposals that have not been accepted by this Congress in years past, and proposals that are being used to replace rather than to supplement what we believe is the government's obligation to ensure quality care for veterans.

To be clear on this, in years past we have championed the idea of VA keeping outside funding sources from private insurers and Medicare, but this has always been done hand in hand with what we believe to be sufficient appropriations. To make these kinds of cuts at this point in time, just when the VA is trying to wrestle with the whole restructuring issue is the wrong time to do it. It is pulling the rug out from under the VA when they are trying to make these big changes in the way they deliver health care.

During the past 3 fiscal years, the VA medical budget has increased, while workload has been fairly static, except for outpatient clinics. VA has just been able to keep its head above water over the past few years with funding increases. We find it pretty difficult to accept that they will be able to greatly increase the number of patients in years ahead without appropriated dollar increases.

As you will see in the *Independent Budget*, we have recommended a \$1.5 billion increase over current services, which we believe would accommodate the increased workload that is being projected by VA.

Also included in our recommendation is an increase in the research component of the budget. The administration's budget recommendation is an unprecedented \$28 million decrease in research funding. If enacted, this decrease will be devastating to VA's research expertise. When you look out at the horizon, you see some of the wonderful things that VA research is doing right now in regards to multiple sclerosis, spinal cord injury medicine and so on. In the case of SCI, we know very well that the question these days

is not if a cure can be found, but when it can be found. The only thing that stands in the way of that day is resources, time and effort, continuity, consistency and all the other things that go with research. So we hope you will take a hard look at that part of the budget and restore appropriate funds.

We urge you not to let anyone gamble with VA health care. For many of our members across the country, VA health care is really a part of their daily lives. It is not a matter of going down to the family doctor next door. It is a matter of going to the VA and getting expert care on specialized services, whether it be spinal cord injury, blind rehab, amputation, post-traumatic stress.

Those areas are fields that the VA excels in. They are largely unmatched oftentimes in the private sector. For many of our members across the country, VA is the only game in town. So we would urge you to restore the appropriated funds to VA's budget and again not let the administration gamble on health care.

It appears to us that they have basically thrown up their hands, and they say this is the best we can do and very clearly placed the problem on your doorstep. So I hope you can handle it. Thank you.

[The prepared statement of Mr. Bollinger, with attachments, appears on p. 206.]

The CHAIRMAN. Thank you, Mr. Bollinger.

I think we will go ahead and proceed with all members of the panel and then reserve questions.

#### STATEMENT OF MICHAEL E. NAYLON

Colonel NAYLON. Mr. Chairman, I am Michael Naylon. I represent more than 200,000 AMVET men and women, both veterans and currently serving U.S. military personnel. I appreciate the opportunity to testify before you and the committee today.

On February 11 at the Veterans of Foreign Wars Voice of Democracy dinner held here in Washington, DC, a young high school student from Bronx, New York, ended her \$25,000 scholarship-winning essay with the words, democracy is a journey, not a destination. In following remarks, Senator Daschle spoke of how Congress and society will be measured not by how many battle monuments we carve names and inscriptions into, but by how we carve our laws and legislation on behalf of the veterans that we represent here today.

The journey that the winning essayist spoke of, democracy, ends for many veterans at the gates of a national cemetery. Depending on how the Congress carves the budgetary authority for the Department of Veterans Affairs for this coming fiscal year will determine whether those same veterans will be given the final entitlement they were promised as they took up arms on our behalf.

The National Cemetery System has a long and proud history of service to Americans and their families. Despite their continued high standard of service, and despite the administration's proposal for a \$7 million increase in budgetary authority over fiscal year 1997 levels, the system continues to be underfunded.

Current and future requirements of the cemetery system are not being adequately funded to meet current or anticipated demands. Based on 1990 census data, annual veteran deaths are expected to peak at 620,000 in the year 2008. The cemetery system's capability

will fall far short of requirements to provide burial spaces for those veterans seeking burial in a national cemetery given current and projected death rates.

Currently 57 of the 114 national cemeteries remain open with in-ground burial plots. By the year 2000, it is projected that only 53 cemeteries will be accepting full-casket interments.

The *Independent Budget* is a factual analysis of the realistic funding required by the VA to adequately carry out the roles and missions designed to meet the needs of American veterans. We urge the Congress to support the VA's efforts at reorganization and refocusing its health care delivery system. Spare the agency and veteran, however, from funding reductions in order to balance the budget. The President's budget represents somewhere between 468 and \$600 million reduction in appropriated funds from fiscal year 1997 levels, and it is dependent on a legislative proposal to retain earnings from the medical care cost recovery program.

Failure to fund the VA at last year's fiscal year 1997 level will result in a reduction in services to veterans. That shortfall could indirectly impact the cemetery system. We urge you to take the necessary action and prevent this potential reduction in services to veterans from occurring.

While we support the concept of retention of copayment or payments from the veterans' health care insurers, it is necessary to allow the Department of Veterans Affairs to meet the obligation to provide health care to the Nation's sick and disabled veterans at the same level as last year.

With respect to the cemetery systems, our recommendations are to add at least 60 more full-time employee equivalents to cover incremental workload increases, to provide an additional \$4 million in funding to reduce NCS equipment maintenance backlog, begin a feasibility study to promote a second national cemetery to ease the demand for space at Arlington Cemetery, aggressively pursue an open cemetery in each State, expand existing cemeteries where possible, and recommit to a policy of an open national cemetery within 75 miles of 75 percent of America's veterans.

Our *Independent Budget* recommendations with respect to the National Cemetery System represent approximately a \$1,370,000 increase over the fiscal year 1998 budget request.

Mr. Chairman, that concludes my remarks.

[The prepared statement of Colonel Naylor, with attachment, appears on p. 214.]

The CHAIRMAN. Thank you sir.

#### STATEMENT OF KENNETH A. STEADMAN

Mr. STEADMAN. Mr. Chairman, members of the committee, first let me thank you for rescheduling this hearing. We are proud to be a coauthor of the veterans' *Independent Budget*, and I will confine my remarks to the VA's construction program.

The *Independent Budget* coauthors believe the VA's construction program should emphasize expanding primary care access, making facilities more modern and attractive, and increasing long-term care capacity in noninstitutional and institutional settings. We recommend that the minor construction project spending be adjusted annually for inflation.

Prompt expansion of VA's ambulatory care program is crucial if VA is to be an effective care provider. VHA must open more clinics in areas convenient to veterans. We support creating private sector points of entry into the system to meet the needs of veterans remote to VA services. We do not, however, support mainstreaming this system.

The aging veteran population can be expected to place increased demands on the system that will require rapid expansion of VA long-term care alternatives. VA must continue to increase access to community and home-based alternatives for long-term care. In addition, the need for institutional long-term term care also exists.

VA has continued to delegate leasing authority to the networks and medical centers through its simplified lease acquisition process and the delegated authority to negotiate leases. Expedited lease acquisition is also important. The IB authors strongly support permanent legislative authority for VA's enhanced-use leasing program, which currently expires on December 31, 1997, and eliminating the five-project-per-year limitation. The *Independent Budget* coauthors believe VA should use a balanced mix of the facility development options available to meet veterans' needs. These include major and minor construction, leasing, and expanding the enhanced-use authority.

With respect to major construction, the *Independent Budget* recommends a \$391.5 million major construction appropriation for fiscal year 1998. This is \$312 million more than the President's request. Less funding in fiscal year 1998 would be catastrophic given the rapidly changing clinical requirements and the existing plants' age.

The *Independent Budget* coauthors believe the VA must consider acquisition and conversion projects as alternatives to new construction.

Most of the *Independent Budget* recommendations pertain to leases for outpatient clinics and nursing homes. The *Independent Budget* funding recommendation accommodates the annual cost of leasing seven new nursing homes and annual leasing costs for 24 new outpatient clinics.

With respect to minor construction, the fiscal year 1998 *Independent Budget* recommends a \$299.9 million appropriation. This is \$134 million more than the President's request. The funding reflects our growing concern about VA facilities' urgent need for update and repair.

VA should allocate funding in the minor construction account to convert unused and unneeded hospital beds to nursing home care. The *Independent Budget* coauthors emphasize conversion as the principal means to make nursing home care available to veterans. This is the only way we feel the VA can keep pace with the demands of the rapidly aging veteran communities.

Congress should encourage and fund grants for the construction of State extended care facilities wherever States will participate. For fiscal year 1998, the *Independent Budget* recommends an \$80 million appropriation for these grants, \$39 million more than the President's request.

Mr. Chairman, members, this concludes my testimony.

[The prepared statement of Mr. Steadman, with attachment, appears at p. 220.]

The CHAIRMAN. Thank you, Mr. Steadman. Mr. Gorman.

#### STATEMENT OF DAVID W. GORMAN

Mr. GORMAN. Thank you, Mr. Chairman. I would like to join with my colleagues in expressing our overall appreciation to you, Mr. Chairman and the committee, for reconvening the hearing today to be able to allow us to present our views so you can learn a little bit more about where we are coming from as far as overall veterans' benefits are coming.

As I said earlier, Mr. Chairman, my remarks will focus principally on the area of the budget. As an organization of more than 1 million service-connected disabled veterans, the DAV has a special interest in the effectiveness of the benefit programs and in their delivery. The administration's budget will maintain the benefit programs intact and provide for a cost-of-living adjustment for compensation while proposing to permanently extend several of the OBRA measures to achieve additional savings. The DAV appreciates, Mr. Chairman, the administration's support for veterans, as do we this committee's.

However, we do oppose making these cost-saving measures permanent, as the administration would propose, especially the proposal to permanently round down compensation COLAs.

We are also concerned about proposals to make more deep cuts in staffing during fiscal year 1998, a reduction of 543 in VBA and 2,135 in VHA. VA's resources are already strained, and the loss of this many more employees will quite likely impact on the quality and time limits of services to veterans.

Mr. Chairman, the DAV does not support the administration's proposal that would prohibit service-connected disability benefits in which smoking may be a factor. To do so, in our judgment, would be unfair under many circumstances such as where the young servicemen began smoking during service at a time and in a climate that fully condoned or even encouraged such behavior. And those of us who have had the pleasure of receiving C Rations on a daily basis know that cigarettes were a part of that daily life.

We also fear that a history of smoking could be a basis for the denial of service connection for respiratory conditions and diseases, especially cancer, although smoking may not necessarily have been the primary cause or even a substantial contributor to the condition.

The DAV believes that, at the very least, this committee should hold hearings on this type of proposal which would alter the service-connected disability compensation program, in our view, before taking any action on it.

Mr. Chairman, we are also concerned about the proposed funding for medical care. First, as everyone else has, we question the principle of robbing Peter to pay Paul, in which the third-party collections will not be made available to VA to help it raise its level and quality of service, but rather will be used to replace the real reductions in the health care appropriation.

Second, we question the expectation that VA can maintain an acceptable level of services, much less improved services, with a

health care budget that increases only 5 $\frac{1}{10}$  percent over a span of 5 years.

A related concern is that because of these third-party collections that are already committed to deficit reduction under OBRA, there might be those that would seek their replacement from VA's funding to the detriment of benefits and services to veterans.

Mr. Chairman, I would invite the committee's attention to our written statement for the details of our full recommendations and for improvements in the benefit programs.

For the general operating expenses portion of the budget, we have supported the VA's concept of reengineering of its business processes to achieve more efficiency in the claims adjudication system, an undisputed area of concern for all of us in recent years.

This is an area, Mr. Chairman, where we have been critical of the lack of decisive and meaningful action on VA's part, but we believe now the VA has identified and acknowledged the real causes for its claims processing difficulties and has, in fact, a good preliminary plan for correcting those problems. We believe that VA's plan follows from an objective, thorough analysis of its performance and a candid acknowledgment that the current situation is primarily the product of an emphasis on quantity rather than quality and an absence of incentives and accountability for quality.

We do observe that many of the details for implementation of the plan are yet to be formulated, and we caution that the criteria by which quality is to be measured must be built primarily around factual and legal accuracy and completeness of adjudicative actions. We also caution that accountability must start with the employee responsible for the decision and must continue appropriately with those who have supervisory responsibility over the decisionmaker.

The concept as presented by VA is a sound one, however, and we urge the committee to support VA's strategy for improving their claims processing.

I would again invite the committee's attention to our written statement for our recommendations for each of the other business lines for the Veterans' Administration.

Mr. Chairman, the *Independent Budget* is in the process of being printed, and we hope to have that back from the printer and available very shortly. And, of course, when we do, we will make copies available to you and to all members of the committee. With that, I am sure I will be happy to answer any questions that you or the committee may have.

[The prepared statement of Mr. Gorman, with attachments, appears on p. 228.]

The CHAIRMAN. Thank you, Mr. Gorman, and thank all of you for agreeing to be rescheduled today.

I know you stated the position of the DAV, and Mr. Naylor and Bollinger touched on this question of third-party collections that some of us have a dim view of. But I would like to ask each one of you if you actually support the administration's proposal for collecting the insurance as part of our budget, which could leave us, if we fail to pass this bill, about \$460 million short I think has been mentioned. Mr. Bollinger?

Mr. BOLLINGER. Mr. Chairman, we certainly do favor that proposal, and we have historically always advocated for the VA to be

able to go after these third-party payments and also to be able to retain them.

However, having said that, we have also been very strong in our proposal that these funds be used to supplement, not take the place of, appropriated money. That is where we see this administration proposal coming up far short. It is clearly far short in appropriated dollars, and, as I said in my opening remarks, it is a gamble to assume this other money is going to be available.

Mr. GORMAN. Mr. Chairman, I would certainly agree with that. I think for years the *Independent Budget* has championed that issue of we should be going out. The VA is treating these patients, and they are taking out appropriations. Whatever money comes back should feasibly and fairly go back to the VA. So we support the concept of that.

But to replace, substitute appropriated dollars, there is a real need for those dollars out there to take care of that workload. With the expectation that Congress and this committee may act favorably to the request to the detriment of veterans being treated on a daily basis is something that we are very, very concerned about.

The CHAIRMAN. Mr. Steadman.

Mr. STEADMAN. Mr. Chairman, we have historically supported that view as well, but we are also very deeply concerned that this funding program would provide no additional appropriations for health care over the previous fiscal year, and we think it—we deem it unsatisfactory that the additional health care dollars come from a plan which requires separate legislative action, the gamble as was mentioned before, and would not be appropriated directly.

Colonel NAYLON. Mr. Chairman, I could add little to that other than to say when I was in the service, we used to refer to this as betting on the come, so we can't support it in that fashion.

The CHAIRMAN. I know we all probably support this, but in the past it has died and never been able to make it through the Congress, and I am just afraid at the last minute we are going to come up short, and who is going to get the blame for it. It should have been based on supplemental dollars if we are successful in collecting money. Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman. I think I would ask all the panel members how realistic they think the VA goals for a 30 percent reduction in health care treatment costs, a 20 percent increase in the number of veterans served, and funding 10 percent of the medical care budget from nonappropriated sources, how realistic is that during the next few years?

Mr. GORMAN. If I could start, Mr. Evans, I think the discussion we just had puts in a lot of question that leads to the latter, the 10 percent.

The 30 percent reduction, I think the VA probably has a good plan to start that ball rolling. There is probably a lot of things that can be done, a lot of things that have been done to try to reduce the operating cost, capital investment being one, moving primary care away from inpatient care and so forth.

I would be concerned that they do not jump right away into until all of a sudden assuming that these costs can be reduced without the necessary processes being put in place first to enable that to happen. And some of that may very well have to do with some cur-

rent dollars being maintained and a gradual entry into some of these programs they want to change to in the longer term to reduce some of those costs.

I think concomitant with that is again moving away from the inpatient care setting and more to a primary care. I don't know if the 20 percent is going to be accurate, but certainly there is going to be able to be seen an increase in the number of patients seen primarily on an outpatient basis. I think that is the goal we have all held to, and I think they are starting to move in that direction.

Mr. EVANS. I want to ask all the VSOs: Do you feel that your organization is being fairly treated by the VA as stakeholders in the consolidation options that are being discussed within the divisions themselves?

Mr. BOLLINGER. Mr. Evans, think we have come—I don't want to say a long way. But I think we have come a part of the way since all this got started about a year ago. Things are moving very quickly. We have extremely important issues to deal with, capitation, enrollment, specialized services, contracting services, all those kinds of things as the VA positions to report back to your committee not too long from now.

Of course, there are the MACs, the management advisory committees, that we are a part of. We are working closely with the Department of Veterans Affairs to try to make that process work better. We would always like to be involved sooner in the process, and I would encourage this committee that if it has the opportunity do any oversight hearings in the future, to put that very issue on the agenda.

Mr. EVANS. Any other comments?

Mr. STEADMAN. Mr. Evans, if we could go back to your previous questions about the VA goals. Their goals might exceed their grasp, but I think they are moving in the right direction, especially bringing more veterans into the system.

Colonel NAYLON. Mr. Evans, I am with AMVETS, and I would like to say although I have been in my current position for a relatively short period of time, and I speak only for myself, I have found from my own experience the VA to be extremely cooperative with our organization in attempting to keep us at the national level informed as to their activities. I cannot comment with respect to the input at the State or post level with respect to the divisions that you asked.

Mr. EVANS. If you could monitor that situation, I am concerned about our situation in Illinois and the Chicago area, and I know many of the other members of the committee are concerned that Members of Congress don't know what input veterans' service organizations are getting into the process, so we value your eyes and ears out there in the future.

Let me ask one more question. Can each one of you give us your views on how long the presumptive period for compensation for Gulf War veterans suffering from undiagnosed illnesses should be extended?

Mr. GORMAN. Mr. Evans, the DAV feels it should be an open-ended presumptive period right now until science comes up with some kind of a conclusion.

Mr. STEADMAN. The VFW agrees.

Mr. BOLLINGER. I concur.

Colonel NAYLON. We concur, as well.

Mr. EVANS. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Everett.

Mr. EVERETT. Thank you, Mr. Chairman.

I appreciate the efforts gone into this. To pick up on Mr. Evans' question, let me put a proposal to you that Secretary Brown has used. Assuming that we have veterans serving in the Persian Gulf now, and when that veteran gets to be 80 years old, he has a problem with his joints, how do we tell—and as you know, at this present time we have no indication that these veterans over there now are exposed to anything that would cause some problems. How would we tell if that was a claim that should be denied or should be granted?

Mr. GORMAN. Perhaps we never can, Mr. Everett. But I think as we go down this road, we have a situation where, and aside from all of the things that have been going on with the Department of Defense as far as them not being on board and them not being up front with what has been going on, aside from all of that issue, I think the principal issue we have to deal with is how do we take care of the disabled veteran, and whether that is being through health care and through compensation purposes.

I think it is premature to say we don't know what this is, we don't know what it is caused from, we don't know how you got it, we don't know how many of you have it, and to say you only have 2 years to show that it is going to be present. Until science can come up with or until medicine can come up with some kind of evidence that is going to rule these disabilities or conditions out or to link them to something that we are sure may have happened to our servicemembers in the Gulf, I think we have to give—the benefit of doubt has to flow with the veteran. And the situation that you described hopefully by that time will have some conclusive evidence one way or the other that can relate whether this veteran's disability is the result of some kind of environmental exposure or hazard, or perhaps it was a direct link where service connection can be granted for the veterans serving in the Gulf directly.

Mr. EVERETT. Most folks 80 years old don't have those kinds of problems, and by law we could not deny that grant.

Let me ask you this, get your viewpoints on this, all of you. What would be wrong with a 10-year extension, and as you know, we have a number of studies going on, and if we find out that we needed to extend the presumption period further than that, do it again?

Mr. GORMAN. I think certainly the 10-year presumptive period would be far better than what we have now, and that being the 2-year. And we may have some legitimate science by that time. But I think at the same time that perhaps in a more compressed period of time that maybe some things come back, and I think we can somehow equate this to what has been going on with Agent Orange over the years.

Once something has been put into law where there was definite presumptives and there was a likelihood or an association with certain disabilities to possible exposure, I think that narrowed the gap a little bit and made it a lot easier for VA to deal with these claims

for service connection. And I would envision perhaps the same kind of scenario playing out with Persian Gulf veterans.

But I think again it goes back to the fact that I do not think we can write off a veteran who unquestionably is disabled. They are sick, a lot of them to the point where they are unable to support themselves and their families. I don't think we should arbitrarily write them off simply by virtue of a set period of years.

Mr. EVERETT. And, of course, none of us on this panel would do that either, but I would maintain that that is not the situation that I am talking about.

Does anybody else have any views on that?

Mr. STEADMAN. Mr. Everett, I think if you were to extend that to 10 years, it would send a strong message of support to veterans. You would send an even stronger message if you would make it an open-ended period.

Colonel NAYLON. Sir, I would just say that it would be difficult for me to try to identify any cut-off period. Your question seems to be linked to the Persian Gulf Syndrome.

Mr. EVERETT. Yes.

Colonel NAYLON. And until we have some more definitive answers as to the nature or causes of that syndrome, I would think it would be presumptive to attempt to establish any point in time where the presumptive period would end.

We need to get the answer to the first question first, which is what is the cause of this problem that the veterans are having.

Mr. EVERETT. Thank you, Mr. Chairman.

I have some additional questions for the record.

The CHAIRMAN. If you gentlemen would kindly answer, we will make them part of the record. Dr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman.

Mr. NAYLON, this one sentence on page 6 of your statement you said, "VA should seek relief from historic preservation requirements at the facilities." Would you tell me, I am just curious, what that is all about?

Colonel NAYLON. If, for example, I can say that a case over at Henderson Hall where there is a structure that belongs to, I believe, the City of Arlington, and for reasons unknown to me the U.S. Marine Corps is unable to do anything with the structure that sits within their property because of the fact that it belongs to the City of Arlington, and there are historic preservation issues with that structure; therefore they are unable to either demolish it or do anything to capture that land space.

The same situation would apply with respect to the cemetery system. If there are local issues, historic preservation issues, that prevent the VA from either expanding into a land space, then we would urge that they seek relief from that.

Mr. SNYDER. I guess my premise would be that you would come asking for more money so that you could comply with the very good requirements of historic preservation of cemeteries. I mean, I go to Arlington for a variety of reasons, one of them because of the historic significance of what that was, and preservation that has gone on in our cemetery in Little Rock, as you know, started as a Confederate cemetery, but there is a lot of historic significance there. Both Union and Confederate soldiers began the cemetery, and it

has now been expanded. But this is, I guess, coming from the same problem, a different perspective.

I want to ask, going back to the issue of the third-party reimbursements and Medicare, and we talk about wanting it to be supplemental, and I understand that. But, I mean, aren't we setting ourselves all up for both financial and fiscal problems and political problems, both me who would support this and you with your membership? Because isn't it just unrealistic to expect, you know, the VA and this Congress and all this type of budget constraints, that we have a big flood of third-party money coming in, not to take that into consideration in the overall budget scheme?

I mean, 10 years from now let's suppose that VA members, the vets, are like me and Lane, and there are others. We like going there. And it is up 25 percent, and we are getting all this third-party money. I mean, isn't it unreasonable to not expect the government to take into consideration as a total of money and not just say, we have got the VA budget, and now we have got this third-party pool sitting out here, and never can we consider how well they are doing in attracting third-party money in determining the VA budget?

My own feeling is we will come out ahead. There is some kind of splitting of the difference there. Because I think you all are going to have to go back and explain to your members the first time you do that and the budget has dropped down a little bit, it dropped down \$5 because the third-party payments have gone up \$10. Well, you come out \$5 ahead, but it was not supplemental, it took into consideration the whole pot of dollars.

I would just like your comments.

Mr. BOLLINGER. We definitely need to take it into consideration. What we are being asked to accept for fiscal year 1998 is something that takes into consideration some very questionable assumptions, some untested assumptions. The bottom line is at this point in time we are just not willing to say, Mr. President, or the administration, you have come to us with an appropriated budget \$55 million less than it is this year, when in years past increased budgets have just enabled the VA to keep its head above water. Now you are asking us to accept that and also assume that these third-party reimbursements are going to be taken into consideration and are going to give the VA enough money they need to provide quality care for veterans. Maybe 10 years from now we can say that, but we sure can't say it for this next fiscal year.

Mr. SNYDER. But we are going to have that problem every year, aren't we? I mean, at some point if we are going to do this, we have got to enthusiastically get behind it in order for it to happen and then make it work. At some point those budgets are going to have to be included.

Mr. BOLLINGER. And I think we have addressed that in the *Independent Budget* as far as the numbers are concerned. We definitely want to consider those third-party reimbursements, but it is clear for the next year, based on what the VA's projections are, that they are going to need more appropriated dollars to get all of this started.

Mr. GORMAN. If I could add just one comment, and just as a clarifying point, when you are talking about third-party reimburse-

ments and Medicare reimbursements, I think we need to remain clear to the fact that this is not for every veteran that walks through the VA doors. Service-connected VA veterans, those, quote, "Category A" veterans who the VA has historically treated, should continue to be treated with appropriated dollars. It is the Government's responsibility to take care of service-connected disabled veterans in the system that was designed to take care of service-connected disabled veterans. And insurance parties, third-party insurers, Medicare, should not have to assume that responsibility. That responsibility, in our view, should always be that of the Federal Government. I just wanted to make that point so we are not lumping all veterans into this question of reimbursements.

Mr. SNYDER. Thank you, Mr. Chairman.

The CHAIRMAN. I think it only applies to nonservice-connected disabled, and that is what the proposal is. Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman.

I just wanted to clarify again, and I think Mr. Evans touched upon it, this 30/20/10 formula that the administration had. Would it be fair to say that you are skeptical that that could work?

Mr. GORMAN. I think—at least right now I think that maybe a gradual move with that, that could be achieved somewhere down the road. To say that it is going to happen in 1998, 1999 or 2000, I think that is very, very optimistic.

Mr. STEARNS. So for the moment you don't endorse that idea?

Mr. GORMAN. Perhaps the goal—obviously, reducing the cost of treatment and operating expenses and treating more patients was a goal we all would like to see conceptually happen.

Mr. STEARNS. One key difference between your *Independent Budget* and the administration's is construction. You propose an appropriation of more than 390 million while the VA requests only 79.5 million, and that is quite a bit more difference. Would you comment on the VA's request and then explain your own just briefly? I have a couple more questions, too, and in your answer could you also tell us what kind of projects that you would recommend the VA undertake that are not in the VA's budget.

Mr. STEADMAN. Thank you Mr. Stearns. This is a good question. We note that our budget, which has been consistent over the last few years, is considerably more than the VA's budget, and we think that is necessary for several reasons.

One, if the VA plan is to work, its reorganization/restructuring is to work, you have to increase access to primary care facilities, you have to make the facilities more attractive to attract the type of patients who can pay with their third-party insurance. Quality care requires quality facilities. And thirdly, we have got aging facilities, very rapidly aging facilities, some of them reaching the point of obsolescence. I think for years this has been overlooked, or at least a decade has been overlooked, and while we are trying to catch up somewhat, we are also looking ahead to additional access to primary care.

Mr. STEARNS. What specific projects would you propose? Can you be specific? When you talk about 390 versus roughly 80, you are talking about four times as much. Can you give specific examples where you would put the money?

Mr. STEADMAN. Nursing home beds, conversion to long-care nursing facilities would be priorities.

Mr. STEARNS. Would you take existing hospitals and do that, or would they be new construction?

Mr. STEADMAN. We have recommended some additional construction. We have recommended grants to the States, and we have recommended that those hospital with underused capacity be refurbished for that purpose.

Mr. STEARNS. So besides nursing homes—

Mr. STEADMAN. A balanced mix is what we are looking for.

Mr. STEARNS. What does that mean, "balanced mix"; you mean between existing facilities and nursing homes?

Mr. STEADMAN. Yes.

Mr. STEARNS. Does that include any care for people, psychiatric people with long-term mental illness that has resulted from the war?

Mr. STEADMAN. Yes, sir. With improved existing VA facilities.

Mr. STEARNS. Separate from a nursing home, but it would be sort of an advanced care. Well, that seems to me be a major difference between you and the administration.

Mr. STEADMAN. Yes, sir, you are correct. The *Independent Budget* proposes a significant increase for Dr. Kaiser's headquarters budget. OMB, on the other hand, proposes to cut it still further. Is there reason to put money into administration rather than directly into medical care, or would it be better to merge these two budgets?

Mr. BOLLINGER. Clearly the provision of direct medical care to veterans is our priority, but what we propose is to ensure that the VHA, the Veterans Health Administration, headquarters can provide the necessary leadership and guidance in this period of time going through the restructuring. So I don't think it is an unreasonable amount of money, but it will give Dr. Kaiser the workforce he needs to get the job done over the next couple of years.

Mr. STEARNS. You are saying bureaucracy is leadership—I mean, administration is leadership is what you are saying? You know, OMB obviously doesn't agree with you, so I am just saying that might be an area you might want to look at.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Quinn.

Mr. QUINN. Thank you, Mr. Chairman.

Mr. Naylor, you reported on the cemetery. Let me begin by saying, as the new chairman of the new Subcommittee on Benefits, I just received as part of my indoctrination or brainstorming or whatever you want to call it—brainwashing I guess—with compensation, pensions, insurance, housing, education committee, and I am overwhelmed with some of the information, but we are getting there, and Mr. Filner and I both will be involved as much as we can in the coming weeks and coming months.

Mr. Naylor, you talked about the cemeteries a little bit earlier. The VA proposes that they would significantly increase funding for State veterans' cemeteries as well as some additional money for operating expenses. How do the VSO's feel about the State veterans' cemetery situation?

Colonel NAYLON. The administration calls for about a \$10 million level of funding for the State cemetery grant program. For the past

5 years I think the expenditures in that category have averaged about \$5 million, so it is about a \$5 million increase per year in the grant program.

If one considers the anticipated increased death rates and the increased demands for burial spaces on the VA, then we would support that. We do support that. We are concerned, however. We—all the VSOs are concerned that increases in the State grant program don't represent a shift in responsibilities from the VA to the States and so we have that concern. We are anxious that the VA and the National Cemetery System remain responsible for the overall administration of the system.

With respect to operating expenses, the increase in operating expenses for the cemetery program is about 80 percent, I believe, of the \$7 million. About 80 percent of that goes to cemeterial programs. About 15 to 18 percent is consumed in administration. So we feel that is fairly acceptable.

Mr. QUINN. Thanks very much.

I just talked yesterday in one of my sessions on housing and the *Independent Budget* recommendations—and maybe I can't get an answer today; but, if we can't, maybe somebody can get to me on this later.

Mr. Chairman, the *Independent Budget* recommendation is a reinstatement of the adjustable rate mortgage program. Some of the data that we have for the pilot program indicates that the foreclosure rate on this program is about 25 percent higher than some of the other mortgage programs. CBO says this is one of those pay-go situations. It might cost \$30 million to restart the program, when we are in a time—all of us have talked about limited resources and shrinking dollars. Any general comments today on why that would be important or are there some ways to get at these foreclosures?

Mr. GORMAN. Well, if we could take you up on your offer and provide something further in writing, we would appreciate that. However, the concept of adjustable rate mortgages is one that allows some entry-level buyers into the market than otherwise would be able to.

Mr. QUINN. The success of this mortgage program for veterans, as I am learning here and learned yesterday in a 2-hour session, is very, very important. I just want to make certain that, because of the big start-up cost and the pay-go situation, that we don't end up leaving some veterans out of the housing market or mortgage market because it is going to cost us more money and we are worried about those forecloses at a later date.

Thank you. If you could provide that at least to me—the chairman of the subcommittee needs it.

One last question while the light is still green. I want to get back to the pro bono question that I asked the judge. Now I realize I probably asked the wrong person.

We talked about that pro bono program and the need for additional funding. The judge talked about it. Another member here on the committee brought it to light. It seems to me that the VSOs would want to see this program flourish and become important and active and successful.

Two questions. I will ask the question I tried to ask the judge. What kind of feedback do you all get from our constituents, the veterans, on the success need for the program? First question.

Second part of it would be, is there any way that the VSOs should be financially involved in this program rather than all of the onus on the Federal government?

Mr. GORMAN. If I could answer the second part first.

DAV has historically been involved in that program. We have over there now a trained National Services Officer who has a history with employment issues and has been around the Veterans' Committee for a long, long time; and he has been assigned over to the pro bono consortium on a full-time basis and to review cases and screen those for the attorneys the judge was talking about.

Mr. QUINN. Let me interrupt you and see if others can answer that question.

Mr. BOLLINGER. Yes, we are involved as well. I might go on to say that we consider this to be an extremely valuable program. I think they have a win record of about 80 percent.

In addition to that, you should know that the donated value of time from attorneys doing this kind of work is around \$9 million. So it is pretty significant.

Mr. QUINN. Mr. Steadman or Mr. Naylor.

Mr. STEADMAN. We are involved, and we support the program as well.

Colonel NAYLON. We are not involved, and I cannot tell you why we are not.

Mr. QUINN. I will talk to you soon.

Is the involvement for the other three gentlemen all time and people rather than money for the most part? I mean, not that people aren't money.

Mr. GORMAN. Time and people are money.

Mr. QUINN. Mr. Naylor, we can talk maybe at a later date.

The first part of the question was—I will get to it later. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Bilirakis, we are pushed for time here because we are going to be running up against a vote pretty soon.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Gentlemen, I want to commend you. I want to commend you, first of all, for a really good document. It always is. I think the way you set it up this year might even be better than usual. And, of course, the way you set it up here, Mr. Gorman, where you each take certain parts of it rather than repeating basically the same sort of things, which is something we have had in the past.

I also commend you for the work that you do for the veterans, all the VSOs, you four and the three that testify afterwards and others that are not on the program here today. I boast about you all the time back home, and I mean that.

But, at the same time, we all know that the real ammunition, the real power behind everything that we do up here are the folks back home, the rank and file. I asked Becky just a few minutes ago, have we received any telephone calls regarding the administration's budget, regarding the point that Mr. Gorman raised, which I know is darn important to our veterans, the smoking end

of it—and this comes from a nonsmoker, by the way—and she said, no.

I have also talked with a leading person in the veterans' hierarchy in Florida who doesn't see any problems in general with the President's budget. I just wonder if the folks back home, the rank and file, the troops, really understand that budget.

We have gotten your opinions. They are very strong opinions. We have our strong opinions up here. Dr. Snyder has asked pretty darn intelligent, profound questions. But the folks back home, I just don't know that they understand it.

Do they understand, for instance, that if the President's budget is enacted without the accompanying legislative proposals—Mr. Naylor mentioned the "the on the come." It is a gambling term. You used the word, John, gamble. There is not only that gamble, but the gamble also is the receipts anticipated in the budget may not be forthcoming in spite of the fact that we may have the legislative proposal to allow the third party payor, which I think we all agree with, the receipts that are expected to come in to substitute for those lesser dollars may not come in.

So that is a hell of a gamble. But if it is enacted without accompanying proposals or even if the legislative proposals take place and the receipts are not what is being anticipated, this request would violate, I guess, the Veterans Healthcare Eligibility Reform Act of 1996, last year's bill, which requires the VA to maintain its capacity in current level of services for specialized services such as spinal cord dysfunctional medicine, etc.

So do the rank and file know about this?

Also keeping in mind in your answer to me, what is it, that only about 20 percent of the veterans, maybe less, are members of the veterans' organizations. The rest of them are being served by all of your guys, all of your efforts benefit them, too; but they are not members of veterans organizations.

Some responses. Do you understand my question?

Mr. GORMAN. I think so, or hope so.

Mr. BILIRAKIS. I say to you that if your answer is not yes or your answer, is, well, they may not be aware as yet of what is happening up here but we are going to make sure that they are aware—if that is not your answer, things are going to be pretty darn tough. Because they control what we do up here, whether they realize it or not.

Mr. GORMAN. This also gives me an opportunity that I didn't have before to respond to one of Mr. Evans' questions about communication and inclusion.

We do our level best, through a variety of mechanisms, to keep our membership involved and aware of what is going on; and I think we all know what those are through mailouts, magazines, bulletins, the whole nine yards.

In about 3 weeks we will be having our midwinter conference here in Washington, and you will see at that time, as you see every year when we come in town, a number of DAV members canvassing the halls up here and trying to talk to their members and their delegations about key points that are germane and important to our organization.

We all have similar issues; and we, some of us, have different issues at the same time. The key and the part of Mr. Evans' question that I didn't get a chance to respond to that fits, I think, hand in glove with yours is that the VA does an enormous job about trying to include the national organizations in Washington about what is going on in order to make this system work; and principally I am talking about the healthcare system and the changes that are going on.

You don't have to necessarily sell it to us, I don't think. You do on the policy level. But when a veteran goes to the doctor and can't see a doctor, only then does that veteran, he or she, know this budget has had an impact on that facility or that things are changing.

Mr. BILIRAKIS. Then it is too late, isn't it?

Mr. GORMAN. It very well could be too late. We do our level best to keep our members involved, but I think the VA needs to do a much better job in communicating from Washington down to the local level and make sure that the veterans' organizations in the local level—local facilities are all included and not excluded. And by included I don't mean they are being talked to all the time; I mean they are not being thrown papers and documents to look at; I mean maybe are being made a part of the process.

Mr. BILIRAKIS. But the VA is not going to tell them this is a hell of a gamble, and particularly in the outyears there might be shortfalls because of the fact what is anticipated did not come in terms of receipts, even if the third party payor is successful.

Well, the red light is on. But the message is, get the veterans involved. The message is always get the veterans involved, but in this particular case I think more than anything else, more than any other time.

Mr. BILIRAKIS. Thank you, Mr. Chairman. My time is up.

The CHAIRMAN. Thank you, sir.

There is a scheduled vote but not until 11:45. However, the Fleet Reserve Association is having a luncheon in here at noon, and we need to try and get out of here before 11:30 if we can for their benefit. Dr. Cooksey.

Mr. COOKSEY. Thank you, Mr. Chairman.

I have some questions just for information. I will comment on third party payments.

I am a physician, as is Dr. Snyder, and I know that in my private practice that I used to have, third party payments oftentimes are delayed; and I am concerned that this is a pie-in-the-sky concept.

That is part of the reason that I ran for Congress, because I discovered when I had all my applicants for—2,000 applicants for 15 positions, that no one in Washington has ever taken an accounting course and very few even know what a balance sheet is. That is the reason there is a lot of hocus-pocus with numbers; and I think it exists in the executive branch, apparently. I have had a couple accounting courses, but I am not an accountant.

Mr. Steadman, my question, we have a new veterans' nursing home in my town, Monroe, Louisiana, that we are very pleased with and proud of. But yesterday I had some nursing home owners from Louisiana in from across the State, and they said that there

are a lot of empty nursing home beds in these privately owned nursing homes, that they would like to have veterans there.

What is the veterans organizations' position on that? Would the veterans like to be in these private nursing homes? They say they can accommodate people for less cost than what they would have in a veterans' nursing home.

Mr. STEADMAN. There are several points of view on that.

Number one, we support the VA in leasing some of that where there is unmet need, yes. But we wouldn't want to see that as part of the mainstream at this point in time—and I will be honest with you—because we are worried about the quality of care. Maybe that veteran is not going to get the best care available that someone coming through the Traveler's Insurance would.

Mr. COOKSEY. As a physician, quality care should be the issue and not cost of care; and I agree with you.

Mr. BOLLINGER. If I may add to that from a very parochial point of view from the Paralyzed Veterans of America dealing with patients that have spinal cord injury, we are very concerned about that. Because there are no standards of care in private nursing homes for people with spinal cord injury. It is a multi-disciplinary field that requires very extensive expertise in the area of how one takes care of a patient with that kind of catastrophic disability. We are convinced that the private sector nursing home community is not in a position to provide that care.

Mr. COOKSEY. Good. That answers the question then. I will convey that message to them.

Another question: We have a veterans' clinic in our area and have an outstanding physician who just left for the private sector because he was working too hard. But do you want more access to private sector medicine for veterans? Because this one physician is not able to take care of all of the people that want to be seen in our area. Would you like to be able to go to more private physicians for primary care?

I am specifically talking about areas—in rural areas where there is not a veterans' hospital or areas like I am in where we have a clinic but we only have one physician serving a 300,000 patient population area—general patient population area.

Mr. BOLLINGER. Again, our concern is the specialized care need, whether it is spinal cord injury or amputation or any of the fields that the VA specializes in right now. I think what we would like to see—and this would apply to nonspecialty care VA facilities—is a good referral system so that when a doctor in a rural area is unable to treat a certain condition, they know through guidelines that there are—through other procedures to refer that veteran to a spinal cord injury center. That has got to be a part of this whole restructuring process.

Mr. COOKSEY. Sure. So the answer to both of my questions is that your preference is still to VA hospitals, VA nursing homes and VA private care, generally speaking?

Mr. STEADMAN. Yes.

Mr. COOKSEY. Okay. Thank you, Mr. Chairman.

The CHAIRMAN. Mrs. Chenoweth.

Mrs. CHENOWETH. Thank you, Mr. Chairman. I have no questions.

The CHAIRMAN. Mr. Peterson.

Mr. PETERSON. Thank you, Mr. Chairman.

I apologize for being late, and this may have been answered. But looking through your budget here, I see that the veterans' housing benefit program under this is decreased; and I was looking through here to try to figure out why that is. I can't find it in here. Could you explain to me why that is—

Mr. GORMAN. Because, Mr. Peterson, the benefit hasn't kept pace with inflation since I think 1989 was the last time it was increased, that together with the automobile allowance. And we are calling for an increase that is going to be able to keep pace with inflation.

Mr. PETERSON. Well, no. Unless I am reading this wrong, it says that this year's appropriation is \$503 million, I guess, and that you are asking for \$352 million, so it is a decrease, if I am reading this right. So there is a \$150 million decrease, and I am just wondering why that is.

Mr. GORMAN. I will get back to you with more details in writing, an answer in writing.

Mr. PETERSON. I was reading through the explanation, and maybe it is there, but I couldn't find it.

Mr. GORMAN. I apologize. I was referring to another proposal we have regarding specially adapted housing for the severely disabled veterans, but we will get you an answer in writing.

Mr. PETERSON. Okay. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Bishop.

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

Let me thank you gentlemen for coming and doing what you always do so well and that is to lift up the standards that we deserve to reach for our veterans.

I am reminded of what my minister always said about trying to reach the high standards. He always set the lights as what we should be reaching for, and I think we should reach for the ceiling, and I think that what you do is to keep us focused on that.

As we are working to do more with less, it is important that we spend our resources where they will benefit the greater numbers of veterans. Therefore, I would be interested in knowing what your thoughts are about the proposed veterans' equitable resource allocation system, which, according to VA, will guarantee that funding is distributed so that the eligible veteran population is receiving care.

Do you think it is effective? Do you think it is just a wish, a pie in the sky, so to speak? Or do you think it can actually work as it has been proposed with the limited resources that we are facing in these budgetary times?

Mr. GORMAN. I think, Mr. Bishop, that the VA is a system; and, as such, it should be treated as a system and funded as a system.

Our concern—yet it is not a tested system yet, this VRA. We are encouraged that it can work and not at the detriment of—we have don't want to see any veterans lose eligibility or be able to lose healthcare and the veterans ultimately suffer because funds have been pulled away from one facility to go to another geographic area of the country. So we will be looking closely at that.

Mr. BOLLINGER. I may answer you and Mr. Bilirakis at the same time on that question, because a lot of it has to do with the rank and file and getting the message out.

I think some of our members in the Southwest and in the South are kind of rubbing their hands, thinking this great wealth is going to come their way. On the contrary. When you look at what is going to happen in the Northeast and in the Midwest, these already scarce funds are going to flow in that top-right, bottom-left direction.

And I think it is almost a double whammy, if you will, for the northeast; and for the Southwest and those in the South it is going to be a case of keeping your head above water, especially true if the third party reimbursement and Medicare reimbursement doesn't become reality.

Mr. BISHOP. Can I just follow up on that? With regard to those legislative needs Mr. Bilirakis referred to, that is going to increase, I think, the need for you to educate your membership so that we can make sure that the Congress does, in fact, pass those.

It is a necessary ingredient. It is in the President's budget. While we probably ought not to be depending on it and we ought to be looking at it as a supplement, the fact is, if we are going to balance the budget and if all of the various parties and interests are going to be met, that this is a necessary ingredient. So we need to make sure and we need your help in making sure that you keep the pressure on the Congress to make sure that the legislative needs are met as they are proposed in the President's budget.

Can we get your commitment to help us do that?

Mr. GORMAN. Certainly can.

Mr. BISHOP. Thank you.

Mr. STEADMAN. We have been in favor of Medicare subvention for some time. As that moves forward, you can count on us to push that.

Mr. BISHOP. Thank you very kindly.

The CHAIRMAN. Thank you, Mr. Bishop.

The CHAIRMAN. Mr. Smith.

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

I want to thank the VSOs and the very able representatives for their testimony and the good work that you provide to us and the guidance you provide.

I just have one question, because most of the other questions I think you have answered either in your testimony or in answer to my colleagues. While the VA's research budget represents only a small fraction of the medical care budget, the administration has repeatedly proposed to cut this budget. As you know, this year they are looking at something on the order of \$228 million, down from the 262, and you want to push it up about \$30 million.

I was just wondering if you could tell us—and if it wasn't for the bipartisan efforts of this committee and the appropriations committee to get that back up, the research part of the budget would fall. Would it make more sense, in your view, to reconstitute the medical care appropriation to include research dollars as a means of providing more predictability and stability for this program? Or should we always come to the rescue every year to try to save it? What is your feeling on that?

Mr. BOLLINGER. Mr. Smith, I am John Bollinger of Paralyzed Veterans of America. I am not sure I can answer the mechanics of that question. I will be happy to provide that for you.

Bottom line for us is that the administration's budget, as it is being proposed now, will have a drastic effect on research. There is no doubt in our mind about this. In fact, even the administration's Secretary Brown said before the Senate committee yesterday, or actually before your committee a couple weeks ago—that it breaks his heart—and Dr. Kaiser mentioned it yesterday in his testimony—that this is clearly an area of the budget that they don't feel real good about.

You know, as I said, it breaks our hearts, too; but it is going to be more than figuratively breaking the hearts of veterans out there who are catastrophically disabled who would otherwise benefit from this type of research. So we hope that your committee will do everything in its power to restore those funds.

Mr. SMITH. I would appreciate that if you would provide that for the record.

(See p. 432.)

Mr. SMITH. Would any of you want to comment on the research side of the budget? You may have earlier, but I was detained over on the House Floor.

Mr. GORMAN. I don't think we have, Mr. Smith.

I would just agree with what Mr. Bollinger had to say and also that a research budget, an adequate one, certainly serves as incentive for cream of the crop, if you will, to be able to look at VA as a place to go and practice medicine and be able to do research also.

I think the VA is trying to target, as they had not in the past, research projects that are very germane and specific to veterans-related illnesses, such as the special disabilities that we are all talking about. So that part is encouraging. The dollar part is very discouraging at this point, and we are going to work hard to get the budget back to where it should be.

Mr. SMITH. Thank you very much. I yield back the balance.

The CHAIRMAN. Thank you. There may be other questions of staff if you gentlemen would kindly respond for the record, please.

Any other questions?

Thank you gentlemen very much.

Our third and last panel for today: The American Legion, Non Commissioned Officers Association, and Vietnam Veterans of America. If you would come to the table, please.

Each of you will be recognized for 5 minutes. Of course, your entire statements will be made part of the record; and you may proceed any way you decide among yourselves.

**STATEMENTS OF JOHN R. VITIKACS, ASSISTANT DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; LARRY D. RHEA, DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS, NON COMMISSIONED OFFICERS ASSOCIATION; AND KELLI WILLARD WEST, DIRECTOR OF GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA**

**STATEMENT OF JOHN R. VITIKACS**

Mr. VITIKACS. Good morning, Mr. Chairman, members of the committee.

The American Legion commends the Department of Veterans Affairs for striving to maintain a consumer-centered health care delivery system. The VA medical care system is truly at a crossroads in its history, and many important issues need to be resolved regarding its future.

Mr. Chairman, the American Legion is concerned that the President's proposed fiscal year 1998 through fiscal year 2002 discretionary budget appropriation for VA medical care provides no inflationary corrections and relies upon unproven assumptions to provide necessary funding increases.

The VA's proposed 30-20-10 plan to deal with expected revenue shortfalls has a challenging goal. We are troubled that there is no draft backup proposal should the plan prove to be unattainable.

The flat appropriation level proposed in the fiscal year 1998 through 2002 medical care budget is far beyond what the system can absorb without jeopardizing the quality, quantity, timeliness and access to care.

According to VHA's calculations, it expects to raise approximately \$3.1 billion over the next 5 years through third party health insurance collections and Medicare reimbursements. This revenue would otherwise be sought through the normal process. It is unclear that VA could obtain this amount of alternative funding even if authorized by Congress.

Additionally, it is questionable if current VHA reorganization efforts will yield sufficient savings to substitute for proposed shortfalls.

Mr. Chairman, there is a need to examine the potential for increasing health care resources through nontraditional means. This effort is a logical extension to the Veterans' Health Care Eligibility Reform Act of 1996. Without a sufficient combination of appropriations and other alternative revenues, the propensity to downsize and reduce the scope of VHA-provided services will continue.

If additional funding sources are not available, the promises of VHA's vision for change will be jeopardized and the VA health care system will be destined to a static future, at best, and one of continuing erosion.

The American Legion believes the GI bill of health is the blueprint to managed change within the veterans' health administration. The proposal was designed to redirect veterans health resources to the VA medical care system while safeguarding the annual appropriations process.

The VA medical system is now on a fast track to change its decades-old health care practices. The American Legion supports the

vision reorganization and the concept underlying the veterans' equitable resource allocation methodology. However, before untested changes occur, it would be reasonable to investigate and evaluate various strategies to help preserve and strengthen the VA medical care system.

In this regard, the American Legion supports H.R. 335, the Commission on the Future for America's Veterans and encourages the Congress to enact the proposal.

Mr. Chairman, the American Legion is also concerned about the fiscal year 1998 budget proposals for medical and prosthetic research services, the minor construction program and the construction program for State extended-care facilities. We urge this committee to carefully review these programs in the course of your budget deliberations.

We would also like to direct the committee's attention to our prepared statement regarding the fiscal year 1998 budget request for the Veterans' Benefits Administration, the proposed cuts to the Compensation and Pension Service staffing and the reengineering plans for the Vocational Rehabilitation and Counseling Service.

The American Legion believes that the committee should request more detailed justification for the fiscal year 1998 BVA budget request in order to fully and fairly evaluate the level of and quality of services being provided to disabled veterans.

Mr. Chairman, that completes my statement.

[The prepared statement of Mr. Vitikacs, with attachments, appears on p. 239.]

The CHAIRMAN. Thank you sir. Ms. West.

#### STATEMENT OF KELLI WILLARD WEST

Ms. WEST. Good morning, Mr. Chairman and members of the committee.

VVA is pleased to present recommendations on the fiscal year 1998 budget. Since this is our first opportunity to appear before the 105th Congress, we wish to extend a special welcome to the new members of this committee. We look forward to working with each of you.

In the interest of time, I will limit my oral remarks to a few key topics; and I will be pleased to elaborate on any point during the question-and-answer period.

Health care has been covered pretty thoroughly by my colleagues, so I won't go into significant detail on VVA's position. VVA does agree with the objective and supports the enactment of legislation to retain third party reimbursements and Medicare payments, but we are very cautious about the President's budget proposal because it does seem extraordinarily optimistic.

Given the fact that nowhere near 10 percent of VA's current health care budget is being collected by third party reimbursements, it seems unlikely that the incentives, the appropriate billing mechanisms and the customer base can be generated quickly enough to meet these targets. We could be looking at a catastrophic budget shortfall.

And if we assume that the system is ready for this monumental shift, VA would have to be very aggressive in collecting payments from veterans and their insurance companies. A wholly dollar-driv-

en VA healthcare system is a frightening proposition, particularly for the service-connected veterans who are dependent upon resource-intensive specialized services. These are the veterans that are VA's primary mission.

VVA feels that protections must be incorporated into any authorizing legislation—for retention of third party and Medicare dollars—to ensure that Congress does not subsequently reduce the VA's budget and appropriation by the amount of its receipts. It is critical that the Federal appropriation be maintained at a level high enough to sustain services to core group veterans.

As we examine the proposed budget, Mr. Chairman, it becomes evident that VA must update its practices, and passage last year of the eligibility reform measure will be an instrumental tool. For this, we again commend your leadership.

VVA is encouraged that this committee plans to do oversight on assistance programs for homeless veterans. It is generally accepted that approximately one-third of the Nation's homeless population are veterans. Yet HUD controls over 75 percent of all Federal homeless dollars, and HUD fails to ensure that the State and local communities distributing these grants do so in a manner that addresses veterans' specific needs. VVA supports legislation which will soon be introduced by Representative Jack Metcalf to correct this inequity.

Investing in comprehensive programs to assist homeless veterans is fiscally responsible. Many of these women and men are ready and able to work and again become productive, tax-paying citizens.

Regarding the Court of Veterans Appeals, VVA applauds the decision by the Chief Judge to withdraw the proposal to downsize the court. VVA opposed this recommendation when it was originally put forward last year, in part because the case load was growing due to increased decisions at the Board of Appeals. We urge full funding for the court.

I would like to make a couple of comments about Agent Orange and Persian Gulf War illnesses particularly. In order to more conclusively determine what conditions are or are not related to service in Vietnam or in the Gulf, we recommend that additional government funded but independently conducted research be done on these issues. We continue to propose research in Vietnam on the Vietnamese population. This committee's support for that kind of research would be instrumental.

This is a challenging time for the veterans community, and fiscal considerations are forcing VA to develop new ways of doing business. These innovations often improve services while at the same time enhancing efficiency, but veterans are very cautious because they have seen budget-driven changes in the VA restrict services through the years.

Recognizing fiscal realities, the veterans community no longer expects that the VA be all things to all veterans. And not all veterans want or need VA services. But veterans do expect that the VA will maintain a necessary level of services for core group veterans, and Congress must provide an appropriate level of funding for this.

Thank you for the opportunity to present VVA's views on the fiscal year 1998 budget. I would be happy to answer any questions.

[The prepared statement of Ms. West, with attachment, appears on p. 251.]

The CHAIRMAN. Thank you. Mr. Rhea.

#### STATEMENT OF LARRY D. RHEA

Mr. RHEA. Thank you, Mr. Chairman and good morning.

Mr. Evans, good morning to you, sir, and to the other members of the committee.

Since we are bumping up against your 11:30 hour, I will not repeat anything or try to not repeat anything that has been said that concerns VA health care. That has been covered pretty well in depth this morning, and NCOA certainly shares those concerns.

I will only comment on it in this respect, though. Two days ago, a rather high-ranking VA official himself admitted—and I wrote the words down so I won't misquote anyone—that "These are almost outlandish targets," followed up by a second quote, "which there is no margin for error in this budget." Whether that individual would admit that to this committee or not I don't know, but that was stated.

What troubles NCOA is that we have been down a very similar path with the Department of Defense beneficiaries. Third party billings have been in effect there for a long, long time; and we can see the result there. And I would just urge the committee to be very careful here if we are going to place greater and greater reliance upon third party recoveries—which I think have been grossly overstated anyway. We have got to know where it is leading us.

I think the whole message of this budget to veterans as far as health care is this: It will be there somehow in the future if you find a way to pay for it, okay? And much like what we have seen in the DOD system, maybe that core Federal obligation that we have held sacred for so long might not be totally dishonored, but it will be chipped away to something that we don't recognize.

Today we have addressed concerns in our statement, Mr. Chairman, on the cemetery system. Your attention to that would also be appreciated.

But I could not walk away from this table this morning if I didn't say something about the post-services education benefit. We are incensed at the nonproposal by this administration on post-services education benefits for veterans. And I would think that somewhere in a 1.7 trillion dollar Federal budget, in a \$51 billion education budget in which we are proposing to spend record levels as far as education, that we could have found something to improve the veteran education benefit. And unless I misread the budget, there was not one cent proposed to do anything relative to the GI bill.

As I put it in my statement, and I make no apology at all in stating it to you now, the Commander in Chief of Education went AWOL.

With that, I would be happy to respond to your questions.

[The prepared statement of Mr. Rhea appears on p. 242.]

The CHAIRMAN. Thank you, Mr. Rhea.

Thank all of you for your testimony today and for all the hard work that you do, not only for your organization but in helping us out.

I am sure I can speak for all the members of this committee when I say that we all support the retention of third-party collection, but we certainly think that should be in the form of supplemental dollars and not to replace appropriated dollars as proposed in this budget. I thank you once again. Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman. I agree.

I would just ask this panel where their organizations stand on keeping the eligibility for Persian Gulf veterans—unlimited eligibility or limited time eligibility?

Mr. VITIKACS. The American Legion, I believe we are on record at this time of supporting an open-ended eligibility period.

Mr. EVANS. Ms. West.

Ms. WEST. The VVA has endorsed your bill which would extend the presumptive period to 10 years. We feel that at this point in time this would be an appropriate time period. It would allow for everyone who is experiencing illnesses now and anyone who becomes sick within the next 3 or 4 years to be accommodated. And ideally science and medicine can come up with some answers in that time frame.

If we reach that point and there are no answers about causes, then we would recommend that it be further extended. But the 10 years seems to be an appropriate time.

Mr. EVANS. Larry.

Mr. RHEA. I think the real question, sir, is not whether it is 5 years or 10 years. I think what we are recognizing here is that two years was rather arbitrarily said, and we certainly support that being extended. We could go with 5 years or 10 years, but I think what we are all recognizing at this point is that 2 years was not the right decision when we made it.

Mr. EVANS. Thank you.

The Chairman and I have written to the administration concerning the GI bill increase. We are of the opinion that, as we rightfully increase money for education, that the first beneficiaries ought to be those that contributed to the defense of our country; and it is a bipartisan effort on our part as committee members.

Mr. RHEA. Appreciate that, sir.

The CHAIRMAN. Thank the gentleman. Mr. Bilirakis.

Mr. BILIRAKIS. Mr. Chairman, just a very brief statement in the interest of time.

You were in the room when I made my comments earlier. I did not use the word precedent, but, boy, what a precedent this would be establishing or the attempt is to establish in this particular case where we are saying that the usual dollars that should go for these services, health care and whatnot are in the future going to be on the come. We may get them or we may not get them.

That is a temporary, I believe, precedent; and I, for one, am pretty put out that we picked the veterans to try to create this precedent on.

Again, it is in your hands. I am a member of the NCOA and American Legion, obviously, and some of the other groups; but it is really in your hands to help us to help you. I don't know how this is going to go. I don't know whether we have a reading yet as far as members are concerned in terms of this idea. But you can see, I think, how most members of the committee, maybe all of the

members of the committee feel. But we can't do it without you, so we need your help with your rank and file.

They have got to contact us. Your members and all those who would qualify to be members but who are not have got to contact us and say, we don't want this to take place.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Smith.

Mr. SMITH. Thank you, Mr. Chairman.

I would just like to ask one question with regard to third party receipts and where they should ultimately end up. Have your organizations given much thought to how much, all or part, of those receipts ought to go to the individual VA medical centers themselves as an additional incentive?

Of course, there could be some disparities if that were 100 percent deal with those with heavily insured people obviously getting more receipts than an inner city medical center, but I wonder if you have given any thought to those local VA medical centers holding on to some of those monies?

Mr. VITIKACS. Mr. Smith, the American Legion has looked at this issue, and we believe a good starting point at least would be a 75 or 80 percent retention at the facility, providing the Chair with the balance of that money being deposited in a system-wide trust account for distribution of needs throughout the system.

Ms. WEST. VVA has not come up with a percentage figure, but we absolutely do agree that there needs to be a balance between monies being retained at the local level and the overall needs of the system. If no monies are retained at the local level, then there is very little incentive for those facilities to go out and serve the patients and collect the money.

Mr. RHEA. I don't have a magic formula for you either, sir. We certainly have to cross that first hurdle, allow the monies to be retained within VVA, and we would hope that that could happen. There are merits both ways that I think you have to consider, whether it is retained at the vision level or at the actual medical center level, and it will probably end up with a balance there some way.

Mr. SMITH. I appreciate that, and as you develop further recommendations on that I would ask that of the other VSOs as well. It would be helpful, I think. Because as this goes forward, I think it ought to be a package deal. And even though the numbers could be tinkered with down the line, it seem to go me—and I agree with Mrs. West—incentives make the world go around. If there is the right incentive and right mix, it will enhance medical care locally and also maximize collection efforts. So I thank you.

The CHAIRMAN. Thank you. And thank you once again, the panel and those here that just testified.

I am sorry. The gentlelady from Idaho, Mrs. Chenoweth. I apologize.

Mrs. CHENOWETH. Thank you, Mr. Chairman. I just—one question that I wanted to ask Mr. Vitikacs.

I am really concerned that the administration proposes to reduce Federal support for the VA State Home Program at a time when there are \$192 million worth of pending projects for which the States have already provided funds. So we are really leaving the

States on the hook there, including one in my home district. So I am very personally concerned about that.

How does the *Independent Budget* address this issue, and do you have any further suggestions?

Mr. VITIKACS. Well, the American Legion is not part of the *Independent Budget*; and I have not looked at that from their perspective.

In our view, this program has been underfunded year after year. VA today is moving more away from long-term care, the provision of long-term care; and our view is that the State Veterans Home Programs would be an excellent complement inventory asset to the VA in this regard.

The Congress over the years has provided more funds than have been requested for this particular program, and we see their being an urgent need for the Congress to really examine this issue and come up with an adequate appropriation, much above the level that the administration is requesting.

Mrs. CHENOWETH. Thank you very much. And I just also wanted to add my appreciation to all of you for your comments. Thank you.

The CHAIRMAN. Thank you, Mrs. Chenoweth. I apologize again. And thank you, ladies and gentlemen, once more.

The Chair does have one more question. There is always the inevitable post-conference—if you could take those down the hall so the crew can get in here and set up for lunch, it would be very much appreciated.

Thank you all very much. The meeting stands adjourned.

[Whereupon, at 11:30 a.m., the committee was adjourned.]



# **A P P E N D I X**

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**HONORABLE BOB STUMP**

**STATEMENT**

**FULL COMMITTEE HEARING ON THE PROPOSED  
BUDGET FOR FISCAL YEAR 1998**

**FEBRUARY 13, 1997**

**I WANT TO WELCOME ALL OF THE WITNESSES WHO  
WILL BE PRESENTING TESTIMONY TODAY.**

**FOR THE FIRST TIME IN RECENT MEMORY, WE WILL  
HEAR TESTIMONY CONCERNING THE BUDGET OF  
THE AMERICAN BATTLE MONUMENTS COMMISSION  
AND ARLINGTON NATIONAL CEMETERY.**

**I URGE MEMBERS TO LISTEN TO ALL OF THE  
TESTIMONY THAT WILL BE PRESENTED THIS  
MORNING.**

**OUR FIRST PANEL IS HEADED BY THE SECRETARY  
OF VETERANS AFFAIRS AND WE ARE LOOKING  
FORWARD TO HIS STATEMENT.**

**HOWEVER, MR. SECRETARY, I MUST TELL YOU I AM  
VERY CONCERNED ABOUT YOUR HEALTH CARE  
BUDGET PROPOSAL.**

**THE ADMINISTRATION'S REQUEST ASSUMES THAT CONGRESS WILL ENACT LEGISLATION THIS YEAR TO ALLOW VA TO KEEP ALL OF THE FEES AND HEALTH INSURANCE COLLECTIONS IT PRESENTLY DEPOSITS IN THE TREASURY.**

**IT ALSO ASSUMES THAT CONGRESS WILL ENACT MEDICARE "SUBVENTION" LEGISLATION WHICH WILL PRODUCE OVER \$1 BILLION IN REVENUE OVER THE NEXT FIVE YEARS.**

**ADDITIONALLY, THIS BUDGET IS BASED ON AN ASSUMPTION THAT VA WILL LOWER ITS COST PER PATIENT BY 30 PERCENT OVER THE NEXT FIVE YEARS.**

**I BELIEVE THIS COMMITTEE WILL PURSUE MEDICARE SUBVENTION AND RETAINING INSURANCE COLLECTIONS AS ADDITIONS TO APPROPRIATED DOLLARS.**

**BUT IT IS UNPRECEDENTED FOR VA HEALTH CARE SPENDING TO BE CONDITIONED ON PASSAGE OF SUCH LEGISLATION.**

**I'M ALSO CONCERNED ABOUT VETERANS GOING TO SCHOOL UNDER THE MONTGOMERY GI BILL.**

**THE GI BILL HAS BEEN CALLED THE MOST IMPORTANT FEDERAL LEGISLATION IN THE 20<sup>TH</sup> CENTURY.**

**IT HAS DONE MORE TO CREATE THE POST-WWII MIDDLE CLASS THAN ANY OTHER LAW PASSED BY CONGRESS.**

**UNFORTUNATELY, IT APPEARS THAT THE BUDGET INCREASES NEARLY EVERY OTHER EDUCATION PROGRAM WHILE IGNORING THE GI BILL.**

**I AM DETERMINED TO RAISE THIS ISSUE IN OUR BUDGET DELIBERATIONS THIS YEAR.**

**MR. SECRETARY, I WOULD ALSO LIKE TO MENTION TWO OTHER PROGRAM AREAS, THE CEMETERY SYSTEM AND BENEFITS ADMINISTRATION.**

**NATIONAL CEMETERY DIRECTOR JERRY BOWEN RECENTLY VISITED ARIZONA TO TOUR THE NATIONAL MEMORIAL CEMETERY OF ARIZONA IN**

**PHOENIX, AND THE POST CEMETERY AT FORT  
HUACHUCA.**

**I WANT TO THANK HIM FOR TAKING THE TIME TO  
COME TO THESE CEMETERIES, AND ALSO EXPRESS  
MY APPRECIATION TO YOU FOR RECOGNIZING THE  
NEEDS OF ARIZONA'S ONLY OPEN NATIONAL  
CEMETERY IN THIS YEAR'S BUDGET.**

**MR. SECRETARY, YOU HAVE BEGUN THE PROCESS  
OF SELECTING A NEW UNDER SECRETARY FOR  
BENEFITS.**

**I HOPE THAT YOU WILL TRY TO FIND SOMEONE  
WHO CAN DO FOR THE VETERANS BENEFITS  
ADMINISTRATION WHAT DR. KIZER IS DOING FOR  
VA'S HEALTH CARE SYSTEM.**

**IT WILL TAKE SOMEONE WHO IS WILLING TO BRING  
INNOVATIVE IDEAS TO THE DIFFICULT TASKS OF  
IMPROVING TIMELINESS AND QUALITY OF CLAIMS  
PROCESSING.**

**I HOPE YOU WILL FIND SUCH A PERSON.**

**I NOW RECOGNIZE MR. EVANS.**

**THE HONORABLE LANE EVANS**  
**OPENING STATEMENT**  
**FY 1998 DVA BUDGET HEARING**  
**FEBRUARY 13, 1997**

THANK YOU, MR. CHAIRMAN.

LIKE OTHER BUDGETS PROPOSED BY PAST ADMINISTRATIONS, THE FISCAL YEAR 1998 BUDGET PROPOSED LAST WEEK FOR THE DEPARTMENT OF VETERANS AFFAIRS IS A STARTING POINT. OVERALL, I BELIEVE IT IS A GOOD STARTING POINT. IT PROVIDES A FOUNDATION ON WHICH TO CONSTRUCT A BUDGET TO MEET THE NEEDS OF VETERANS.

FOR EXAMPLE, I COMMEND THE PRESIDENT AND SECRETARY BROWN FOR RECOMMENDING VA RETAIN ALL INSURANCE AND OTHER THIRD PARTY REIMBURSEMENTS VA COLLECTS. VA RETENTION OF THESE FUNDS TO PROVIDE VETERANS HEALTH CARE IS A PROPOSITION THIS COMMITTEE HAS LONG SUPPORTED. WE SHOULD GIVE THIS

PROPOSAL FULL CONSIDERATION. OUR JOB IS TO MAKE A FAIR AND INFORMED DECISION WHEN THE DETAILS OF THIS PROPOSAL ARE AVAILABLE.

ON THE OTHER HAND, I AM DISAPPOINTED THAT A BUDGET THAT CORRECTLY EMPHASIZES EXPANDING EDUCATION OPPORTUNITIES FOR OUR CITIZENS DOES NOT INCLUDE AN INCREASE IN VA EDUCATION BENEFITS. THE STRENGTH OF OUR NATION'S ECONOMY AND NATIONAL SECURITY DEPEND ON, AND WILL BENEFIT DIRECTLY FROM, IMPROVING EDUCATION. IT IS CLEAR TO ME, HOWEVER, THAT THE YOUNG MEN AND WOMEN WHO EARN THEIR GI BILL BENEFITS THROUGH HONORABLE MILITARY SERVICE SHOULD BE AMONG THE FIRST TO BENEFIT FROM THE PRESIDENT'S COMMITMENT TO IMPROVING THE QUALITY AND AVAILABILITY OF EDUCATION IN THIS COUNTRY.

AS AMERICANS, WE VALUE OUR NATIONAL HONOR AND DEEPLY RESPECT OUR NATIONAL

COMMITMENTS. IF WE DO NOT KEEP AMERICA'S PROMISE "TO CARE FOR HIM WHO SHALL HAVE BORNE THE BATTLE, AND FOR HIS WIDOW AND FOR HIS ORPHAN," OUR INTEGRITY AS A NATION IS UNDERMINED. IT WILL BE OUR TASK AND RESPONSIBILITY TO ENSURE THAT THE BUDGET WE IN CONGRESS ADOPT PROVIDES THE RESOURCES VA NEEDS TO OFFER EXCELLENT HEALTH CARE TO VETERANS IN A TIMELY MANNER. THE BUDGET MUST PROVIDE VA THE TOOLS IT NEEDS TO PROCESS CLAIMS QUICKLY AND ACCURATELY. THE BUDGET MUST BE SUFFICIENT TO ENSURE THAT THE VOCATIONAL REHABILITATION OPPORTUNITIES WE PROVIDE FOR OUR DISABLED VETERANS ARE SECOND TO NONE. THE BUDGET MUST ENSURE THAT SPECIALIZED SERVICES FOR BLINDED VETERANS AND THOSE WITH SPINAL CORD DYSFUNCTION CONTINUE TO BE AMONG THE FINEST IN THE WORLD. IN SHORT, THE BUDGET MUST BE ONE THAT KEEPS

AMERICA'S PROMISE TO OUR VETERANS AND  
THEIR FAMILIES.

I LOOK FORWARD TO WORKING CLOSELY  
WITH YOU, MR. CHAIRMAN, TO ACHIEVE THAT  
GOAL.

**Rep. Joseph P. Kennedy II**  
**Hearing on Administration's Fiscal Year 1988 Budget**  
**February 13, 1997**

Mr. Chairman, thank you for convening this hearing on the Administration's Fiscal Year 1988 budget. I would also like to thank everyone who has come to testify today. As we all know, providing veterans quality health care with today's budget limitations is a very difficult and challenging mandate.

But it is unconscionable that the Veterans Administration's budget that is before us today does not fully fund veterans care through appropriations. Looming budget constraints does not mean that we toss veteran's health care to chance. But today that is exactly what is being proposed.

We are "chancing" that new hospital funds will increase by 10 percent, even before Congress approves a plan to authorize Medicare payments and third party insurance payments.

We are "chancing" that patient workload will increase by 20 percent. And we are "chancing" that the Veterans Administration will be able to cut 30 percent in costs of per patient care -- all in five years.

I can't think of a single business that would be able to achieve these kinds of goals in five years. Yet we are relying on these "chances" to provide for our nation's veterans. And what if the VA cannot achieve these goals? Will it have sufficient funds to keep the hospital system operating? According to the

budget before us today, the answer to that question is "NO."

It is critical that we begin to plan for the future so that we will always be able to meet the health care needs of this nation's veterans. In today's era of budget-driven priorities, and with these additional demands placed on the system, the VA faces the serious task of outlining budget needs, setting medical priorities, and finding new ways to provide cost-effective, quality health care.

I am very supportive of the efforts to streamline the VA system - and determine the challenges of the future so that we can design the system to meet the continuing needs of veterans. It is crucial, however, that we do not cut the quality of care to our veterans.

This nation has made a commitment to providing timely and quality health care to our veterans. We have established an independent VA as a source of health care for our veterans. The Veterans Administration must not leave our veterans' care up to "chance."

THE HONORABLE MICHAEL BILIRAKIS  
COMMITTEE ON VETERANS' AFFAIRS  
FEBRUARY 13, 1997

HEARING ON DEPARTMENT OF VETERANS' AFFAIRS  
FISCAL YEAR 1998 BUDGET

THANK YOU, MR. CHAIRMAN.

I WANT TO COMMEND YOU FOR SCHEDULING THIS TIMELY HEARING ON THE ADMINISTRATION'S FISCAL YEAR 1998 BUDGET REQUEST FOR THE DEPARTMENT OF VETERANS' AFFAIRS. I WOULD ALSO LIKE TO TAKE A MOMENT TO WELCOME SECRETARY BROWN AND OUR OTHER WITNESSES TO THE COMMITTEE.

I AM ANXIOUS TO HEAR SECRETARY BROWN'S TESTIMONY REGARDING THE ADMINISTRATION'S OVERALL BUDGET RECOMMENDATIONS FOR THE UPCOMING FISCAL YEAR. HOWEVER, I DO HAVE SOME SERIOUS CONCERNS ABOUT THIS BUDGET SUBMISSION AND SOME OF ITS UNDERLYING ASSUMPTIONS THAT I WOULD LIKE TO SHARE WITH THE SECRETARY.

SPECIFICALLY, I AM TROUBLED THAT THE ADMINISTRATION'S BUDGET REQUEST INCLUDES ESSENTIALLY FLAT APPROPRIATIONS LEVELS FOR VA MEDICAL CARE FOR THE NEXT FIVE YEARS. THESE PROJECTED FUNDING LEVELS DO NOT APPEAR TO TAKE INTO ACCOUNT INFLATION AND OTHER UNAVOIDABLE COST INCREASES. CONSEQUENTLY, I AM AFRAID THAT WE COULD BE

CONFRONTED WITH SUBSTANTIAL REDUCTIONS IN HEALTH CARE FUNDING FOR VETERANS IN THE FUTURE.

IN ADDITION, THE BUDGET REQUESTS RELIES ON LEGISLATIVE INITIATIVES WHICH HAVE NOT YET BEEN ENACTED TO SUPPLEMENT APPROPRIATED RESOURCES FOR VETERANS MEDICAL CARE.

THE ADMINISTRATION'S BUDGET REQUEST ASSUMES THAT THE VA WILL COLLECT MORE THAN \$3 BILLION OVER THE NEXT FIVE YEARS THROUGH THE MEDICAL CARE COST RECOVERY (MCCR) PROGRAM WHICH BILLS PRIVATE HEALTH INSURERS FOR THE TREATMENT OF NON-SERVICE CONNECTED CONDITIONS. AS I UNDERSTAND IT, THIS PROJECTION WOULD REQUIRE THE VA ALMOST TO DOUBLE ITS CURRENT YEAR COLLECTION BY FISCAL YEAR 2002. CAN THE VA REALISTICALLY MEET THIS GOAL?

THIS ASSUMPTION DOES NOT TAKE INTO ACCOUNT CHANGES IN THE DELIVERY OF HEALTH CARE SUCH AS THE SHIFT TO MORE COST-EFFECTIVE OUTPATIENT CARE WHICH COULD ACTUALLY DIMINISH VA COLLECTIONS. MOREOVER, THE LEGISLATIVE CHANGES REQUIRED TO PERMIT THE VA TO RETAIN THESE REVENUES DO NOT FALL UNDER THE JURISDICTION OF THIS COMMITTEE.

THERE IS NO GUARANTEE THAT CONGRESS WILL ENACT THE CHANGES NECESSARY TO ALLOW THE VA TO RETAIN THIRD PARTY REIMBURSEMENTS. IF THIS LEGISLATIVE INITIATIVE IS NOT ENACTED, WILL THE VA HEALTH CARE SYSTEM BE ABLE TO PROVIDE ADEQUATE SERVICES TO OUR NATION'S VETERANS?

THE ADMINISTRATION HAS ALSO PROPOSED THE ENACTMENT OF "MEDICARE SUBVENTION" LEGISLATION THAT WOULD ALLOW THE MEDICARE PROGRAM TO REIMBURSE THE VA FOR THE TREATMENT OF MEDICARE ELIGIBLE VETERANS.

AS A VETERAN AND THE REPRESENTATIVE OF A CONGRESSIONAL DISTRICT WITH A LARGE VETERANS POPULATION, I STRONGLY BELIEVE THAT THIS PROPOSAL DESERVES FURTHER EXAMINATION. AS THE CHAIRMAN OF ONE OF THE CONGRESSIONAL SUBCOMMITTEE'S WITH JURISDICTION OVER THE MEDICARE PROGRAM, I MUST ALSO TAKE INTO ACCOUNT THE IMPACT THAT SUBVENTION COULD HAVE ON THE MEDICARE TRUST FUND WHICH IS FACING SEVERE FINANCIAL DIFFICULTIES.

ACCORDING TO THE BUDGET REQUEST, THE VA'S "GOAL IS THAT BY THE YEAR 2002, MEDICARE COLLECTIONS WILL PROVIDE APPROXIMATELY \$557 MILLION ANNUALLY TOWARDS THE CARE OF HIGHER INCOME VETERANS." WHAT THE BUDGET REQUEST DOCUMENTATION DOES NOT MAKE CLEAR IS HOW THIS PROPOSAL WILL BE FUNDED BY THE MEDICARE PROGRAM. I HOPE THE ADMINISTRATION WILL BE ABLE TO ADDRESS THIS CONCERN DURING OUR HEARING TODAY.

LIKE THE MCCR PROPOSAL, MEDICARE SUBVENTION IS ALSO A LEGISLATIVE INITIATIVE THAT IS OUTSIDE THE JURISDICTION OF OUR COMMITTEE. DURING THE 104TH CONGRESS, MY HEALTH SUBCOMMITTEE HELD A HEARING ON THE SUBJECT OF SUBVENTION. GENERALLY, THE MEMBERS OF MY SUBCOMMITTEE WERE OPEN-MINDED ABOUT THE ISSUE. HOWEVER, THE WAYS AND MEANS COMMITTEE, WHICH ALSO HAS JURISDICTION OVER

**THE MEDICARE PROGRAM, HAS HISTORICALLY OPPOSED  
MEDICARE SUBVENTION LEGISLATION.**

**IN LIGHT OF THAT HISTORICAL OPPOSITION TO MEDICARE  
SUBVENTION LEGISLATION, I AM WORRIED THAT THE  
ADMINISTRATION'S FISCAL YEAR 1998 BUDGET REQUEST WILL BE  
INSUFFICIENT TO MEET THE NEEDS OF OUR VETERANS IF A  
MEDICARE SUBVENTION PROPOSAL IS NOT ENACTED INTO LAW.**

**ACCORDING TO THE BUDGET REQUEST, THE "MISSION OF THE  
VETERANS HEALTH CARE SYSTEM IS TO SERVE THE NEEDS OF  
AMERICA'S VETERANS." I HAVE SERIOUS DOUBTS ABOUT THE  
VA'S ABILITY TO SATISFY THIS MISSION UNDER THE FISCAL YEAR  
1998 BUDGET PROPOSAL.**

**WE MUST NEVER FORGET THAT OUR NATION'S OBLIGATION TO  
CARE FOR OUR VETERANS. I HOPE THAT SECRETARY BROWN  
WILL BE ABLE TO ALLAY SOME OF MY CONCERNS TODAY.**

**THANK YOU, MR. CHAIRMAN.**

THE HONORABLE JACK QUINN  
COMMITTEE ON VETERANS' AFFAIRS  
FEBRUARY 13, 1997

HEARING ON ADMINISTRATION'S FY 98 BUDGET

THANK YOU MR. CHAIRMAN AND THANK YOU FOR HOLDING THIS HEARING. I WANT TO JOIN IN WELCOMING SECRETARY BROWN AND THE OTHER WITNESSES FOR APPEARING TODAY AND I LOOK FORWARD TO HEARING TESTIMONY ON THE FISCAL YEAR 98 BUDGET.

THROUGH THE BUSINESS PROCESS REENGINEERING, VA IS WORKING TOWARD A CLAIMS PROCESSING TIME OF LESS THAN 60 DAYS BY THE YEAR 2002, THEREFORE I'M CONCERNED ABOUT THE ADMINISTRATION'S FY 1998 REQUEST TO CUT 543 FTE WHILE EXPECTING A SIGNIFICANT INCREASE IN PERFORMANCE.

I AM CONCERNED ABOUT THE SLOW AND INEFFECTIVE PROGRESS ON REORGANIZING THE VOCATIONAL REHABILITATION PROGRAM. GAO HAS CRITICIZED THE VA ON THESE VERY ISSUES, AND WE ARE STILL WAITING FOR A REPORT THAT WAS DUE IN JUNE OF '96. AS CHAIRMAN OF THE SUBCOMMITTEE

ON BENEFITS, I LOOK FORWARD TO EXAMINING THIS PROGRAM AND ITS ADMINISTRATION.

THE PRESIDENT HAS OFFERED \$50 BILLION IN EDUCATION IMPROVEMENTS, BUT NOTHING FOR THE MONTGOMERY GI BILL PROGRAM. THIS CONCERNS ME AND I LOOK FORWARD TO HEARING SECRETARY BROWN'S COMMENTS ON THIS SUBMISSION.

AFTER THREE YEARS OF HOLDING STEADY, I AM PLEASED THAT THE ADMINISTRATION HAS PROVIDED AN INCREASE FOR THE NATIONAL CEMETERY SYSTEM. I'M ALSO PLEASED WITH THE ADDITIONAL \$7.4 MILLION AND 52 FULL TIME EMPLOYEES. HOWEVER, I LOOK FORWARD TO HEARING MORE ABOUT THE PROPOSED GRANT CHANGES FOR THE STATE CEMETERY PROGRAM.

THANK YOU MR. CHAIRMAN AND THANK YOU AGAIN TO THE WITNESSES FOR BEING HERE TODAY. I LOOK FORWARD TO WORKING WITH EACH OF YOU ON THESE AND OTHER ISSUES DURING THE 105TH CONGRESS.

## PREPARED STATEMENT OF HON. LUIS V. GUTIERREZ

Thank you Chairman Stump and Ranking Member Evans for convening this important hearing to discuss the fiscal year 1998 budget for the Department of Veterans Affairs.

As we all know, the process of change and reform of the DVA has picked up speed dramatically during the past year. Nowhere is this more evident than in President Clinton's budget request for the fiscal year 1998.

While overall funding has not decreased from the 1997 levels, the already scarce resources available to the VA will be allocated in a different manner than in years past. A number of service networks will face significant shortfalls this year and may be forced to consolidate and eliminate some services in their regions.

The ramifications of the new VA resource allocation framework will be profound. VISN 12, based around the Chicago area will lose approximately \$57 million. VISN 1 in Boston will lose \$52 million and VISN 3 in the Bronx will lose \$148 million over the next few years.

The question the members of this committee must ask and seek answers for, is how these cuts will affect veterans? Now, Secretary Brown you explain in your testimony that the VA will reduce per patient costs by 30 percent while serving 20 percent more veterans.

That sounds remarkable. I hope the VA achieves this goal.

However, in Chicago—and in areas facing similar reductions—will the VA be able to provide more care with so few resources?

This committee must find answers to these important questions or else we are failing to serve our Nation's veterans properly.

It is the obligation of this committee to guarantee that veterans throughout our Nation receive the best care available and that VA restructuring does not take from some veterans to give to others. I am sure that this is not the intended goal of the VERA. However, ensuring that this plan does not adversely affect the vital care that veterans depend on, have earned and deserve must be our mission.

As the ranking member on the Subcommittee on Health, I intend to pursue this issue vigorously in conjunction with Chairman Stearns.

I look forward to working with Secretary Brown and my colleagues on the committee to achieve this goal.

Thank you, I will present my questions later.

## PREPARED STATEMENT OF HON. SANFORD D. BISHOP, JR

Good Morning, Mr. Chairman, Mr. Evans, members of the committee and distinguished panelists and guests. I am pleased to be here today to receive testimony about the President's proposed Department of Veterans Affairs Fiscal Year 1998 Budget.

We have a long day ahead of us so I would like to take this opportunity to thank our panelists for coming today to present their views on the President's Fiscal Year 1998 budget. Particularly, I want to commend Secretary Brown for his efforts, over the last 4 years, to help improve the lives of our Nation's veterans. I am hopeful that under his continued leadership and guidance, the Department of Veterans Affairs will continue to work for the best interests of the veterans community.

I am pleased to see that our panel includes individuals who are quite knowledgeable about employment, veterans appeals, and burial concerns. These particular issues are of great importance to veterans. As a member of the Subcommittee on Benefits, I am most interested in hearing your thoughts and recommendations for improvements in these areas.

I also want to thank the veterans' service organizations for their role in serving as the voices for the veterans of America. You continue to be on the forefront of the fight to provide a better quality of life for our veterans community, and I applaud your efforts.

Our veterans have always made the ultimate sacrifices when called to do so. It is our duty to respond to them in kind by providing them with the necessary benefits and resources. As an ardent supporter of veterans issues, I look forward to working with all of you to ensure that the necessary resources, programs, and policies are in place to assist our veterans.

## PREPARED STATEMENT OF HON. CORRINE BROWN

Mr. Chairman, thank you for holding this important hearing today. I am honored to be hearing today's star witness—Veterans Affairs Secretary Jesse Brown. Secretary Brown has spent his entire professional career as an advocate for veterans. He has been a true champion for the brave men and women who have served their country.

The President has just released his proposed budget for fiscal year 1998. As you know, Florida's veterans population has grown substantially in the last few years. The President's budget specifically states that "The East Central Florida area has been identified for over 10 years as a critically underserved area with a growing population of retired, limited income veterans." I look forward to hearing your comments on what the President's budget will mean for Florida's veterans.

There are nearly 2 million Florida veterans are concerned about what will happen to them when they get sick and need medical attention. According to some estimates, there are 100 new veteran residents in Florida each day.

The President and Secretary Brown knows that we must never forget the sacrifices made by our veterans. In our quest to pass a responsible budget, it would be wrong to do this by cutting back on health care for our veterans, who have made this country what it is today. So, I commend President Clinton and VA Secretary Jesse Brown for responding to veterans' needs with such strong advocacy. And, I look forward to hearing testimony from Secretary Brown and the other witnesses here today.

**Statement of the Honorable Mike Doyle [PA-18]  
Committee on Veterans' Affairs  
Hearing on the Administration's FY98 Budget**

**February 13, 1997**

Passing a budget for the Department of Veterans' Affairs is a task that Congress addresses every year. However, the DVA has recently begun dramatically altering the way the Agency provides services to our nation's veterans, especially in the area of veterans' health care. These changes will require this Committee to take an especially close look at the Agency's budget, to ensure that the changes being proposed and those that have been executed thus far do not diminish the quality of service provided to veterans.

I support efforts to balance our federal budget, and increasing the efficiency of federal programs and organizations, including the DVA, is an option that should be considered. However, we cannot put these goals ahead of the DVA's primary mission, to help our veterans who have sacrificed their health and safety defending this nation and democracy around the world. Additionally, we must ensure that any changes made to veterans programs improve services to all veterans and don't simply shift quality service from one group to another or from one region of the country to another.

One part of the DVA's restructuring that is of great concern to me and the veterans in Western Pennsylvania is the proposed shift of veterans health care funds from VISN 4, which serves all of Pennsylvania, to other regions of the country. My district has one of the largest veterans populations of any district in the nation. Any proposal to take resources away from such a large population of veterans should be carefully reviewed to ensure that those funding reductions don't result in decreased access to quality health care for the veterans in Western Pennsylvania and in other regions where large funding cuts are being proposed.

Another part of this budget proposal that concerns me is the new revenue structure proposed in this budget. While making large assumptions regarding future revenue from non-appropriated sources, the proposal makes bold goals of drastically reducing per patient costs and increasing the number of patients served by DVA health care facilities. This budget reaches beyond FY98 and makes permanent funding decisions that could very well leave the DVA without sufficient revenue in future years to adequately provide health care services to our nation's veterans. We have a responsibility to our veterans to provide long-term solutions to their health care needs, and I am concerned that the new funding structure included in this budget proposal will not be sufficient to meet those needs.

I want to thank all the witnesses who have come here today to help this Committee understand the President's vision for the DVA for the 1998 fiscal year, and it is my hope, Mr. Chairman, that the members of this Committee can continue to make the voices of our veterans heard in the budget process so that the budget allocation for veterans programs in FY98 truly reflects the needs of all of our nation's current and future veterans.

OPENING STATEMENT - Congressman Silvestre Reyes

VETERANS AFFAIRS COMMITTEE 2/12/97

HEARING ON ADMINISTRATION'S FISCAL YEAR 1998  
VETERAN AFFAIRS BUDGET

2/13/97

Thank you, Mr. Chairman. In convening this hearing regarding the President's fiscal year 1998 budget for the Department of Veteran Affairs, we must scrutinize all components of this budget.

It is incumbent upon us to ascertain whether the needs and obligations to our nation's veterans are truly met. We must ensure that there are adequate resources for research, facilities, healthcare, training, employment, and benefits. I look forward to hearing from Secretary Brown, and all the other witnesses who have examined the President's budget. With their testimony, the questions regarding appropriate allocations for the various services and benefits of the Veteran's Administration must be answered. It is my position that we can not speculate on sources of funding.

Similarly, our commitment to such things as research, especially in light of the continuing controversy regarding Gulf War Illnesses, can not be shortchanged.

The mission of Veteran's Affairs requires a solid budgetary foundation. One that does not rest on assumptions, and provides fully for our country's commitment to Veterans. As we examine this budget, I am confident that we will meet this priority.

**Statement of Representative Helen Chenoweth**

Thank you Mr. Chairman, and thank you Secretary Brown for being here with us today. I am very appreciative of the effort and dedication that has gone into the proposal before us. It represents an excellent starting point. However, I am concerned that this budget depends on assumptions that are ambiguous, or at least overly optimistic, and which certainly require scrutiny.

I understand the budgetary constraints involved -- and no one wants to balance the budget more than myself -- but think we can all agree that the budget must not be balanced on the backs of our veterans. I look forward to working with the Committee and the Administration to devise a budget that will provide veterans with the care and resources they were promised and which they certainly deserve.

## STATEMENT OF THE HONORABLE JESSE BROWN

## SECRETARY FOR VETERANS AFFAIRS

FOR PRESENTATION BEFORE THE  
HOUSE COMMITTEE ON VETERANS' AFFAIRS

FEBRUARY 13, 1997

Mr. Chairman, members of the committee, I am pleased to present the President's 1998 budget proposal for the Department of Veterans Affairs (VA). We are requesting \$41.1 billion in new budget authority and 210,625 FTE for veterans' programs. This budget will allow VA to continue providing quality care and services to our veterans and their families.

The President's proposal is innovative and historic. It builds upon the significant progress we have already made in preparing VA to operate within current and future fiscal realities. Our request strikes the appropriate balance between upholding our commitment to veterans and supporting deficit reduction. It also includes new management and revenue tools to keep our system viable and promote overall savings to the Federal Government. The 1998 budget for Medical Care is the first installment of a five year strategy to improve the delivery of healthcare to veterans. I wish to highlight several key elements of our budget request.

**A New Course for Veterans' Healthcare**

VA has reinvented its approach to healthcare delivery and implemented a new national network management structure. We are moving toward becoming a truly national system, with coordinated networks of patient-centered healthcare services. Beginning in FY 1997, we propose to allocate medical care funds on a capitation-based model called the Veterans Equitable Resource Allocation (VERA) system. This resource allocation system complies with the Congressional mandate contained in P.L. 104-204. The recently enacted Eligibility Reform Act (P.L. 104-262) offers VA a great new opportunity to provide improved healthcare services to current customers, attract new revenue-generating customers, and provide value to taxpayers.

VA will expand and improve healthcare delivery with a 2.8 percent increase in funding but without any increase in appropriated funds above the current 1997 enacted level for Medical Care. This "baseline" strategy is tied directly to our proposed legislation to retain all third party medical collections and user fees. The estimated \$468 million in net collections will provide the funds necessary for us to cover the costs of inflation and continue to improve services.

In future years, VA's goal is also to collect Medicare reimbursements for higher income, non-service-connected veterans who choose VA healthcare. This assumes authorization of the Medicare subvention demonstration, successful pilot testing, and authorization to expand nationwide. To keep our system vibrant and in step with modern medicine, we will reach out with a high quality product and expanding our customer base.

With these incentives come new challenges. Our budget request commits us to reduce the per patient cost for healthcare by 30 percent, increase the number of veterans served by 20 percent, and fund 10 percent of the VA healthcare budget from non-appropriated revenues by the year 2002.

### **Improving Benefits Delivery**

We continue to process compensation and pension claims in a more timely manner. The Veterans Benefits Administration (VBA) is on schedule to process original compensation claims in 1998 in 106 days, a reduction of 38 days from 1996 actual and an improvement of 107 days from a high of 213 days in 1994. Progress also continues in reducing the total pending caseload as well. By 1998, the total pending caseload will be reduced by nearly 38 percent from its highest point of 570,000 in 1994 to 356,000 in 1998.

In addition to the Compensation & Pension (C&P) medical exam pilot program funded from the C&P appropriation, our budget also proposes that exams be funded directly from VBA resources with a transfer of \$68 million from the Veterans Health Administration (VHA) to VBA for this purpose. We propose that VBA reimburse VHA for the cost of medical exams conducted in conjunction with a veteran's claim for benefits. Establishing a customer/provider relationship should improve the quality and timeliness of medical exams and, in turn, enhance the quality of VBA claims adjudication. Claims remanded to VBA for deficient medical exams should decline. This budget reflects the continuation of VBA's Business Process Reengineering (BPR) for the C&P claims process which will significantly improve service to veterans. When completed in 2002, this reengineered process will allow most claims to be processed in less than 60 days and will reduce C&P costs by over 20 percent in the same time frame.

### **Ensuring a Lasting Tribute for Veterans and Family Members**

We project that annual veteran deaths will increase 13 percent, from 525,000 in 1996 to 592,000 in 2002. Based on the 1990 census, annual veteran deaths are expected to peak at 620,000 in 2008. As deaths increase, we anticipate a corresponding increase in the number of annual interments performed at our national cemeteries from 71,786 in 1996 to 92,300 in 2002. During the same time period, the total number of graves maintained will increase from 2.1 million to 2.5 million.

Our request for the National Cemetery System begins to position VA to meet future requirements. The budget includes funding and personnel to completely open a new National cemetery at Tahoma, WA, begin the activation process for three additional new national cemeteries, and address workload growth at existing cemeteries. Infrastructure needs will also be addressed.

The budget includes a change in Administration policy for the National Cemetery System. The Federal Government will focus on providing additional incentives for states to participate in the veterans cemetery grant program in order to improve future access to veterans cemeteries. We propose to increase the maximum Federal share of the costs of construction from 50 percent to 100 percent. In addition, the entire cost of initial equipment for cemetery operations could be funded from Federal resources.

### **Administrative Services – Maintain High Quality at Reduced Costs**

Reinvention efforts continue under VA's Franchise Fund. In 1998, we anticipate gross billings of nearly \$82 million compared to \$55 million in 1997. In addition to the six Service Activities already in the fund, we have added the remaining portion of the Austin Finance Center's fiscal operation.

Our budget also reflects the phased expansion of the Shared Service Center (SSC). The SSC is an integrated facility in which VA employees and

managers can obtain fast, accurate responses to their payroll and human resources questions. In FY 1998, the SSC will provide services to additional VA facilities and locations. The SSC will centralize payroll processing and personnel information in a cost-competitive way and will reduce the Department's overhead.

### **Performance Based Budgeting**

The Government Performance and Results Act of 1993 (GPRA) is the primary vehicle through which we are developing more complete and refined strategic goals and performance information. This will allow us to better determine how well VA programs are meeting their intended objectives. We are continuing to move our focus away from program inputs and toward program results. Our strategic management process has been reinvigorated to bring about a stronger "One VA" focus that emphasizes our commitment to becoming a world-class service delivery organization.

We have blended the performance plan required by GPRA into our budget submission so that program goals, objectives, and performance information are presented in an integrated fashion with our request for resources. This provides much better information on what we are trying to achieve, how we will measure our success, and what resources we believe are needed to accomplish our stated goals and objectives.

Along with our enhanced planning efforts, we have strengthened our focus on accountability for results. Our Accountability Report documents the Department's financial and programmatic performance and serves to meet the performance reporting requirements of GPRA. We continue to move closer to our ultimate objective of having a single set of performance measures that are used throughout the program planning, budget formulation, budget execution, and accountability processes. This emphasis on program results will position us to make more informed budget and management decisions.

I will now briefly summarize our 1998 budget request by program.

### **Medical Programs**

#### **MEDICAL CARE**

This year, funding of the veteran's health system is based upon four elements: the appropriation, third party collections, sharing reimbursements and copayments, and a demonstration pilot for billing Medicare for higher income veterans. For 1998, VA's request provides an additional \$468 million -- a 2.8 percent increase -- over last year's enacted level. Essentially, the appropriation is straight-lined at the enacted level for 1997 with a slight adjustment, a decrease of \$68 million for C&P examinations to be transferred to the VBA and an adjustment for Franchise Fund supported financial services (an increase of \$14 million). VA is proposing that all third party medical collections and user fees be merged with the Medical Care appropriation. This will provide additional resources estimated to be \$591 million of which \$123 million is required to cover the cost of collections and \$468 million is available for veterans' healthcare services.

The Administration is also proposing legislation to authorize a demonstration pilot project for Medicare subvention which will allow VA to bill Medicare for higher level income veterans (Category C) and retain these funds. Although we do not estimate significant collections from this pilot in 1998, it is VA's goal to accomplish national implementation of Medicare billing before

2002. We estimate that by 2002 the combined collections from MCCR and Medicare could contribute \$1.4 billion in revenue to support veterans' healthcare. Important to note, we believe VA can provide high quality care for Medicare eligible veterans cheaper than the private sector so this will benefit the Trust Funds and VA. We believe this is a "win-win" situation.

The net result of these proposals for 1998 is the total availability of new funding of \$17.6 billion, which will support 187,317 FTE. We expect to provide care to 3.1 million unique patients, an increase of 135,000. The new funding level should support almost 891,000 inpatient admissions -- 560,000 acute care, 18,000 rehabilitation, 168,000 psychiatric care, 87,000 nursing home care, 28,000 subacute care, 30,000 residential care, and 33.2 million outpatient visits.

This year's funding request includes a proposal that will make a month's worth of funding (8.3 percent) available for two years. This will increase network directors ability to plan procurement of medical services, supplies and equipment more rationally and effectively than if they were constrained by the end of the fiscal year.

This budget makes an extraordinary commitment over the next five years to reduce per patient cost for healthcare by 30 percent, serve 20 percent more veterans, and increase the percent of the operating budget obtained from non-appropriated sources to 10 percent of all medical care funding by 2002.

VA's healthcare system is at a crossroads. VA is now implementing its most significant management restructuring since its inception. Creation of the Veterans Integrated Service Networks (VISNs) assures that scarce resources will be focused upon high priority patient healthcare. VA is also planning to move forward with the Veterans Equitable Resource Allocation System (VERA). This process guarantees that VA funding is distributed based on the eligible veteran population receiving care in a network rather than on historic funding patterns. With enactment of eligibility reform, Congress has given VA the tools to restructure the delivery of healthcare in a practical, logical and cost-effective manner reflecting the priorities of the Nation. Combined with VERA, eligibility reform will help VA serve all veterans better and more fairly.

It is essential that VA receive Congressional support to allow us to expand our non-appropriated funding sources to support veteran's healthcare. This includes VA retaining third party insurance collections and copayments and, after successful pilot testing, VA billing Medicare for higher-income non-service-connected veterans. Allowing VA to retain all third party collection and user fees will provide the incentive to improve collection performance. In addition, providing the medical care program with access to these alternative revenue sources will allow VA to meet the five-year funding levels envisioned in this budget while meeting the healthcare needs of our Nation's veterans.

In this competitive health care environment, VA is becoming more customer-focused. We are measuring customer satisfaction and timeliness of services, while comparing community standards for quality measures to ensure that veterans receive high quality, compassionate care.

Decentralization of network management will continue to promote innovations and generate more cost-effective care. VA will continue its shift from a hospital-centered specialty-driven healthcare delivery system to an integrated network delivery system that is grounded in ambulatory and primary care. VA now has a Primary Care program in place at each of its medical centers.

### MEDICAL AND PROSTHETIC RESEARCH

For Medical and Prosthetic Research, a total of \$234 million and 2,953 FTE will support over 1,469 high priority research projects that will enhance the quality of health care to the veteran population and will maintain operations of research centers in the areas of Persian Gulf illnesses, diabetes, environmental hazards, and women's issues, as well as rehabilitation centers and Health Services Research and Development Service (HSR&D) field programs. In addition to the projects supported by VA appropriations, VA's staff will conduct over 5,200 projects supported by outside funding sources, such as the National Institute for Health (NIH) and private grants and studies.

The following are areas of focus within research: Persian Gulf Syndrome, Prostate Cancer, Outcomes Research, Nursing, Diabetes, Occupational and Environmental Hazards, R&D Program Oversight, Reorganize Cooperative Studies Program, R&D Program Research Project Portfolio, Revitalize the Career Development Program, and DoD Collaborative Research into Human Reproductive System Consequences from Traumatic Military Experience.

### MEDICAL CARE COST RECOVERY

A total of \$123 million and 2,295 FTE are provided for the administrative costs of the Medical Care Cost Recovery program in order to improve collections from third parties, copayments, and other sources. With this proposal, any increase in performance will directly benefit veterans by providing additional resources for veterans healthcare. Collections in FY 1998 are estimated to increase by \$58 million over the 1997 level to \$591 million. Legislation is being proposed to merge this function with the Medical Care appropriation to allow VA to retain medical collections.

The Administration has proposed permanently extending several Omnibus Budget Reconciliation Act (OBRA) provisions, most of which would expire in 1998 under current law. They are: extending authority to recover copayments for outpatient medication and nursing home and hospital care; extending authority for certain income verification authority; and extending authority to recover third party insurance payments from service-connected veterans for nonservice-connected conditions.

### Benefits Programs

VA benefits programs provide assistance to veterans in recognition of their service to their country and the impact of that service on their quality of life. We provide compensation payments to veterans who suffered disabling illnesses or injuries during military service and to survivors of those who died from service-connected causes, pension payments to needy disabled wartime veterans and the needy survivors of wartime veterans, education and training assistance to help veterans readjust to civilian life, vocational rehabilitation and counseling assistance to help disabled veterans obtain employment, credit assistance to enable veterans and active duty personnel to purchase and retain homes, and life insurance. VA seeks to use strategic planning and performance measurement to improve benefits and services for veterans and their families and ensure the best use of taxpayer investments.

The Administration is requesting \$19.7 billion to support 1998 compensation payments to 2.3 million veterans and 307,000 survivors, and to support pension payments to 410,000 veterans and 304,000 survivors. This request reflects caseload and funds for benefits under P.L. 104-204 for the child of

a Vietnam veteran born with spina bifida. Additionally, vocational training is also available to these children. This training may consist of vocationally-oriented services and assistance and may include a vocational education program at an institution of higher learning. Caseload increases in compensation also reflect the anticipated increases in accessions for Persian Gulf veterans as well as increases anticipated due to the addition of prostate cancer to the presumptive list for herbicide exposure in Vietnam and the extension of the Vietnam era for veterans who served in the Republic of Vietnam.

Legislation is being proposed to amend title 38 to prohibit service connection of disabilities or deaths based solely on their being attributable, in whole or in part, to veterans' use of tobacco products during service. This proposal would not preclude establishing service connection based on a finding that a disease or injury became manifest or was aggravated during active service, or became manifest to the requisite degree of disability during an applicable statutory presumptive period. There are no costs or savings associated with this proposal.

We are also proposing in this budget a 2.7 percent cost-of-living adjustment (COLA), based on the projected change in the Consumer Price Index, to be paid to compensation beneficiaries, including spouses and children receiving Dependency and Indemnity (DIC). Proposed legislation is included which makes permanent a provision of current law that provides VA access to certain Internal Revenue Service data for determining eligibility for VA income based benefits. It also permanently limits the monthly pension benefit to \$90 for certain Medicaid-eligible veterans and surviving spouses receiving nursing home care. Also proposed is the requirement that all future compensation COLAs be rounded down to the next lowest full dollar amount.

This budget request also reflects a need for an additional \$753 million for the FY 1997 Compensation programs to fund the COLA that took effect December 1, 1996, and to fund increases in caseload and average benefit payments. Several factors account for the increase in projected average payments, including awards of original backlogged claims, which generated significant retroactive benefit payments, increases in the number of service-connected disabilities claimed and granted to veterans, and changes in program eligibility, such as additions to the list of conditions associated with exposure to herbicides.

An appropriation of \$1.37 billion is requested for the Readjustment Benefits program to provide education opportunities to veterans and eligible dependents and for various special assistance programs for disabled veterans. Education benefits will be provided for about 516,000 trainees in 1998 including 345,300 training under the Montgomery GI Bill. This request includes funds for the annual Consumer Price Index adjustment, estimated to be 2.9 percent effective October 1, 1997, for education programs.

This budget proposes legislation which will combine the separate Guaranty and Indemnity Fund, Loan Guaranty Fund and Direct Loan Fund into one new fund, effective October 1, 1997. Beginning in FY 1998 all income generated by the VA housing loan programs, except the Native American Pilot Program, would be deposited into the new fund along with appropriated monies. Under the credit reform legislation, 13 distinct accounts were necessary for the old structure. The consolidation would merge the remaining eleven accounts into four accounts under a new fund entitled the *Veterans Housing Benefit Program Fund (VHBPF)*. No program or cost changes would result.

We are also proposing legislation to repeal certain restrictions on the collection of debts owed to the Government resulting from the foreclosure of VA housing loans. The budget also proposes to permanently extend VA's authority to (1) increase most housing loan fees by 0.75 percent and (2) charge a 3 percent fee for certain multi-use home loans. In addition, this budget proposes to permanently extend the resale loss provision in the formula that determines whether VA should acquire a foreclosed property or pay the default claim. Also included are proposals that would permanently extend the loan asset sale enhancement authority, so that VA can continue selling loans at a greater return, and increase the vendee funding fee to match the FHA fee structure on loans. VA's vendee loan program offers financing of VA real estate obtained as a result of property foreclosures and is available to both veteran and non-veteran purchasers.

#### **GENERAL OPERATING EXPENSES**

A total of \$846.4 million is requested for the General Operating Expenses (GOE) appropriation in 1998. This funding level, combined with \$161.5 million of administrative costs associated with VA's credit programs (funded in the loan program accounts under credit reform provisions), \$11.3 million in reimbursements from the Compensation and Pensions account for costs associated with the implementation of the Omnibus Budget Reconciliation Act of 1990 as amended, and \$35.8 million from insurance funds' excess revenues, together with other reimbursable authority, will provide \$1.159 billion to support operations funded in the GOE account.

#### **Veterans Benefits Administration**

The 1998 budget request for the Veterans Benefits Administration (VBA) is \$661 million which will support an average employment level of 11,400, which is 543 FTE below the 1997 level. This request, combined with \$157 million associated with credit reform funding, will result in an increase of \$55.6 million in discretionary appropriated funding over the 1997 level. Included in these totals are \$68 million transferred from the Medical Care account for the cost of medical examinations conducted with respect to veterans' claims for compensation or pension.

This budget reflects the continuation of VBA's Business Process Reengineering (BPR) for the C&P claims process which will significantly improve service to veterans. The BPR effort has examined C&P core business processes and addressed the entire claims processing environment. The present lengthy process will be reengineered to reduce internal handling and emphasize VBA interaction with veterans and their representatives. When completed in 2002, this reengineered process will allow most claims to be processed in less than 60 days and will reduce C&P original claim costs by over 20 percent in the same time frame.

This also reflects several on-going and new information technology initiatives that will support the needs of a reengineered environment. A major component of the VETSNET initiative is scheduled for completion in 1998. VETSNET will provide a user friendly interface and a standard payment and accounting system for the C&P benefits programs. Also included are funds for the Claims Processing System (CPS). CPS is an integrated, rules based data collection and case management instrument designed to assist field staff in the development of disability claims and tracking the current status of pending claims. This system will ensure greater accuracy and consistency during the development process.

This budget also includes funds to continue the development and installation of the Education Electronic Data Interchange (EDI)/Electronic Funds Transfer (EFT) project. We will use the EDI, an expert system, to automatically process education enrollment certifications where possible and the EFT to deliver the benefit to the claimant's financial institution. When fully implemented, it is expected that the EDI will automatically process up to 40 percent of all education claims, resulting in a 45 percent improvement in processing time.

#### **General Administration**

A total of \$185.6 million is requested for the Office of the Secretary, five Assistant Secretaries and three VA-level staff offices. This request, combined with \$4.7 million associated with credit reform funding, will result in a total resource level of \$190.3 million.

The FY 1998 budget includes a request to add the fiscal operations of the Austin Finance Center to VA's Franchise Fund. The revolving fund will continue to be used to supply common administrative services on a reimbursable basis. All service activities under this revolving fund for 1998 will have annual billings of nearly \$82 million and 659 employees, who were transferred from their parent organizations.

The FY 1998 budget reflects the phased expansion of the Shared Service Center (SSC) to encompass additional VA employees and sites. The SSC will centralize payroll processing and personnel information. For FY 1998, the SSC is requesting \$23 million in reimbursement authority from other VA organizations. Average employment requested for the SSC is 252 FTE.

#### **Board of Veterans' Appeals**

The Board of Veterans' Appeals will continue working to improve appellate decision-making timeliness in 1998. Response time for the Board will decrease from 549 days in 1997 to 538 days in 1998. The 1998 request is \$37.6 million for the Board in the General Administration total.

#### **NATIONAL CEMETERY SYSTEM**

The National Cemetery System proposes a budget of \$84 million which will support 1,375 FTE. This represents an increase of \$7.3 million and 52 FTE over the 1997 level. The funding increase over last year's level is for the first full year of operations at the new Tahoma National Cemetery in the Seattle, Washington area; for the partial activation of three new national cemeteries near Chicago, IL; Dallas, TX; and Albany, NY; for the increasing workload and infrastructure needs at existing cemeteries; for equipment replacement; and for inflation.

#### **OFFICE OF INSPECTOR GENERAL**

The FY 1998 request of \$31 million for the Inspector General will allow for continued audits of financial statements and a continuing focus on high pay-off areas that are most vulnerable to fraud, waste, and inefficiency.

#### **CONSTRUCTION, MAJOR PROJECTS**

A total of \$79.5 million is requested for the Major Construction program. The Major Construction request would fund the final phase of a project to correct seismic deficiencies at the Memphis, TN VA Medical Center and expand VA's

National Cemetery System. A new cemetery will be constructed near Cleveland, OH, and funds are requested to expand national cemeteries in Arizona and at Fort Sam Houston, TX. Additional funds are requested to remove asbestos from VA-owned buildings and to support advanced planning and design activities.

#### **CONSTRUCTION, MINOR PROJECTS**

A total of \$166.3 million is requested for the FY 1998 Minor Construction program. The request includes \$140.5 million for Veterans Health Administration projects. Of this amount, \$42.4 million is targeted for the outpatient care and support category. This will enable VA to continue its commitment to provide primary and preventive care. Additionally, \$53.2 million will be earmarked for the inpatient care and support category. This category includes projects that improve the patient environment, such as providing private and semi-private bedrooms. A total of \$16 million is also included for the National Cemetery System. Funds in the amount of \$6.3 million are requested for the Veterans Benefits Administration. Staff Office and Emergency projects are provided \$3.5 million.

Legislation is being proposed to increase the appropriation limit on minor construction projects from \$3 million to \$5 million.

#### **GRANTS FOR THE CONSTRUCTION OF STATE EXTENDED CARE FACILITIES**

The FY 1998 request of \$41 million for the Grants for the Construction of State Extended Care Facilities will provide funding to assist the States to establish new, or renovate existing, nursing homes and domiciliaries.

#### **GRANTS FOR THE CONSTRUCTION OF STATE VETERANS CEMETERIES**

The FY 1998 request of \$10 million for the Grants for the Construction of State Veterans Cemeteries will provide funding to assist the States to establish, expand or improve State Veterans Cemeteries.

We propose legislation to increase the maximum Federal share of the costs of construction from 50 to 100 percent. This legislation would also permit Federal funding for up to 100 percent of the cost of initial equipment for cemetery operations. The State would remain responsible for paying all costs related to the operation of the state cemeteries, including the costs for subsequent equipment purchases.

#### **Closing**

Mr. Chairman, the challenges before us are great but they do not exceed our dedication and commitment to ensuring the best possible care and service to our Nation's veterans. We owe our veterans the best we can provide. I look forward to working with you and the members of this Committee to meet these challenges. This completes my prepared statement. I will be pleased to answer any questions the Committee might have.

FOR RELEASE ON DELIVERY  
Expected at 10:00 A.M. EST  
February 13, 1997

STATEMENT OF  
HONORABLE FRANK Q. NEBEKER  
CHIEF JUDGE, U.S. COURT OF VETERANS APPEALS  
FOR PRESENTATION BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
U.S. HOUSE OF REPRESENTATIVES  
FEBRUARY 13, 1997

MISTER CHAIRMAN AND DISTINGUISHED MEMBERS OF THE COMMITTEE:

On behalf of the Court, I appreciate the opportunity to present for your consideration the fiscal year (FY) 1998 budget of \$9,379,804 for the United States Court of Veterans Appeals.

The Court's total FY 1998 budget request contains the same dollar amount for personnel and operations as in the Court's FY 1997 appropriation. It also includes \$850,804 requested by the Pro Bono Representation Program (Program), which is 121.5% of the \$700,000 appropriated for FY 1997. The Program has provided its own supporting statement for its budget request.

Last year I urged that the Pro Bono Representation Program be authorized and funded outside the Court's appropriation. I outlined the reasons for the Court's concerns with the continued inclusion of the Program's funding in the Court's appropriation. The Court continues to be of the view that such a funding method impermissibly links the Court to one class of litigants, and thereby exposes the Court to an appearance of partiality and a consequent erosion in the public's trust and confidence in the judicial review of veterans' claims. I ask again that the funding for the Program be separated from the Court's appropriation, not only in the budget deliberations in Congress, but in the actual budget enactment.

Notwithstanding these reservations, and consistent with Congress' direction, the Court is forwarding the Program's FY 1998 request for \$850,804 as an appendix to the Court's submission and, consistent with that direction, is including that amount in the Court's total FY 1998 budget request. The Legal Services Corporation administers the grants for the Program and, according to its evaluations, the Program is working the way it should. The Program has provided its own supporting statement for its budget request, which, as noted, represents a 21.5% increase over the \$700,000 appropriated for FY 1997.

The Court has kept a flat budget by continuing a number of cost-saving measures, including a 25% reduction in the budget allotted for travel, with no funding requested for Court hearings outside Washington. Also, as I stated in my testimony last year, the Court now is holding its judicial conference every other year, rather than annually. This event focuses on continuing education for the Court's practitioners and is held locally. Of even more significance, the Court is requesting funding for only 79 full-time equivalent (FTE) positions in FY 1998 which is a voluntary reduction of 2 FTE positions from the FY 1997 authorized FTE level, and matches the FY 1998 FTE target level recommended by the Office of Management and Budget in its implementation of the National Performance Review. The requested 79 FTE positions are required to maintain high-quality service to litigants seeking judicial review, particularly those who come to the Court unrepresented.

As the Court's budget statement illustrates, in a chart the Clerk has compiled, after a drop in number of appeals in FY 1994, the numbers have continued to climb in FY 1995 and FY 1996, and the upward trend seems to be continuing. The number of denials by the Board of Veterans' Appeals, from whose decisions the Court's appeals derive, increased from 6400 appeals in FY 1995 to 10,455 appeals in FY 1996. Furthermore, as noted in the Court's budget submission, the statistics kept by the Board of Veterans' Appeals (Board) on "denials" do not include Board decisions that deny some, but not all, of the benefits sought. The denials in such cases are also appealable to the Court. Thus, the number of pending cases may continue to increase at an even greater rate than is predictable as a set

percentage of the number of full Board "denials." The percentage of unrepresented appeals has fallen from 80% in FY 1995 to 72% in FY 1996. However, this rate remains much higher than the 46% unrepresented civil appeal rate in U.S. courts of appeals. While the Court has, voluntarily, kept pace with the recommendations of the National Performance Review, which propose an 11.5% FTE reduction over six years, further reductions in staff may need to be re-evaluated based on the likelihood of an increased caseload and a percentage of pro se appellants that continues to be relatively high.

It is my understanding that the Independent Budget Veterans Service Organizations (IBVSOs) have reached similar conclusions as to increasing caseload in the chapter on the U.S. Court of Veterans Appeals in their *Independent Budget for Fiscal Year 1998*. The IBVSOs document a presently rising caseload and oppose downsizing of the Court for that reason.

On another matter, I am appending to this testimony a copy of my letter to Chairman Stump emphasizing the importance of passing Title II of the legislative proposal submitted last year to make the Court's retirement/survivor program comparable to the systems of other Article I Courts. As I point out in my letter, the legislative proposal was initially submitted in response to Congressional inquiries regarding the Court's caseload relative to the requisite number of judges on the Court and regarding the comparability of the Court's judicial retirement/survivor program. Following last year's transmittal, there was an increase in the number of notices of appeal filed with the Court, and a consequent increase in the number of pending cases. Some veterans service organizations have either opposed enactment of Title I or, more cautiously, favored a "wait and see" approach to it. I am aware of no negative comments with regard to the largely administrative provisions of Title II.

I ask for your active support in obtaining enactment of Title II to make the Court's retirement/survivor program more comparable with other Article I Court programs. Because of Judge Hart Mankin's death in May 1996, his widow, Ruth Mankin, is now a

survivor under the Court's survivor annuity program. Survivors under the Court's annuity program are at a considerable disadvantage, over time, in comparison to the survivors of other deceased Article I judges covered by the Survivors' Annuity Systems enacted to provide such benefits to them. I ask that you take expeditious action to enact Title II, which is estimated to be without actuarially significant cost impact and without any appropriations impact.

In conclusion, I appreciate this opportunity to present the Court's budget request for fiscal year 1998. On behalf of the judges and staff, I thank you for your past support and request your continued assistance and favorable report to the Appropriations Committee on our budget request. I, or those with me, will be pleased to answer any questions you may have.



**United States  
Court of Veterans Appeals**

Chambers of  
Chief Judge Frank Q. Nebeker

February 4, 1997

625 Indiana Avenue, N.W., Suite 900  
Washington, D.C. 20004  
202-501-5862

Honorable Bob Stump  
Chairman  
Committee on Veterans' Affairs  
335 Cannon House Office Building  
U.S. House of Representatives  
Washington, DC 20515

Dear Mr. Chairman:

On June 10, 1996, I transmitted to the Chairmen and Ranking Minority Members of the Senate and House Committees on Veterans' Affairs a proposal to downsize the number of the Court's associate judges (Title I of the proposal) and to make the Court's retirement/survivor program comparable to the systems of other Article I Courts (Title II of the proposal). The proposal, a duplicate of which I again transmit with this letter, was submitted in response to Congressional inquiries regarding the Court's caseload relative to the requisite number of judges on the Court and regarding the comparability of the Court's judicial retirement/survivor program. The 104th Congress took no action on either Title I or Title II.

With respect to Title I, I indicated in my transmittal letter that case filings during the FY 1990-92 period had averaged 1942 per year but had dropped in the FY 1993-95 period to an annual average of 1224. At the time of my transmittal, case filings for the first 6 months of FY 96 were estimated to be 595 which suggested that FY 96 filings would be less than average annual filings for FY 93-95. During the last 6 months of FY 96, filings rose so that total FY 96 filings reached 1620. For the first quarter of FY 1997 the Court received 457 filings. I further indicated in my transmittal letter that cases pending at the end of each year of the FY 1990-92 period had averaged 1865 but had dropped to an average of 1182 at the end of each year of the FY 1993-95 period. At the time of my transmittal, it is estimated that 1438 cases were pending. At the end of the first quarter of FY 1997, 1707 cases were pending. It should be further noted that the Board of Veterans Appeals, from which the Court's appeals derive, denied 6400 appeals in FY 1995 and 10,455 appeals in FY 1996.

Several veterans service organizations either opposed enactment of Title I or, more cautiously, favored "a wait and see" approach to it. Enactment of Title I would result in estimated net annual savings of \$650,900.

With respect to Title II, my June 10, 1996, transmittal letter stated:

In the matter of the retirement/survivor program, I have received several letters from past chairmen of the Senate Veteran's Affairs Committee regarding the comparability of the Court's program with those established for other federal courts and have twice responded to the invitation to provide comments on a Congressional Research Service Report (Dennis W. Snook & Jennifer A. Neisner, CONGRESSIONAL RESEARCH SERVICE REPORT FOR CONGRESS, INCOME PROTECTION FOR JUDGES OF SELECTED FEDERAL COURTS, dated December 29, 1993) (CRS REPORT), that was prepared on that subject. The Court was asked to continue to review the matter and to advise the Committee of its findings. Enclosed also is a copy of the CRS REPORT, annotated so that it may be used in conjunction with a memorandum dated November 14, 1994 (Memorandum), also enclosed, prepared by the Court's Committee on Legislative Matters, which addresses certain minor deficiencies in the CRS REPORT. The Court's review has revealed that each judicial retirement/survivor program has unique features and also that the retirement programs of other Article I federal courts have generally been enhanced over the last 7 years, whereas this Court's program has generally remained static since its creation in 1989. The Court believes that certain aspects of this resulting disparity should be addressed in corrective legislation to make the Court's program more comparable with other Article I federal court retirement programs. Accordingly, the Proposal also provides for systemic reforms in the Court's retirement/survivor system that are designed to put the Court on a more equal footing with the systems provided for other Article I courts.

I ask for your active support as Chairman in obtaining enactment of Title II to make the Court's retirement/survivor program more comparable with other Article I court programs. Because of the death of Judge Hart Mankin, on May 28, 1996, his widow, Ruth Mankin, is now a survivor under the Court's survivor annuity program. Over time, she will be at considerable disadvantage in comparison to widows of deceased Article I judges covered by the Joint Survivors' Annuity System. In this regard, I am hopeful that you will respond with expeditious action to enact Section 204 of Title II which is estimated to be without actuarially significant cost impact and without any appropriations impact. Enactment of all sections of Title II other than Section 204 is estimated to be without cost or appropriations impact.

I would also ask that you consider enacting legislation that would change the Court's name to the United States Court of Appeals for Veterans Claims. Many veterans and attorneys believe that the Court is an administrative tribunal of the Department of Veterans Affairs rather than an independent judicial entity. The present name of the Court appears to add to that belief especially in view of the fact that the name, "United States Court of Veterans Appeals", is often reduced to the acronym "CVA", which is not readily distinguishable from "BVA," the acronym for the Board of Veterans Appeals which is an administrative tribunal of the Department, or "DVA," the common acronym for the Department. It is important that the Court be perceived as both judicial and independent. Adoption of the name "United States Court of Appeals for Veterans Claims" should promote that perception. Such a change would also be consistent with action in recent years with respect to the names of other Article I Courts. The United States Court of Claims became the United States Court of Federal Claims in 1992. The United States Court of Military Appeals became the United States Court of Appeals for the Armed Forces in 1994.

Finally, I bring to your attention one additional matter. The Court was created in 1988 without any antecedent structure and with no judges in place (Veterans' Judicial Review Act, Pub. L. No. 100-687, Div. A., 102 Stat. 4105 (Nov. 18, 1988)). All 6 of the Court's original associate judges assumed office within a period of approximately 1 year of each other. Assuming that Title I of the proposal is not enacted, the 15-year terms of the Court's remaining 5 original associate judges will expire within a period of approximately 1 year-of each other. As a consequence, and again assuming no downsizing, I recommend that consideration be given to attempting to eliminate the undesirable dislocating effect of such a rapid turnover by permitting early retirement of remaining original associate judges who meet certain age and service requirements which, in turn, could space the sequencing of retirements so as to assure continuity of experience in the Court's judicial component. Implementation may be achievable, pursuant to 38 U.S.C. § 7298(2) (A), within existing appropriations. It should be noted that several Article I Courts have early retirement programs applicable to all their judges.

Thank you for your consideration. I am sending the same letter and enclosures to Chairman Specter, and Ranking Minority Members Rockefeller and Evans.

Sincerely,



Frank Q. Nebeker  
Chief Judge

Enclosures



**UNITED STATES COURT OF VETERANS APPEALS**

**FISCAL YEAR 1998**

**BUDGET ESTIMATE**

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## UNITED STATES COURT OF VETERANS APPEALS

## INTRODUCTION

The United States Court of Veterans Appeals is a court of record established under Article I of the Constitution by The Veterans' Judicial Review Act, Pub. L. No.100-687, (1988). The Act, as amended, is codified in part at 38 U.S.C. §§ 7251-7298. The Court is one of four created pursuant to Article I in the federal judicial system. It is composed of a chief judge and six associate judges. 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 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 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 can 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 the law, contrary to constitutional right, in excess of statutory jurisdiction or authority, or without observance of the procedures required by law. The Court can hold unlawful or set aside findings of material facts if the findings are clearly erroneous.

The Court is located in Washington, D.C.; however, it is a national court empowered to sit anywhere in the United States.

UNITED STATES COURT OF VETERANS APPEALS

APPROPRIATION LANGUAGE  
GENERAL AND SPECIAL FUND

SALARIES AND EXPENSES

For necessary expenses for the operation of the United States Court of Veterans Appeals as authorized by 38 U.S.C. §§ 7251-[7292]7298, [\$9,229,000] \$9,379,804, of which [\$700,000] \$850,804 [, to remain available until September 30, 1998,] 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, 1997.)

## UNITED STATES COURT OF VETERANS APPEALS

## 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. However, in FY 1996 there were 1620 new case filings, an increase of 27%, and an upward trend appears to be continuing.

Appeals to the Court come from the pool of cases in which the BVA has denied some benefits sought by claimants. The BVA does not report the number of its cases in which it denied some, but not all, benefits. 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. However, in FY 1996, the number of BVA total denials increased by 63%. This chart shows the relationship between BVA total denials and appeals to the Court:

	FY 90	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
BVA TOTAL DENIALS	28884	25082	10946	9734	6194	6407	10444
APPEALS TO USCVA	1261	2223	1742	1265	1142	1279	1620
APPEALS AS % OF DENIALS	4.4%	8.9%	15.9%	13.0%	18.4%	20.0%	15.5%

Unrepresented Appeals:

Unrepresented appeals continue to pose a challenge for the Court. The percentage of appeals filed by unrepresented appellants rose from 61% in FY 1990 to 80% in FY 1995, then fell to 72% in FY 1996. This rate remains much higher than the 46% unrepresented civil appeal rate in U.S. courts of appeals. That is not surprising, because nearly half of the claimants who were denied all benefits by the BVA were unrepresented there or were represented by organizations which have chosen not to represent anyone before the Court. Moreover, by law, attorney fees may not be charged for representation provided before the Board of Veterans' Appeals first makes a final decision in a case.

To address the problem, the Court requested authority to keep \$950,000 from its FY 1992 appropriation available through FY 1993 to implement a pilot Pro Bono Representation Program (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 (Pub. L. No. 103-124), \$790,000 in FY 1995 (Pub. L. No. 103-327), and \$405,000 (plus \$228,000 carried over unspent from prior years) in FY 1996 (Pub. L. No. 104-134). In prior years, 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). During FY 1997 budget hearings, the Court argued unsuccessfully against inclusion of the Program's funding in the Court's appropriation. The Court's judges continue to believe that this funding method links the Court to one class of litigants and exposes it to charges of lacking impartiality, thereby degrading the public's trust and confidence in judicial review of veterans' claims. However, consistent with Congress' direction, the Court provides the Program's FY 1998 request for \$850,804 as an appendix to this submission, without comment as to its substance.

**Staffing Requirements:**

The Court requests funding for 79 full-time equivalent (FTE) positions. This is a reduction of 2 FTE positions from the FY 1997 authorized level and matches the FY 1998 target recommended by the Office of Management and Budget (OMB) in its implementation of the National Performance Review.

The requested FTE positions are required to maintain high-quality services to litigants--especially those who are unrepresented--seeking judicial review. The Court continues to reevaluate its personnel requirements and processes.

**Practice Registration Fund:**

This fund is established under 38 U.S.C. § 7285. It is generated from registration fees paid by new practitioners and receives no appropriations. It is used to employ independent counsel for disciplinary matters involving practitioners and to defray costs of implementing standards of practice.

**FISCAL YEAR 1996 ACTIVITY**

The Court's FY 1996 program accomplished the following:

Maintained arrangements with the United States Marshals Service (USMS) for court security, but reduced the number of security personnel by one staff year to effect dollar savings.

Maintained arrangements with the Department of Agriculture's National Finance Center (NFC) for payroll/personnel, administrative payments, funds control, and financial support to accounting and reporting functions.

Continued the pilot Pro Bono Representation Program under a revised Memorandum of Understanding with the LSC.

**FISCAL YEAR 1997 PROGRAM**

The Court's FY 1997 program includes the following:

Continuation of contractual arrangements with the USMS for security services and the NFC for the processing of pay, personnel records, and financial documents.

Continuation of the pilot Pro Bono Representation Program under revised procedures for the transfer of all funding, both grant and administrative, to the Legal Services Corporation. This separates the Court, to the greatest extent possible under current legislation, from direct involvement in the Program.

**FISCAL YEAR 1998 BUDGET REQUEST**

The Court's FY 1998 budget request reflects the following:

A funding level for Court operations equal to that of FY 1997 funding.

A 2-FTE reduction from the FY 1997 approved personnel level, for a cumulative 8-FTE (or 9%) reduction from the FY 1993 level.

A decreased contribution to the Judges Retirement Fund (Fund) because the death of one associate judge within the last year has changed the Fund composition and the actuarial factors on which the Court's contribution is based.

A 21.5% increase in funding for the pro bono representation program, as explained by the program grantee in the attached request.

**SUMMARY OF FISCAL YEAR 1998 BUDGET REQUEST**  
 (\$ in Thousands)

A summary of the FY 1998 funding requirements for conducting the Court's activities follows:

	1997 Budget	1998 Estimate	Change
FTE Positions.....	81	79	-2
<hr/>			
Personnel Compensation and Benefits.....	\$5,820	\$5,965	+\$145
Other than Personal Services .....	\$3,409	\$3,264	-\$145
Grants.....	\$ 700	\$ 851	+\$151
<hr/>			
Budget Authority/ Appropriation.....	\$9,229	\$9,380	+\$151

**FISCAL YEAR 1998 PROGRAM FUNDING CHANGES**

The FY 1998 budget request of \$9,379,804 reflects no increase over the funding for Court operations appropriated for FY 1997, but does include \$850,804--a 21.5% increase over the FY 1997 appropriation--for the Pro Bono Representation Program.

**Personnel Compensation and Benefits:**

Pay raises and locality pay using as a base an FY 1997 pay figure reflecting a general schedule pay raise of 2.3 percent for nonjudicial personnel and the total locality-pay adjustment due Washington area government employees.

+\$145,000

**Other Objects:**

Increases in contract security personnel pay and in the cost of administrative and financial services are more than offset by savings in other administrative areas.

-\$145,000

**Grants:**

The increase is explained in the grantee's request which is in the appendix.

+\$150,804

**Total Changes:** +\$150,804

DETAILS OF FISCAL YEAR 1998 FUNDING CHANGES

The following provides details for the funding changes from FY 1997 funding levels:

PERSONNEL COMPENSATION AND BENEFITS .....+\$145,000

Staffing level decreases two FTE to 79 for FY 1998. In conformance with OMB economic assumptions, the request includes funding for a pay adjustment only for nonjudicial staff, with no differentiation between general pay raise and locality pay, and includes necessary funding for benefits.

OTHER OBJECTS.....-\$145,000

**TRAVEL: (-10,000)**

Funding is reduced by 25 percent. No funding is provided for Court hearings outside of Washington, D.C.

**TRANSPORTATION OF THINGS: (-2,000)**

Funding is reduced to reflect historical costs.

**RENTAL PAYMENTS TO GSA: (- 0 -)**

Funding for rent reflects GSA guidance.

**COMMUNICATIONS, UTILITIES AND MISCELLANEOUS CHARGES: (- 0 -)**

**PRINTING AND REPRODUCTION: (- 0 -)**

**OTHER SERVICES: (-123,000)**

Small increases in contract security personnel pay and in NFC accounting and administrative costs are more than offset by other efficiencies. Careful review of service and maintenance contracts also reduced costs in those areas.

**SUPPLIES AND MATERIALS: (-10,000)**

**EQUIPMENT: (- 0 -)**

GRANTS.....+\$150,804

The increase is explained in the grantee's request which is in the appendix.

## UNITED STATES COURT OF VETERANS APPEALS

## Program and Financing (in thousands of dollars)

	1996 actual	1997 budget	1998 estimate
<b>OBLIGATIONS BY PROGRAM ACTIVITY</b>			
10.00 Total obligations .....	8,716	9,229	9,380
<b>BUDGETARY RESOURCES AVAILABLE FOR OBLIGATION</b>			
21.40 Unobligated balance available, start of year .....	147	---	---
22.00 New budget authority (gross)	8,993	9,229	9,380
22.30 Unobligated balance expiring	-424	---	---
23.90 Total budgetary resources available for obligation			
23.95 New obligations	-8,716	-9,229	-9,380
24.40 Unobligated balance available, end of year .....	---	---	---
<b>NEW BUDGET AUTHORITY (GROSS) DETAIL</b>			
40.00 Appropriation.....	9,000	9,229	9,380
40.35 Appropriation rescinded....	-7	---	---
43.00 Appropriation (total)	8,993	9,229	9,380
<b>CHANGE IN UNPAID OBLIGATIONS:</b>			
72.40 Obligated balance, start of year.....	804	888	908
73.10 New obligations.....	8,716	9,229	9,380
73.20 Total outlays (gross).....	-8,632	-9,212	-9,386
74.40 Obligated balance, end of year .....	888	905	911
<b>OUTLAYS (GROSS), DETAIL</b>			
86.90 Outlays from new current authority.....	7,906	8,768	8,911
86.93 Outlays from current balances.....	726	444	475
87.00 Total outlays.....	8,632	9,212	9,386
<b>NET BUDGET AUTHORITY AND OUTLAYS</b>			
89.00 Budget authority.....	9,000	9,229	9,380
90.00 Outlays.....	8,632	9,212	9,386

**UNITED STATES COURT OF VETERANS APPEALS  
SALARIES AND EXPENSES**

Object Classification (in thousands of dollars)

	1996 actual	1997 budget	1998 estimate
<b><u>Direct Obligations:</u></b>			
<b>Personnel Compensation:</b>			
11.3	4,183	4,475	4,620
11.5	31	25	25
11.9	4,214	4,500	4,645
12.1	1,304	1,320	1,320
13.0	...	...	...
21.0	15	40	30
22.0	0	3	1
23.1	1,667	1,667	1,667
23.3	52	85	85
24.0	22	23	23
25.2	193	366	347
25.3	89	157	53
25.4	0	8	8
25.7	72	92	92
26.0	136	160	150
31.0	400	108	108
41.0	552	700	851
99.9	8,716	9,229	9,380

UNITED STATES COURT OF VETERANS APPEALS  
 COURT OF VETERANS APPEALS RETIREMENT FUND

This fund, established under 38 U.S.C. § 7298, will be used to pay retired pay to judges and to pay 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 3.5 percent 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 1996 the Court began paying one survivor annuitant from fund assets.

UNITED STATES COURT OF VETERANS APPEALS  
 COURT OF VETERANS APPEALS RETIREMENT FUND

	1996 actual	1997 budget	1998 est.
<u>Unavailable Collections Schedule:</u>			
Balance, start of year:			
01.99 Balance, start of year.....	2,184	2,749	3,191
Receipts:			
02.01 Earnings on investment.....	139	145	150
02.02 Employer contributions.....	436	325	325
02.03 Employee contributions.....	10	5	5
02.99 Subtotal, receipts.....	585	475	480
03.00 Offsetting collections.....	-20	-33	-33
04.00 Total: Balances and collections	2,749	3,191	3,638
Appropriations:			
05.01 Judges survivors annuity fund...	-20	-33	-33
07.99 Balance, end of year.....	2,749	3,191	3,638

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December 19, 1996

The Honorable Frank Q. Nebeker  
 Chief Judge  
 U.S. Court of Veterans Appeals  
 Suite 900  
 625 Indiana Avenue  
 Washington, D.C. 20004

Dear Chief Judge Nebeker:

On behalf of the Veterans Consortium Pro Bono Program, I submit to you herewith the Program's proposed budget for fiscal year 1998, as approved by the Advisory Committee, together with a document titled Budget Highlights, which explains the difference between the FY98 budget and the current, FY97 one. I respectfully request that the Court submit the pertinent budget figures along with the Court's own proposed budget for FY98, at the appropriate time, to the pertinent congressional committees. We are not, of course, asking the Court to assume any responsibility for justifying the Program's budget: as was the case with respect to the current fiscal year, we expect to assume entire responsibility for that effort. We will also again be seeking specific legislative authorization for the Program.

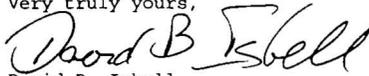
With regard to the substance of the proposed budget, you will note that the total projected costs of \$850,804 exceed the FY97 budget figure of \$743,838 by \$106,966: the explanation of this is provided in the Budget Highlights. The projected total expenditures exceed by \$150,804 the FY97 appropriation of \$700,000. As you know, we were able to adhere to the budget on which our appropriation request was based despite the fact that the amount actually appropriated was less than the amount contemplated by the budget because the reduced level of operations in FY96, resulting from the

COVINGTON & BURLING

Hon. Frank Q. Nebeker  
December 19, 1996  
Page 2

uncertainty as to whether the Program would continue at all,  
left us with a surplus that allowed us to fund the incremental  
expenditures in question.

Very truly yours,



David B. Isbell  
Chair, Advisory Committee  
Veterans Consortium

Enclosure

cc w/enc: Advisory Committee

Veterans Consortium Pro Bono Program  
Proposed Budget -- FY 1998

	Outreach FY 98	Education FY 98	Screening FY 98	Proposed Budget 10/1/97-09/30/98	Outreach FY 97	Education FY 97	Screening FY 97	Budget 10/1/96-09/30/97	Actual 10/1/95-09/30/96
1	7,754	46,165	135,006	188,925	7,379	48,004	127,845	183,228	125,665
2	0	0	197,816	197,816			123,236	123,236	66,754
3	7,545	24,214	86,017	117,776	3,518	20,261	81,808	105,587	96,599
4	3,250	18,694	127,072	149,016	2,303	11,874	95,954	110,131	71,076
	18,549	89,073	545,911	653,533	13,200	80,139	428,843	522,182	360,094
Total Personnel									
6	2,003	9,654	56,689	68,346	1,915	9,000	61,448	72,363	62,127
9	300	1,500	5,463	6,953	200	1,500	5,253	6,953	8,859
10	1,500	4,500	7,180	13,180	1,275	4,100	10,000	15,375	15,445
11	280	818	7,177	8,275	280	870	7,850	9,000	7,412
12	150	500	2,500	3,150	150	1,500	1,000	2,650	852
15	200	1,500	2,850	4,550	150	1,000	1,850	3,000	3,227
16	250	1,000	4,000	5,250	200	700	4,000	4,900	3,605
17	75	300	100	475	50	195	50	295	305
18	250	1,200	1,500	2,950	200	623	827	1,650	2,275
19	0	500	0	500	0	0	10,000	10,000	27,555
21	0	0	2,000	2,000	0	0	5,000	5,000	707
22	1,100	16,000	0	17,100	1,000	15,920	0	16,920	2,764
Total Non-Personnel									
	6,108	37,472	89,459	133,039	5,420	35,408	107,278	148,106	135,133
Total "A" Grant									
	24,657	126,545	635,370	786,572	18,620	115,547	536,121	670,288	495,227
"B" Grant									
			44,232	44,232				53,550	35,500
Oversight									
			20,000	20,000				20,000	???
Grand Total									
			850,804	850,804				743,838	528,727

34 CASES @ \$1,843/CASE

**THE VETERANS CONSORTIUM PRO BONO PROGRAM  
FY 1998 Proposed Budget Highlights**

**CASE EVALUATION AND PLACEMENT (CEPC)**

**\$635,370**

CEPC proposes a \$99,249 increase over the FY97 budget.

Budget Increase Summary:

**Personnel** costs reflect an increase of \$117,068 (which is partially offset by reductions in non-personnel costs of \$17,819). This would provide for five full time case evaluators, with one position contributed by DAV at no cost to the Program. [The FY97 budget provides for two and a half paid case evaluators. This assumed that two positions would be filled by supporting veterans service organizations (VSOs) without reimbursement. In fact, only one such no-cost case evaluator has been provided (by DAV); the American Legion has been unable to continue its prior multi-year commitment to providing a no-cost case evaluator to the Program.] The increase from the two and a half case evaluators whose cost is reflected in the FY97 budget, to four case evaluators contemplated by the FY98 budget, is necessitated by the following:

a. A large backlog of cases awaiting evaluation (approximately 140 cases), and in consequence roughly a five-month delay from the time a case is received until completion of the evaluation process. This backlog resulted from the fact that although we expected to operate with four case evaluators (including one donated by a VSO) in FY96, we in fact lost case evaluators due to uncertainty over federal funding for the Program, resulting in operations with only two case evaluators for a substantial part of the year. Given the shortfall in staffing for FY97, described in the preceding paragraph, we are not likely to make much if any headway in reducing the backlog in the current year.

b. Increased number of case filings at the Court in FY-96 and early FY-97.

c. Actual increase, and projected further increase, in number of BVA decisions (resulting from improved BVA productivity, and hiring of additional attorney advisors at the BVA in FY-97), which will be reflected in increased case filings at the Court.

Salaries and benefits are budgeted to increase by 5%; this consists of a 3% cost-of-living raise and a 2% allocation for merit raises. These allocations are essential to adequate funding for the Program, since Program staff are actually employees of the supporting VSOs, and those VSOs control cost-of-living and merit increases.

Travel - We have requested an increased allocation of \$1,500, to provide for continuing legal education for CEPC attorney staff.

Property Acquisition and Contract Services - These would decrease by \$13,000. Major improvements to the databases will be completed in FY97.

**OUTREACH**

**\$24,657**

Outreach proposes a \$6,037 increase over the FY97 budget. As indicated below, all but \$688 of the increase is in Personnel. The \$688 difference reflects line item adjustments based on our past experience.

Budget Increase Summary:

Personnel costs are budgeted to increase by \$5,349 because we anticipate a continued increase in recruiting costs. We assume a greater need for counsel in FY98 because of the known and anticipated number of BVA decisions; the budget also assumes that we will continue outreach efforts outside the Metropolitan Washington area. Personnel costs include an increase of 5%, as discussed previously under Case Evaluation and Placement.

Office supplies and expenses include \$1,100 to cover the cost of mailing 2000 program brochures to attorneys.

Other includes \$1,100 to reprint the standard Program brochure.

**EDUCATION****\$126,545**

Education proposes an increase of \$10,998 over the FY97 budget. All but \$2,064 of the increase is accounted for in the personnel line. Various line items have been adjusted based on our past experiences.

Budget Increase Summary:

Personnel costs are budgeted to increase by \$8,934. We anticipate an increase in mentoring duties, from \$15,650 in FY97 to \$17,659 in FY98, due to the cumulative effect from previously assigned but still pending cases. We plan to minimize this cost by assigning mentoring duties to personnel with lower personnel costs. Grant administration has been increased to 25% for both the Grant Administrator and the Administrative Assistant, based on our past experiences. We will revise and reprint the appellant brochure and videotape (and edit) a new training tape. Personnel cost include an increase of 5%, as discussed previously under Case Evaluation and Placement.

The Other line increases by only \$80. We anticipate distributing 112 copies of the revised *Veterans Benefits Manual*. The estimate cost at this time is \$100 per copy (\$11,200). As indicated in the Education personnel line, we will revise and reprint the appellant brochure (\$1,500). \$4,000 is budgeted to cover the cost of taping one training session and purchasing videotapes for reproduction.

**"B" GRANT**

This line assumes a total of 24 cases at a cost of \$1,843 per case. This represents a 10% per case increase over the FY96 budget of \$1,675 per case; it also reflects a reduction from the total number of budgeted cases (30) in FY96 and FY97, as we continue to fine-tune this requirement.

**GRANT ADMINISTRATION****\$ 20,000****TOTAL****\$850,804**

STATEMENT OF PRESTON M. TAYLOR JR.  
ASSISTANT SECRETARY FOR  
VETERANS' EMPLOYMENT AND TRAINING  
SUBMITTED TO THE  
COMMITTEE ON VETERANS AFFAIRS  
U.S. HOUSE OF REPRESENTATIVES

February 13, 1997

Mr. Chairman and Members of the Committee:

I appreciate the opportunity to submit for the record the Fiscal Year 1998 Department of Labor budget request for veterans' employment and training programs.

For the benefit of the new members of this committee, I would like to preface my remarks by sharing with you the Veterans' Employment and Training Service's mission, my vision for the agency, a brief description of how our programs operate, and some of our accomplishments during fiscal year 1996.

The mission of the Agency is to help veterans, reservists and National Guard members in securing employment and the rights and benefits associated with such, through existing programs, the coordination and merger of programs, and the implementation of new programs. Services provided are to be consistent with the changing needs of employers and the eligible veterans' population.

VETS delivers employment services to veterans in partnership with State Employment Security Agencies, also called Job Service or the public employment service system. VETS administers grants to these agencies to support Disabled Veterans' Outreach Program (DVOP) staff and Local Veterans' Employment Representatives (LVER) in each State, who personally help veterans and other eligible persons. Their specific purpose and responsibilities are described in Chapter 41 of Title 38, United States Code. VETS establishes performance standards to reinforce priority of service for special disabled and disabled veterans, veterans, and other eligible persons and evaluates the States' policies and processes to ensure that veterans receive services leading to economic security and well being.

Generally, LVERs supervise services to veterans by other local employment service office staff to ensure that they provide maximum employment and training opportunities to disabled veterans, veterans, and other eligible persons. They also provide job placement and supportive services directly to veterans. LVERs also network with employers, community and veteran service organizations, and other public agencies to assure that veterans receive the best available services.

Disabled Veterans' Outreach Program staff conduct outreach, particularly directed at special disabled and disabled veterans, and develop job opportunities with employers. DVOP staff spend about 20 percent of their aggregate time stationed at VA facilities and other places where veterans can be found who may be in need of employment and training assistance.

DVOP and LVER staff, in cooperation with the Department of Defense, the Department of Veterans Affairs. VETS Federal staff, contract facilitators and human resources' staff from private employers, deliver Transition Assistance Program workshops to separating service members and their spouses at over 185 military installations in the continental United States.

DVOP and LVER staff also work cooperatively with the Department of Veterans Affairs, Vocational Rehabilitation and Counseling program (VR&C) staff to provide individualized attention to VR&C participants and help those completing VA training programs find suitable employment. Through the National Veterans' Training Institute (NVTI), VETS offers a special training program to make sure that we are effective in helping Vocational Rehabilitation Program participants.

Page 2

As you will see in our budget request, LVER staff will give particular emphasis to monitoring Federal contractor job listings. As a result of amendments by the 104th Congress, new approaches have been initiated to enable referrals to higher paying jobs. These include enabling Federal contractors to list their vacancies electronically in America's Job Bank. VETS is working with SESAs to help them upgrade or purchase new equipment to enable LVER staff to see such job openings and promptly refer quality veteran applicants for these jobs.

VETS is also relying on the One-Stop Career Services concept and new electronic tools, including a resume-writer developed specifically by VETS for veterans, to enable DVOP and LVER staff to more efficiently help our customers -- veterans. VETS will encourage SESAs to use the resulting time savings to give more time and attention to special disabled, disabled, minority, female, young and recently separated veterans under a case management approach to service delivery. VETS is also asking for a shift in resources from the DVOP to the LVER program to maintain the best system coverage possible and support shifts in emphases to higher paying jobs, and giving better assistance to veteran subgroups with high unemployment rates.

My vision is that VETS be recognized as a "world class" organization ensuring employment, training and enforcement services to our veterans. I expect VETS through its staff to keep pace with the demands and rewards of putting our customers -- veterans and their prospective employers -- first. This will give each veteran a chance for real job security and job opportunity in a changing world.

#### **Accomplishments - Last year (Fiscal Year 1996 and Program Year 1995)**

During fiscal year 1996, VETS and its grantees' efforts resulted in accomplishments that had significant impacts on our target population:

- \* 2.2 million veterans registered with the SESAs in the program year ending on June 30, 1996. Of these veterans, SESAs helped over 535,666 into jobs, including 190,937 Vietnam era veterans and 41,949 disabled veterans. SESAs also referred more than 542,000 veterans to supportive services.
- \* Disabled Veterans' Outreach Program staff contributed to the public employment service system efforts and achievements noted in the paragraph above. The \$76,913,000 provided for this program supported 1,579 positions. DVOP staff helped 166,591 veterans into jobs. Of these, over 26,000 were disabled veterans and more than 7,000 were special disabled veterans.
- \* Local Veterans' Employment Representatives also contributed to the effort and achievements of the public employment service system. The \$71,386,000 provided for the LVER program supported 1,404 positions. LVERs helped 160,795 veterans into jobs. Of these veterans, more than 13,000 were disabled, and 6,670 were special disabled veterans.
- \* During FY 1996, over 73,000 Federal contractors listed more than 550,000 jobs with the public employment service system. As a result of referrals made to these vacancies, almost 64,000 veterans got jobs, including more than 20,000 Vietnam era and 2,638 special disabled veterans.
- \* In addition to their direct employment services to veterans, DVOP and LVER staff also conduct Transition Assistance Program (TAP) workshops. A total of 145,211 separating service members or their spouses attended Transition Assistance Program workshops. Over 3,200 workshops, the majority conducted by DVOP and LVER staff, were presented at 186 sites in 43 States.
- \* VETS staff provide assistance directly to veterans, Reservists and National Guard members to protect their employment and reemployment rights, including anti-discrimination, seniority and pension rights, as defined by the Uniformed Services

Employment and Reemployment Rights Act of 1994 (USERRA). In FY 1996, VETS staff opened 1,270 cases under USERRA, and carried over 297 from the previous fiscal year. From this total, 1,344 were closed -- 85% within 120 days from the filing of the claim.

- \* The total of \$2,672,000 provided for the National Veterans' Training Institute (NVTI) supported 71 classes, in which training was given to 1,574 veteran service providers. NVTI also provided TAP training to 550 Department of Defense participants under a reimbursement agreement with the Department of Labor, for a total of 2,124 training participants during the fiscal year.
- \* A total of \$8,800,000 provided in FY 1995 for Veteran Employment Programs under Title IV, Part C of the Job Training Partnership Act (JTPA IV-C). From this total, \$7 million were provided to 14 grantees to serve 4,100 service-connected disabled veterans, Vietnam era veterans or recently separated veterans. These grants operated from July 1, 1995 to June 30, 1996. The funds were used to provide training, supportive services and/or employment assistance. Of those served, more than 2,600 were placed in jobs. The remaining funds were set-aside for innovative, pilot, demonstration and research projects with the American GI Forum, the New York Veterans Leadership Program, the Alabama Department of Industrial Relations Federal Contractor Project, and others.

#### **Fiscal Year 1998 Budget Request**

The Agency's FY 1998 request is designed to promote the maximum employment and training opportunities for veterans, particularly those in veteran subgroups who suffer higher than average unemployment rates -- disabled veterans, minority, female, young and recently separated veterans within Government-wide resource constraints. To do this, the Veterans' Employment and Training Service (VETS) has been streamlining, shifting resources to where they will do the most good, and promoting the use of electronic tools to better serve our customers.

The Agency's request is divided into three activities: (1) State Grants, which is further divided between the Disabled Veterans' Outreach Program (DVOP) and the Local Veterans' Employment Representative (LVER) program; (2) Administration, which includes funding for the Transition Assistance Program (TAP) for separating service members, the investigation and resolution of Uniformed Services' Employment and Reemployment Rights Act (USERRA) claims from veterans, Reservists and National Guard members, and funding for VETS' grant administration operations; and (3) National Veterans' Training Institute (NVTI), which provides training to Federal and State employees and managers involved in delivery of services to veterans.

Funds are requested under the Employment and Training Services account of the Department of Labor for employment and training programs for veterans under the Job Training Partnership Act, Title IV, Section C at 29 U.S.C. 1721 (JTPA IVC) and the Stewart B. McKinney Act at 42 U.S.C. 11448 (as amended by the 104th Congress) for Homeless Veterans Reintegration Projects (HVRP).

The Department is requesting \$7,300,000 for the JTPA IVC. It is anticipated that \$6,900,000 of these funds will be awarded through a competitive process to State entities through each State's Governor's office. This competition will result in up to 20 grant awards to provide employment and training services to eligible veterans. The remainder of the funds will be used to provide specialized and targeted services as well as research and demonstration projects at the Assistant Secretary's discretion. It is expected that such grants will continue to target those eligible veteran subgroups experiencing higher unemployment rates (e.g., minority, female, recently separated and disabled veterans). Overall, VETS will process, award and monitor up to 30 grants to various service providers.

The request includes \$2,500,000 for the Homeless Veterans Reintegration Project program under the Training and Employment Services account. It is anticipated that these funds

Page 4

will be awarded through a competitive process, requiring the processing, awarding, and monitoring of up to 20 grants with service providers. The funds provided will support services to more than 4,000 homeless veterans and the resulting placement of about 2,100 in jobs.

The Agency requests a total of \$157,118,000 for grants-to-States, the same funding provided in FY 1997. The FY 1998 funding request for the LVER program is \$77,078,000, and for the DVOP is \$80,040,000. These amounts reflect a small shift of funding from the DVOP to the LVER program to support increased system activity in direct services to veterans, to achieve better system coverage with the resources available, to enhance services to certain veterans, to give adequate emphasis to the Federal contractor program, and to achieve increased utilization of electronic services such as America's Job Bank, resume-writer, talent-bank and other electronic helpers planned for FY 1998.

The \$77,078,000 requested for the Local Veterans' Employment Representative program is sufficient to fund 1,339 LVER positions and to help 152,000 veterans into jobs. As a result of the emphasis VETS is placing on helping special disabled and disabled veterans, and the small shift in funds requested from the DVOP, we estimate well over 6,700 special disabled veterans will be among those veterans helped into jobs. The centralized listing of vacancies by Federal contractors should result in better paying jobs for veterans. The efforts started last year to help Vocational Rehabilitation and Counseling program participants will continue, and we expect that, through closer coordination with the VA and better training of those working with program participants, we will do better both this year and during FY 1998.

LVERs will ensure delivery of services to those needing intensive help, with a primary focus being VA Vocational Rehabilitation and Counseling program participants, using a case management approach to services. LVER staff will play a greater role in monitoring the provision of priority services to veterans by all State Employment Security Agency (SESA) staff. LVER staff will emphasize referral of disabled veterans to Federal contractor vacancy listings. Also, LVER staff will promote veterans' participation in Federally-funded programs and will provide services to soon-to-be-separated military service members who participate in Transition Assistance Program (TAP) sessions. Emphasis will be placed on special disabled and disabled, minority, young, recently separated and women veterans. This shift in emphasis to veterans with greater barriers to employment will cause an increase in the number of job-ready veterans that will be served by the One-Stop Career Services system.

The \$80,040,000 requested for the Disabled Veterans' Outreach Program is sufficient to support 1,494 positions and to help over 156,000 veterans into jobs, including over 7,000 special disabled veterans. DVOP staff will continue to provide outreach and other legislatively prescribed services to veterans, giving priority to special disabled and disabled veterans. The DVOP staff will identify disabled veterans, determine their needs, establish employability plans, and help them secure employment for them in FY 1998, placing their primary focus on intensive services to VA Vocational Rehabilitation and Counseling program participants and economically disadvantaged veterans. DVOP specialists will network with other sources of services, including Private Industry Councils, service providers funded by the Job Training Partnership Act in service delivery areas, and the vocational rehabilitation counselors of the VA. DVOP specialists will utilize the case management approach in their services to veterans, and will continue to play a vital role in delivering TAP workshops.

The current priority given to TAP workshops, VR&C program participants and priority of services to special disabled and disabled veterans, veterans and other eligible persons will continue. The Agency expects that as a result of One-Stop Career Services, increased use of electronic tools such as America's Job Bank, Talent Bank and veterans' resume-writer, and others planned by the Department for FY 1998 implementation, that DVOP and LVER staff should have more time to concentrate their efforts, using a case management approach, on those veterans most in need of intensive personal assistance. Emphasis will be placed on disabled, minority, female, young, and recently separated veterans. Also, emphasis will be placed on getting better quality and better paying jobs for veterans.

Page 5

A total of \$22,837,000 is requested for the administration of the Veterans' Employment and Training Service. This funding level is sufficient to support about 254 employees. VETS is responsible for ensuring that the legislative mandates for providing special services to veterans, Reservists, National Guard members, and other eligible persons are provided by the DOL and its grantees in accordance with Chapters 41, 42, and 43 of Title 38, United States Code. VETS administers grants-to-States for the Local Veterans' Employment Representative (LVER) program and the Disabled Veterans' Outreach Program (DVOP). It also administers grants-to-States and other entities as authorized under the JTPA IVC and HVRP programs. VETS also ensures the delivery of services by State Employment Security Agencies (SESAs) to veterans on a priority basis through on-site monitoring and management assistance.

VETS also acts as liaison with other Federal agencies, including the Office of Personnel Management, to protect veterans' hiring preference in the Federal sector; the Office of Federal Contract Compliance Programs, to ensure the enforcement of affirmative action requirements for special disabled and Vietnam-era veterans; the Department of Veterans Affairs, to coordinate vocational rehabilitation and on-the-job training programs; the Departments of Defense and Veterans Affairs, to conduct the Transition Assistance Program providing service members separating from active duty with labor market information and job search skills training to expedite their transition from military to civilian employment.

VETS staff provide assistance directly to veterans, Reservists, and National Guard members to protect their employment and reemployment rights, including anti-discrimination, seniority, and pension rights, as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). VETS administers the Job Listing component of the Federal Contractor Program (FCP), under 38 U.S.C. Section 4212, which requires Federal contractors to list their openings with SESAs and to submit annual employment reports on special disabled and Vietnam-era veterans. The agency is responsible for fact finding when a veteran complains that a Federal agency violated veterans preference provisions in hiring activities and coordinates resolution of such complaints with the Office of Personnel Management.

In addition, VETS collects and summarizes information, as required by law, concerning the quantity and quality of services provided to veterans by DOL and DOL-funded programs, and provides this information to the Congress. VETS administers the National Veterans Training Institute (NVTI) which trains veteran service delivery providers.

VETS staff will continue to work on the following priorities:

- \* Maintaining an effective Transition Assistance Program. The agency, along with its partners, will present workshops to 160,000 separating service members and their spouses. This number represents about 60 percent of those who will separate from the military worldwide in FY 1998. To do this, we will utilize DVOP and LVER staff, Federal contract facilitators and VETS employees. Efforts to support TAP for separating military personnel realize cost savings that are significantly greater than the amount being requested due to the fact that TAP participants obtain their first civilian job three weeks faster than do non-participants--demonstrating that there is a substantial return on investment in this program. The high priority we place on TAP is supported by recent findings in a Department of Defense study which indicated notably high satisfaction ratings among service members who had attended TAP workshops.
- \* Improved use of technology. The Agency sees improved use of technology as the means of getting better quality and better paying jobs for veterans coming into the DOL service delivery system. I view improved technology as a means to improve the access of veterans to employers and vice-versa and a way of improving efficiency among VETS and DVOP and LVER staff. America's Job Bank is a good example of where we are headed. The veterans' resume-writer is another good example. Each of these makes the job of the service providers a little easier and enables them to use the time it would have taken to help those that avail themselves of these electronic tools to help those with

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severe employability barriers. Although we acknowledge that not all veterans or our service providers are versed in the new electronic tools, we are developing plans to train our Agency staff and work with SESAs to train service deliverers in the use of these electronic tools.

- \* Placing emphasis on services to young, recently separated, minority, female, and disabled veterans. VETS will work with SESAs to ensure that services to those veteran sub-groups suffering from higher than average unemployment rates increase and to increase consciousness as to their employability barriers and how they can be mitigated.

A total of \$2,000,000 is requested for the National Veterans' Training Institute which provides training to Federal and State employees and managers involved in delivery of services to veterans. The funding will support over 61 classes and train more than 1,400 service providers.

The training institute has proven to be an extremely effective instrument for significantly improving both the quality and quantity of services provided to veterans. NVTI has proven efficient at meeting new training needs as they arise, such as in the case of TAP, USERRA, grants management, and case management. VETS programs and operations will have to change substantially to meet the challenges set forth by the One-Stop Career Services concept, to concentrate its resources on training and retraining and on case management for those most in need. This will require training and retraining not only of DVOP and LVER staff, but also of VETS staff and program recipients. In addition, One-Stop Career Service providers will need training on the veterans' priority of service requirements and the case management approach used by VETS for those that have severe employability barriers.

I want to acknowledge the efforts of this Committee and others in Congress and the Administration who made it possible for the Department of Labor and its Veterans' Employment and Training Service and our State agency partners to continue to offer "world class" services to our customers in FY 1997. I also wanted to point out, in particular, the importance we give to our FY 1998 funding request to help homeless veterans get jobs. Thank you for authorizing this very worthy program for fiscal year 1998.

#### **Fiscal Year 1997**

For FY 1997, the \$81,993,000 provided for the DVOP program will support 1,568 positions. We project about 165,000 veterans will be helped into jobs at this level of funding. The funds provided for the LVER program, \$75,125,000, will support 1,340 positions and should result in 152,000 veterans being helped into jobs.

The \$22,733,000 provided for Federal administration in FY 1997 will support 260 employees and will enable VETS staff, Federal contract facilitators and DVOP and LVER staff to provide TAP workshops serving about 164,000 separating service members and their spouses. Also, the funds provided for enforcement of veterans' rights will enable VETS to appoint 10 investigators to protect the rights of veterans. This together with training currently being developed by NVTI to further train VETS staff on investigative techniques will increase our effectiveness in handling USERRA and Federal Veterans Preference claims. Also, because of delays in filling these jobs during the first quarter, savings were realized -- VETS has already fielded a Veterans Preference electronic expert system, is working on a USERRA expert system, and a claim tracking system with these savings. The Federal Veterans Preference expert system is available through the Internet (in DOL's home page) and was made available to veteran service organizations in diskettes that can be loaded on any personal computer. Similarly, the Internet version can be downloaded to a personal computer or onto a floppy diskette and used from the diskette. This will help veterans who believe their veteran preference rights may have been harmed, as well as veteran service organizations and others who offer advice and counsel to veterans on these issues. The expert system simply asks questions from a decision tree that enables the veteran or service provider to determine whether a claim to veterans' preference exists.

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The \$2,000,000 provided for NVTI will support the conduct of over 63 classes and train over 1,400 veteran service providers.

With the \$7,300,000 provided from General Revenue funds through the Employment and Training Services account, VETS -- through grants to States and innovative projects - will serve over 4,000 veterans and place over 2,000 into jobs.

I appreciate this opportunity to give you some highlights of the FY 1998 budget request for the Veterans' Employment and Training Service. I look forward to working closely with the Committee on behalf of our Nation's veterans.

BEFORE THE COMMITTEE  
ON  
VETERANS' AFFAIRS

STATEMENT OF MAJOR GENERAL JOHN P. HERRLING, USA (RET)  
SECRETARY  
AMERICAN BATTLE MONUMENTS COMMISSION

February 13, 1997

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to testify on our Fiscal Year 1998 Appropriation Request. The special nature of the American Battle Monuments Commission places it in a unique and highly responsible position with the American people. The manner in which we care for our Honored War Dead is, and should remain, a reflection of the high regard in which we, as a nation, honor their service and sacrifices.

As you know, the American Battle Monuments Commission is a small, one-of-a-kind organization, that is responsible for commemorating the services of American Armed Forces where they have served since April 6, 1917 (the date of U.S. entry into World War I) through the erection of suitable memorial shrines; for designing, constructing, operating, and maintaining permanent American military burial grounds in foreign countries; for controlling the design and construction of U.S. military monuments and markers in foreign countries by other U.S. citizens and organizations, both public and private; and for encouraging the maintenance of such monuments and markers by their sponsors. In performing these functions, the American Battle Monuments Commission administers, operates, and maintains twenty-four permanent memorial cemeteries and twenty-eight monuments, memorials, and markers in fifteen countries around the world.

We have eight World War I and 14 World War II cemeteries located in Europe, the Mediterranean, North Africa, and the Philippines. All of these cemeteries are closed to burials except for the remains of the War Dead who may occasionally be discovered in World War I or World War II Battlefield areas. In addition, we are responsible for the American cemeteries in Mexico, established after the Mexican War, and Panama.

Presently 124,914 U.S. War Dead are interred in these cemeteries -- 30,921 of World War I, 93,243 of World War II and 750 of the Mexican War. Additionally, 5,857 American veterans and others are interred in the Mexico City and Corozal (Panama) American Cemeteries. Commemorated individually by name on stone tablets at the World War I and II cemeteries and three memorials on U.S. soil are the 94,120 U.S. servicemen and women who were Missing in Action, or lost or buried at sea in their general regions during the World Wars and the Korean and Vietnam Wars.

We continue to provide services and information to the public, friends, and relatives of those interred in, or memorialized, at ABMC cemeteries and memorials. This includes information about grave and memorialization sites as well as location, suggested routes, and modes of travel to the cemeteries or memorials. Immediate family members are provided letters authorizing fee-free passports for overseas travel to specifically visit a loved one's grave or memorial site. Photographs of headstones and sections of the Tablets of the Missing on which the service person's name is engraved are also available. These

photographs are mounted on large color lithographs of the cemeteries or memorials. In addition we assist those who wish to purchase floral decorations for placement at grave or memorial sites in our cemeteries. A photograph of the in-place floral arrangement is provided to the donor.

The care of these shrines to our War Dead requires a formidable annual program of maintenance and repair of facilities, equipment, and grounds. This care includes upkeep of 131,000 graves and headstones; 73 memorial structures; 41 quarters, utilities, and maintenance facilities; 67 miles of roads and paths; 911 acres of flowering plants, fine lawns and meadows; nearly 3,000,000 square feet of shrubs and hedges and over 11,000 ornamental trees. Care and maintenance of these resources is exceptionally labor intensive, therefore, personnel costs account for 72 percent of our budget for FY 1998. The remaining 28 percent is required to fund our operations, including unprogramed requirements resulting from natural disasters or foreign currency fluctuations. We do not have the option of closing or consolidating cemeteries. In light of this, we have increased our efforts to achieve greater efficiency and effectiveness, through automation and contracting, in the operational and financial management areas, where we do have control.

This Commission fully recognizes and supports the efforts of the President and the Congress to improve efficiency, focus on results, and streamline the government overall. During Fiscal Year 1996, we completed the upgrade to our automation system and offset telephone, fax, and mail costs while increasing productivity. We have contracted with the Department of Treasury's Financial Management Services Center to study our accounting system, provide alternatives and recommendations, and design a new system, if findings warrant. We anticipate these recommendations will be implemented during FY 1998. In addition, we have begun development of our Strategic and Annual Performance Plans in accordance with the Government Performance and Results Act. We believe, when finalized, our plans will provide a comprehensive roadmap for accomplishing our mission.

On July 27, 1995, President Clinton and President Kim Young Sam dedicated the Korean War Veterans Memorial. On February 6, 1997, we opened the Korean War Memorial Kiosk. This Kiosk houses the Korean War Veterans Memorial Honor Roll. This Honor Roll allows friends and relatives to query a data base containing the names and information about those who died during the Korean War. With the opening of the Kiosk we are pleased to be able to report to you that the Korean War Veterans Memorial is now complete.

Our focus for Fiscal Year 1998 and for the next several years will be the World War II Memorial. As you know, on May 25, 1993, President Clinton signed Public Law 103-32 directing the ABMC to build a World War II Memorial. The World War II Memorial Site at the Rainbow Pool was dedicated by President Clinton on November 11, 1995. Since that time, a national design competition was held with over 400 preliminary designs submitted for evaluation. Six finalists were selected and announced on August 21, 1996. Final designs were submitted to a design jury on October 25. Criteria included concept, past performance, specialized experience and technical competence, professional qualifications and the capacity to accomplish the work in the required time. The jury interviewed the finalists and made its recommendation to the Commission on October 31. The World War II Advisory Board met and provided its advice to the ABMC on November 18. ABMC Commissioners considered the advice and recommendations and selected the winning design team/concept on November 20. On January 17, 1997, at a White House Ceremony, President Clinton unveiled the winning design by Friedrich St. Florian, former Dean of the Rhode Island School of Design, and a current professor at the school. Teaming up with Professor St. Florian are George E. Hartman, Hartman-Cox Architects, and Oehme van Sweden & Associates, Inc., both of Washington D.C. Leo Daly will be the architect - engineer of record.

As directed by the Congress, the \$100 Million memorial will be funded through private donations after expending the \$4.7 Million that Congress authorized from the surcharge proceeds of World War II Commemorative Coin sales and the \$5 Million transferred from Department of Defense. The American Battle Monuments Commission is working closely with the World War II Memorial Advisory Board to raise the funds to meet the planned dedication on Veterans' Day in the year 2000.

While our attention has been focused on management improvements and the design and construction of the World War II Memorial, we have not ignored our primary mission of operating and maintaining twenty-four memorial cemeteries and twenty-eight monuments. The Congress has been instrumental in our success in maintaining its high standard of excellence by providing the funds required to accomplish our objectives, and for that we thank you.

Fiscal Year 1998 will present new challenges. For the first time in nine years we have repriced our foreign currency budget rates. This repricing, with OMB support, conforms with the Department of Defense's budget rates for foreign currency. With this repricing, we estimate that we will require \$2,097,000 to satisfy foreign currency fluctuation requirements. This amount has been included in our budget request. In addition the FY 1998 request provides for cost of living increases for our U.S. and foreign national personnel, rental expenses for space previously provided at no cost, funding to integrate ABMC financial systems in accordance with OMB, GAO, and recent Congressional directions, and small increases for maintenance and equipment. Perhaps our greatest challenge will be in dealing with aging facilities and equipment. Our cemetery memorials range in age from 50 to 80 years old with Mexico City being over 100 years old. The permanent structures and plantings which make our facilities among the most beautiful memorials in the world are aging and require increased funding to maintain them at the current standards. Our maintenance and engineering budget is stretched to the limit. Accordingly, we are prioritizing this spending carefully. In addition, much of our equipment is aging and rapidly reaching the end of its useful life. We have requested additional funding for equipment replacement this fiscal year and will be implementing phased replacement in order to take advantage of new labor saving technology.

Since 1923, the American Battle Monuments Commission's memorials and cemeteries have been held to a high standard in order to reflect America's continuing commitment to its Honored War Dead, their families, and the U.S. national image. The Commission intends to continue to fulfill this sacred trust.

The American Battle Monuments Commission appropriation request for Fiscal Year 1998 is \$23,897,000.

This concludes my prepared statement. I will be pleased to respond to your questions.



Appropriation Request for Fiscal Year 1998  
1<sup>st</sup> Session, 105<sup>th</sup> Congress of the United States

Submitted to the Appropriation Subcommittee on Veterans Affairs,  
Housing and Urban Development and Independent Agencies

February 1997

**AMERICAN BATTLE MONUMENTS COMMISSION**

**Appropriation Request for Fiscal Year 1998**

**1ST Session, 105th Congress of the United States**

**Submitted to the Appropriations Subcommittees on  
Veterans Affairs, Housing and Urban Development and  
Independent Agencies**

**February 1997**

American Battle Monuments Commission  
 Fiscal Year 1998 Appropriation Request  
 Salaries and Expenses

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**General and Special Funds:**

**Salaries and Expenses**

For necessary expenses, not otherwise provided for, of the American Battle Monuments Commission including the acquisition of land or interest in foreign countries; purchase and repair of uniforms for caretakers of national cemeteries and monuments outside of the United States and its territories and possessions; rent of office and garage space in foreign countries; purchase and hire of passenger motor vehicles; and insurance of official motor vehicles in foreign countries, when required by law of such countries; \$23,897,000 to remain available until expended: *Provided*, That where station allowance has been authorized by the Department of Army for officers of the Army at certain foreign stations, the same allowance shall be authorized for officers of the Armed Forces assigned to the Commission while serving at the same foreign stations, and this appropriation is hereby made available for the payment of such allowance: *Provided further*, That when travelling on business of the Commission, officers of the Armed Forces serving as members or as Secretary of the Commission may be reimbursed for expenses as provided for civilian members of the Commission: *Provided further*, That the Commission shall reimburse other Government agencies, including the Armed Forces, for salary, pay, and allowances of personnel assigned to it. (Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1997.)

## GENERAL STATEMENT

The principal functions of the American Battle Monuments Commission (ABMC) are: to commemorate the achievements and sacrifices of United States Armed Forces where they have served since April 6, 1917, through the erection and maintenance of suitable memorial shrines; to design, construct, operate and maintain permanent American military burial grounds in foreign countries; to control the design and construction on foreign soil of U.S. military monuments and markers by other U.S. citizens and organizations both public and private; and to encourage U.S. governmental agencies and private individuals and organizations to adequately maintain the monuments and markers erected by them on foreign soils.

In performance of these functions, ABMC administers, operates and maintains twenty-four permanent American military cemetery memorials and thirty-one monuments, memorials, markers and offices in fifteen countries around the world, the U.S. Commonwealth of the Northern Mariana Islands and the British dependency of Gibraltar. These cemeteries and memorials are among the most beautiful and meticulously maintained shrines of their nature in the world. Few others combine such fitness of design, beauty, landscaping, memorial features, and care. Interred in the cemeteries are 124,914 U.S. War Dead - 30,921 of World War I, 93,243 of World War II, and 750 of the Mexican American War. Additionally, 5,857 American Veterans and others are interred in the Mexico City and Corozal Cemeteries. The World Wars and Mexico City Cemeteries are closed to future burials except for the remains of U.S. War Dead still to be found from time to time in the World War I and II battle areas. In addition to burials, the World War I and II cemeteries, together with three memorials on U.S. soil, commemorated individually by name on Tablets of the Missing, the 94,120 U.S. servicemen and women who were Missing in Action or lost or buried at sea in their general region during the World Wars, and the Korean and Vietnam Wars.

The care of these shrines to our War Dead requires a formidable annual program of maintenance and repair of facilities, equipment, and grounds maintenance. This care includes upkeep of 131,000 graves and headstones; 73 memorial structures; 41 quarters, utilities, and maintenance facilities; 67 miles of roads and paths; 911 acres of flowering plants, fine lawns and meadows; 3,000,000 square feet of shrubs and hedges and 11,000 ornamental trees. The estimated replacement cost of these facilities is approximately \$380,000,000. All of the plantings, including the lawns and to some extent the meadows, must be cut and/or shaped, fed and treated with insecticides and fungicides at regular intervals during the growing season. The plantings also must be replaced when their useful lives are exhausted or they receive major storm damage. Much of the maintenance and care is performed by casual labor as the permanent cemetery staffs are not large enough to provide it on a continuous basis.

In 1985, the U.S. Government embarked on a long term program to lower the value of the U.S. dollar in foreign markets in order to make U.S. goods and services more competitive. Through its efforts, the dollar's exchange rate has decreased significantly in most of the countries where ABMC's installations are located. In order to insulate the Commission's annual

appropriation against major changes in its purchasing power due to currency exchange fluctuations, legislation was enacted in 1988 establishing an ABMC currency fluctuation account in the U.S. Treasury. Monies from the current appropriation are deposited in the account when the exchange rates are less than the budgeted rates. During Fiscal Year 1996, \$2,300,000 in exchange losses in Europe were partially offset by gains of \$500,000 in the Mediterranean area. ABMC's net currency exchange loss for FY 1998 was \$1,817,301. The FY 1997 Appropriation included \$2,000,000 for foreign currency losses. Through December 1996, foreign currency losses have amounted to \$457,728, leaving a reserve balance of \$1,542,272 for the remainder of the Fiscal Year. Based on historical experience we anticipate total expenditures in foreign currency to reach the \$2,000,000 level.

As a service and maintenance organization ABMC's operations are labor intensive. During Fiscal 1996, 71% of obligations were to pay the salaries and personnel benefits of employees. Cost of living increases for ABMC employees average over \$500,000 annually. Most of these increases go to ABMC's foreign national employees. By treaty agreements with the countries where ABMC installations are located, the United States has agreed to pay its foreign national employees' cost of living increases during the year as decreed by these governments. Since pay supplemental appropriations are no longer being enacted, fund allocations due to these cost of living increases have been defrayed from funds earmarked for maintenance, repairs, supplies, materials, spare parts, equipment, and capital improvements. This has contributed in part to the current and anticipated growth in our backlog. Based on receipt of requested funding in our Fiscal Year 1998 President's Budget, we anticipate our backlog of maintenance, repair, and capital improvements will be \$8,400,000 at the end of the Fiscal Year.

In addition to its other activities, ABMC provides information and assistance on request by relatives and friends of the War Dead interred in or commemorated at its facilities. These services include burial and memorialization information; letters authorizing fee-free passports for members of the immediate family traveling overseas primarily to visit the cemetery; travel and accommodation information; floral decorations of grave or memorial sites utilizing funds provided by the donor; color Polaroid photographs of the decoration in place, when weather permits; color lithographs of the cemetery or memorial where a serviceman or woman is buried or commemorated by name on which has been mounted a photograph of the appropriate headstone or section of the Tablet of the Missing; and escort of relatives within the cemetery to the grave or memorial site.

On May 25, 1993 President Clinton signed Public Law 103-32 authorizing the American Battle Monuments Commission to establish a World War II Memorial in Washington D. C. or its environs. This memorial will be the first national memorial dedicated to all who served during the war, and will recognize the commitment and achievement of the entire nation. A site on the National Mall at the east end of the Reflecting Pool between the Lincoln Memorial and the Washington Monument was selected and dedicated by the President on Veterans Day in 1995. A design by Friedrich St. Florian, former dean of the Rhode Island School of Design, and current professor, was selected and announced at the White House on January 17, 1997. The \$100 million memorial will be funded through private donations. The first public solicitation for the capital campaign began in January 1997. Dedication of the memorial is projected on Veterans Day in the year 2000. (See Section VI for further details)

This appropriation request is submitted pursuant to the Act of March 4, 1923, 42 Stat. 1509, as amended (36 U.S.C. 121-138c).

SUMMARY OF ABMC  
BUDGET AUTHORITY  
(\$ In Millions)

Budget Account	FY 96 Budget Authority Actual	FY 97 Budget Authority Estimate	FY 98 Budget Authority Estimate
74-0100-0-1-705			
Salaries & Expenses	\$22	\$22	\$24
Transferred To FCFA *	-1	-2	-2
Transferred From FCFA	1	2	2
Trust Fund Contributions ** (World War II Memorial Fund)	0	6	12
Total ABMC	\$22	\$28	\$36

\* Foreign Currency Fluctuation Funds are transferred between FCF and S&E as follows: \$1M in FY 96, \$2M in FY 97, and \$2M in FY 98.

\*\* Budget Authority is equal to expected obligation for fund raising. Contributions from fund raising estimated to be \$10 Million in FY 97, \$50 Million in FY 98.



FOREIGN CURRENCY FLUCTUATION

74-0101-0-1-705 FINANCING:	1996 Actual	1997 Estimate	1998 Estimate
21.4001 Unobligated Balance Start of Year	-1,145	...	...
24.4001 Unobligated Balance End of Year	...	...	...
39.0001 Budget Authority	-1,145	...	...
<b>Budget Authority</b>			
41.0001 Transferred to Other Accounts	-1,817	-2,000	-2,097
42.0001 Transferred from Other Accounts	672	2,000	2,097
43.0001 Appropriation (Total)	-1,145	0	0

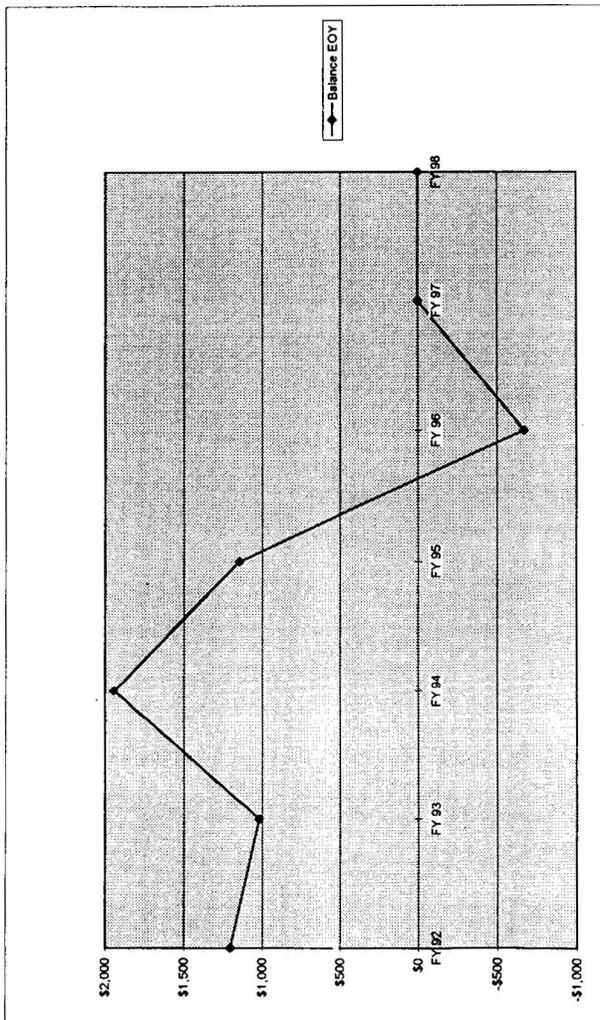
As explained above, legislation in 1988 established ABMC's Foreign Currency Fluctuation Account (FCFA). The account is to offset foreign currency costs when the dollar is less favorable than the budgeted rate, and to collect gains when the dollar is in a more favorable currency position. Our monthly history of losses and FCFA balances are shown on the chart on the following page.

		AMERICAN BATTLE MONUMENTS COMMISSION FOREIGN CURRENCY FLUCTUATION FY 1996-FY 1998 (As of Dec 1996)							
Month	LOSSES	FY 96 REPLNSMNT	BALANCE	LOSSES	FY 97 (Note 1) REPLNSMNT	BALANCE	LOSSES	FY 98 (Note 2) REPLNSMNT	BALANCE
B/F			<b>\$1,145,023</b>			<b>\$0</b>			<b>\$0</b>
Oct	\$141,680		\$1,003,343	\$177,769	\$2,000,000	\$1,822,231	\$174,750	\$2,097,000	\$1,922,250
Nov	155,203		844,140	148,284		1,673,947	174,750		1,747,500
Dec	141,037		703,103	131,675		1,542,272	174,750		1,572,750
Jan	200,300		502,803	175,596		1,366,676	174,750		1,398,000
Feb	147,665		355,138	164,897		1,201,779	174,750		1,223,250
Mar	140,698		214,440	168,546		1,033,233	174,750		1,048,500
Apr	150,836		63,604	178,569		854,664	174,750		873,750
May	144,396		-80,792	178,561		676,103	174,750		699,000
Jun	131,363		-212,155	175,898		500,205	174,750		524,250
Jul	120,434		-332,589	168,521		331,684	174,750		349,500
Aug	169,101		-501,690	165,789		165,895	174,750		174,750
Sep	\$170,588		-\$672,278	\$165,895		\$0	\$174,750		\$0
	<b>\$1,817,301</b>		<b>-\$672,278</b>	<b>\$2,000,000</b>		<b>\$0</b>	<b>\$2,097,000</b>		<b>\$0</b>
	Reprogrammed from operating accounts		\$672,278						

Note 1. October through December Actual. January through September Estimated.

Note 2. Estimated losses straight lined for planning purposes. Without replenishment, operations program will have to be reduced by \$2.1 Million or 31.3%.

AMERICAN BATTLE MONUMENTS COMMISSION  
END OF YEAR BALANCE  
FOREIGN CURRENCY FLUCTUATION ACCOUNT  
FY 1992 THROUGH FY 1998  
(\$ In Thousands)



Note 1. Losses for FY 96 Reprogrammed from Operations.  
Note 2. Without replenishment requested for FY 1998, Operations Program will have to be reduced by \$2.1 Million or 31.3%.

STATEMENT OF PERSONNEL

	<u>1996</u> Actual	<u>1997</u> Estimate	<u>1998</u> Estimate
Total Number of Full-Time Permanent Positions	364	364	363
Total Compensable Work Years (FTE)	364	364	363
Full-Time Equivalent (FTE) of Overtime and Holiday Pay	4	4	4
Average GS Grade	10.9	10.10	10.10
Average GS Salary	40,387	41,598	42,763
Average Salary of Ungraded Positions	24,589	25,326	26,035

STATEMENT OF  
INCREASES AND DECREASES BY ACTIVITY  
(In Thousands)

	Administration and U.S. Memorials	European Cemeteries and Memorials	Mediterranean Cemeteries and Memorials	Asian Cemeteries and Memorials	Latin Cemeteries and Memorials	Totals
1. Fiscal 1996 Obligations (Actual)	2,024	15,305	3,082	906	345	21,662
2. Fiscal 1997 Obligations (Est)	1,800	15,801	3,473	818	373	22,265
Change from 1996	-224	496	391	-88	28	603
3. Fiscal 1998 Obligations (Est)	2,313	16,778	3,516	920	370	23,897
Change from 1997	513	977	43	102	-3	1,632

STATEMENT OF  
INCREASES AND DECREASES BY OBJECT CLASSIFICATION  
(In Thousands)

	<u>11</u>	<u>12</u>	<u>13</u>	<u>21</u>	<u>22</u>	<u>23</u>	<u>24</u>	<u>25</u>	<u>26</u>	<u>31</u>	<u>32</u>	<u>42</u>	<u>Total</u>
Fiscal 1996 Obligations (Actual)	10,997	4,258	76	289	332	794	43	1,748	1,371	1,258	443	53	21,662
Fiscal 1997 Obligations (Est)	11,908	4,643	184	276	120	950	37	1,339	828	569	1,405	6	22,265
Changes from 1996	911	385	108	-13	-212	156	-6	-408	-543	-689	962	-47	603
Fiscal 1998 Obligations (Est)	12,250	4,770	183	276	120	1,164	38	1,649	1,135	860	1,447	5	23,697
Changes from 1997	342	127	-1	0	0	214	1	310	307	281	42	-1	1,632

AMERICAN BATTLE MONUMENTS COMMISSION  
CHANGES BY OBJECT CLASSIFICATION

This appropriation request provides \$23,897,000 for the administration, operation, maintenance, and supervision for 24 burial grounds and 31 separate monuments, memorials, markers and offices around the world, an increase of \$1,632,000 over the current year. At the request of the Office of Management and Budget, the ABMC repriced the budget rates for foreign currency, for the first time since 1989. Revised rates are the same rates utilized by the Department of Defense. As DoD rates change, ABMC estimates will be revised. These revisions will provide an up to date and more accurate picture of our foreign currency requirements.

**11. Personnel Compensation.** \$12,250,000 is requested for salaries of 5 military, 54 U.S. civilian and 309 foreign national employees indigenous to the foreign countries where our installations are located; \$342,000 more than the current year. Included in the request are in-grade increases, promotions, and cost of living increases for U.S. employees.

**12. Personnel Benefits.** \$4,770,000 is requested for personnel benefits; \$127,000 more than the current year. These benefits or allowances are authorized by U.S. Federal law, the laws of the countries where our installations are located, and the treaty agreements between host countries and the U.S. Federal Government. They include U.S. and foreign national (FN) social security; GS medicare taxes; GS and FN life insurance; GS education allowances; GS, military, and FN retirement; GS quarters allowances; GS post allowances; GS and FN health insurance; GS and military temporary lodging allowances; GS thrift savings programs; GS and FN COLAS; bonuses; and FN family allowances.

**13. Benefits for Former Personnel.** \$183,000 is requested for severance pay of FN employees and reimbursement of Department of State for currency exchange losses incurred in payment of FNs on U.S. Civil Service retirement; \$1,000 less than the current year.

**21. Travel and Transportation of Persons.** \$276,000 is requested for the travel and transportation of ABMC's U.S. and FN employees for operational purposes, its U.S. employees and dependents traveling on permanent change of stations, its U.S. student dependents traveling to or from school, and its Presidentially appointed Commissioners, charged with oversight of ABMC operations. No change from the current year.

**22. Transportation of Things.** \$120,000 is requested for transportation of supplies, materials, spare parts, vehicles and equipment utilized in the operation, maintenance, and repair of ABMC facilities and for the transportation of household goods in connection with permanent change of station. No change from the current year.

AMERICAN BATTLE MONUMENTS COMMISSION  
CHANGES BY OBJECT CLASSIFICATION

- 23. Rent, Communications and Utilities.** \$1,164,000 is requested for rental of quarters, storage and garage space; postal, telephone, and fax services; water, gas and electricity; and Department of State International Cooperative Administrative Support Service (ICASS). In addition, ABMC Headquarters will begin paying rental costs for Headquarters office space; \$214,000 more than the current year.
- 24. Printing and Reproduction.** \$38,000 is requested for printing and reproduction of reports, photographs, general information pamphlets, cemetery booklets, lithographs of the cemetery memorials for presentation to the members of the families interred in them or commemorated by name on The Tablets of the Missing; \$1,000 more than the previous year.
- 25. Other Services.** \$1,649,000 is requested for contractual maintenance and repairs and vehicular insurance in those countries that require such coverage by law; \$310,000 more than the current year. \$110,000 is attributable to the funding for a new comprehensive accounting system to be implemented for our worldwide operations. This will allow the Commission to fully comply with OMB Circular A-127 guidance on integrated accounting systems. In addition, passage of the Veterans' Benefits Improvements Act of 1996, Public Law 104-275, included provisions which were supported by GAO, that require the ABMC to begin preparing financial statements beginning in March 1998. Implementation of the accounting system will assist in meeting these requirements. \$200,000 is designated for maintenance and engineering requirements.
- 26. Supplies and Materials.** \$1,135,000 is requested to replenish stockages of plantings and seeds; horticultural, repair and utility, custodial and office supplies; petroleum, oils and lubricants; tires and tubes; and spare replacement parts for vehicles and equipment; \$307,000 more than the current year. \$207,000 of this increase is directly attributable to the repair requirements for aging equipment and restockage of plantings and seeds. Also, \$100,000 of this funding is for the new accounting system.
- 31. Equipment.** \$860,000 is requested for the replacement of worn-out and uneconomically repairable vehicles, equipment and furniture; \$291,000 more than the current year. On the average, our equipment is ten years old or older and numerous pieces have reached the point of being uneconomical to repair. \$80,000 is reserved for required equipment to implement the worldwide accounting system.
- 32. Lands and Structures.** \$1,447,000 is requested for capital improvement; \$42,000 increase to prior year to reduce backlog of engineering projects.

AMERICAN BATTLE MONUMENTS COMMISSION  
CHANGES BY ACTIVITY

General. This Appropriation Request provides \$23,897,000 for the administration, operation, maintenance, and supervision of 24 burial grounds and 31 monuments, memorials, markers, and offices around the world. Increases of \$1,632,000 are offset by reductions of \$3,000 in our Latin American Operations. Included in the budget is a reduction of one FTE position in concert with the Administrations program to streamline the Federal Government. At the request of the Office of Management and Budget, the ABMC repriced the budget rates for foreign currency, for the first time since 1989. Revised rates are the same rates utilized by the Department of Defense. This revision will provide a more accurate picture of our foreign currency requirements.

**Administration and U.S. Memorials.** \$2,313,000 is requested for the Washington D.C. office, \$513,000 more than the current year to administer operations worldwide and supervise directly three burial grounds, one in Panama, one in Mexico, and one in the Philippines. Also under the direct supervision of the Washington D.C. office are ten monuments and memorials, five in the United States, one in the Northern Marianas, one in the Philippines, one in the Solomon Islands, one in New Guinea, and one in Cuba. Increases of \$214,000 are required for rental of office space previously provided at no charge, \$50,000 for capital improvements to be utilized in our regional operations, \$40,000 for maintenance of the Korean War Memorial Honor Roll, and \$300,000 to implement a new comprehensive accounting system. These increases are partially offset by reductions of \$61,000 in equipment.

**European Cemeteries and Memorials.** \$16,778,000 is requested for the European region to administer, supervise, operate, and maintain 17 burial grounds and 14 separate monuments, memorials, markers, and one office, in France, England, Belgium, Luxembourg and The Netherlands; \$977,000 more than the current year. Increases in personnel costs, supplies, and equipment are partially offset by decreases in insurance and retirement benefits.

**Mediterranean Cemeteries and Memorials.** \$3,516,049 is requested for the Mediterranean Region to administer, supervise, operate, and maintain four burial sites, two monuments/markers, and one office; \$43,000 more than the current year. These installations are located in Italy, North Africa, and Gibraltar (a British dependency on the southern coast of Spain). Increases in personnel costs, supplies, equipment, and transportation are offset by decreases in construction, communications, and utility costs.

AMERICAN BATTLE MONUMENTS COMMISSION  
CHANGES BY ACTIVITY

**Asian Cemeteries and Memorials.** \$920,000 is requested for the Manila American Cemetery and Memorial to administer, operate, and maintain one burial ground and one separate memorial; \$102,000 more than the current year. Increases of \$14,000 in personnel costs and \$64,000 in capital improvements are offset by small decreases in travel and transportation.

**Latin Cemeteries and Memorials.** \$370,000 is requested for the operation and maintenance of two burial grounds and one monument in Panama, Mexico, and Cuba; \$3,000 less than the current year. Increases of \$13,000 in personnel costs are offset by decreases of \$14,000 in equipment and \$7,000 in capital improvements.

## COMPARISON OF CEMETERY BUDGETS

Cemetery/Office	Fiscal * 1996	Fiscal ** 1997	Fiscal ** 1998
Washington Office	2,024,148	1,800,000	2,312,900
Paris Office	3,722,823	5,023,484	3,907,889
Aisne-Marne	588,154	556,785	644,107
Ardennes	1,037,202	970,082	1,035,624
Brittany	506,591	476,855	554,212
Brookwood	192,428	157,877	163,213
Cambridge	494,094	509,834	621,018
Epinal	552,987	480,963	614,906
Flanders Field	384,311	386,573	423,070
Henri-Chapelle	967,095	971,923	1,020,519
Lorraine	1,133,115	986,084	1,338,852
Luxembourg	548,594	474,235	577,987
Meuse-Arnonne	1,374,157	1,256,256	1,827,876
Netherlands	956,092	814,773	1,122,949
Normandy	1,040,214	1,055,438	1,140,228
Oise-Aisne	582,498	541,889	574,833
Somme	408,244	380,771	382,192
St. Mihiel	488,982	469,212	495,137
Suresnes	327,796	307,960	333,272
Rome Office	740,963	822,411	924,889
Florence	730,390	826,231	822,920
North Africa	395,529	452,402	392,435
Sicily-Rome	890,228	933,601	1,007,772
Rhone	325,284	338,151	368,033
Manila	905,967	818,000	919,529
Corozal	261,854	281,200	281,098
Mexico City	82,813	92,000	89,540
<b>ABMC TOTAL</b>	<b>21,662,553</b>	<b>22,265,000</b>	<b>23,897,000</b>

\* Actual

\*\* Estimated

ABMC INSTALLATIONS

<u>Name &amp; Location</u>	<u>No. of Burials</u>	<u>Missing Memorialized</u>	<u>No. of Acres</u>	<u>No. of Employees</u>	<u>Highest Grade</u>
U.S. Installations	...	33,809	3.2	1ES, 1SES, 9GS, 3 Mil	EX SCH LEVEL IV
Washington Office	...	...	0.0	1ES, 1 SES, 9GS, 3Mil	EX SCH LEVEL IV
American Expeditionary Force Monument Pershing Park, Washington D.C. (1)	...	...	0.1	...	...
East Coast Memorial, New York City, New York (2)	...	4,601	0.8	...	...
Honolulu Memorial, Honolulu, HI (3)	...	28,796	1.0	...	...
West Coast Memorial, Presidio of San Francisco, California (4)	...	412	1.3	...	...

ABMC INSTALLATIONS

<u>Name &amp; Location</u>	<u>No. of Burials</u>	<u>Missing Memorialized</u>	<u>No. of Acres</u>	<u>No. of Employees</u>	<u>Highest Grade</u>
<b>EUROPEAN INSTALLATIONS</b>	<b>90,993</b>	<b>15,507</b>	<b>1,252.4</b>	<b>32 GS 220 LN, 1 MIL</b>	<b>GS-15</b>
Paris Office	...	...	...	5 GS, 21 LN 1 MIL	GS-15
Aisne-Mame American WWI Cemetery & Memorial, Belleau Aisne, France	2,289	1,060	242.1	1 GS, 12 LN	GS-11
Belleau Wood (U.S.) Marine Monument (5)					
Ardennes American WWII Cemetery and Memorial, Neupre, Belgium	5,328	462	90.5	2 GS, 15 LN	GS-11
Audenarde Monument, Audenarde, Belgium (6)	...	...	0.4	...	...
Bellicourt Monument, St Quentin, Aisne, France	...	...	3.6	...	...
Brest Monument, Brest, Finistere, France (7)	...	...	1.0	...	...
Britany American WW I Cemetery and Memorial, St James, Manche, France	4,410	498	7.5	2 GS, 8 LN	GS-11
Brookwood American WW I Cemetery and Memorial, Brookwood, England	468	563	4.5	1 GS, 2 LN	GS-9

ABMC INSTALLATIONS

<u>Name &amp; Location</u>	<u>No. of Burials</u>	<u>Missing Memorialized</u>	<u>No. of Acres</u>	<u>No. of Employees</u>	<u>Highest Grade</u>
Cambridge American WW II Cemetery and Memorial, Cambridge, England	3,812	5,126	30.5	2 GS, 10 LN	GS-11
Cantigny Monument, Cantigny Somme, France (8)	...	...	0.4	...	...
Chateau-Thierry Monument, Chateau-Thierry, Aisne, France (8)	...	...	58.9	...	...
Epinal American WW II Cemetery and Memorial, Epinal, Vosges, France	5,255	424	48.6	2 GS, 10 LN	GS-11
Flanders Field American WW I Cemetery and Memorial, Waregem, Belgium	368	43	6.2	1 GS, 5 LN	GS-9
Henri-Chapelle American WW II Cemetery and Memorial, Henri-Chapelle, Belgium	7,989	450	57.0	2 GS, 15 LN	GS-11
Kemmel Monument, Ypres, Belgium (6)	...	...	1.6	...	...
Lorraine American WW II Cemetery and Memorial, St. Avoild, Moselle, France	10,489	444	113.5	2 GS, 19 LN	GS-12
Luxembourg American WW II Cemetery and Memorial, Luxembourg	5,076	371	48.7	2 GS, 10 LN	GS-11
Meuse-Argonne American WW I Cemetery and Memorial, Romagne-sous-Montfaucon, Meuse, France	14,246	954	130.5	2 GS, 16 LN	GM-13

ABMC INSTALLATIONS

<u>Name &amp; Location</u>	<u>No. of Burials</u>	<u>Missing Memorialized</u>	<u>No. of Acres</u>	<u>No. of Employees</u>	<u>Highest Grade</u>
Monifaucon Monument, Monifaucon, Meuse, France (10)	...	...	9.6	...	...
Montisc Monument, Thiaucourt, Meurthe and Moselle, France (11)	...	...	47.5	...	...
Netherlands American WW II Cemetery and Memorial, Margraten, Holland	8,302	1,723	65.5	2 GS, 16 LN	GS-11
Normandy American WW II Cemetery and Memorial, St Laurent, Calvados, France	9,387	1,557	172.5	2 GS, 20 LN	GM-13
Oise-Aisne American WW I Cemetery and Memorial, Fere-en-Tardenois, Aisne, France	6,012	241	36.5	1 GS, 12 LN	GS-11
Pointe du Hoc Monument Cricqueville-en-Bessin, Calvados, France (12)	...	...	29.8	...	...
Somme American WW I Cemetery and Memorial, Bony, Aisne, France	1,844	333	14.3	1 GS, 6 LN	GS-9
Sommepy Monument, Somme, Marne, France (10)	...	...	15.0	...	...
St. Mihiel American WW I Cemetery and Memorial, Thiaucourt, Meurthe, France	4,153	284	40.5	1 GS, 5 LN	GS-9

ABMC INSTALLATIONS

<u>Name &amp; Location</u>	<u>No. of Burials</u>	<u>Missing Memorialized</u>	<u>No. of Acres</u>	<u>No. of Employees</u>	<u>Highest Grade</u>
Suresnes American WW I Cemetery and Memorial, Suresnes, Seine, France (13)	1,565	974	7.5	1 GS, 5 LN	GS-9
Tours Monument, Tours, Indre-et-Loire, France (7)	...	...	0.5	...	...
Utah Beach Monument, Site Marie Du Mont, Calvados, France (12)	...	...	0.5	...	...

ABMC INSTALLATIONS

<u>Name &amp; Location</u>	<u>No. of Burials</u>	<u>Missing Memorialized</u>	<u>No. of Acres</u>	<u>No. of Employees</u>	<u>Highest Grade</u>
Mediterranean Installations	15,965	8,522	186.6	7 GS, 50 LN, 1MI	LT COL
Rome Office	...	...	...	5 LN, 1 MI	LT COL
Florence American WW II Cemetery and Memorial, Florence, Italy	4,402	1,409	70.0	2 GS, 14 LN	GS-11
Casablanca Marker, Casablanca, Morocco	...	...	...	...	...
Gibraltar, Monument, Gibraltar (14)	...	...	0.1	...	...
North Africa American WW II Cemetery and Memorial, Carthage, Tunisia	2,841	3,724	27.0	2 GS, 9 LN	GS-11
Sicily-Rome American WW II Cemetery and Memorial, Nettuno, Italy	7,861	3,095	77.0	2 GS, 16 LN	GS-12
Rhone American WW II Cemetery and Memorial, Draguignan, Var, France	861	294	12.5	1 GS, 6 LN	GS-9

ABMC INSTALLATIONS

<u>Name &amp; Location</u>	<u>No. of Burials</u>	<u>Missing MemorIALIZED</u>	<u>No. of Acres</u>	<u>No. of Employees</u>	<u>Highest Grade</u>
Asian Installations	17,206	36,282	182.6	2 GS, 31 LN	GS-13
Asian Office/Manila American Cemetery and Memorial Luzon, Philippines	17,206	36,282	182.0	2 GS, 31 LN	GS-13
Guadalcanal Monument, Guadalcanal, Solomon Islands (1)	...	...	0.5	...	...
Papua New Guinea Marker Port Moresby, New Guinea (15)	...	...	...	...	...
Saipan Monument, Saipan, Northern Mariana Islands (1)	...	...	0.1	...	...

ABMC INSTALLATIONS

<u>Name &amp; Location</u>	<u>No. of Burials</u>	<u>Missing Memorialized</u>	<u>No. of Acres</u>	<u>No. of Employees</u>	<u>Highest Grade</u>
<b>Latin Installations</b>	<b>6,607</b>	...	<b>17.0</b>	<b>2 GS, 8 LN</b>	<b>GS-9</b>
Latin Office/Corozal American Cemetery, Canal Zone, Panama	5,044	...	16.0	1 GS, 7LN	GS-9
Mexico City National Cemetery Mexico City, Mexico (16)	1,563	...	1.0	1 GS, 1 LN	GS-9
<b>GRAND TOTAL</b>	<b>130,771</b>	<b>94,120</b>	<b>1,611.8</b>	<b>1 ES, 1 SES, 52 GS, 309 LN, 5 MIL</b>	<b>EX SCH LEVEL IV</b>

## NOTES

- (1) Satelited on National Park Service
- (2) Satelited on City of New York for day-to-day care
- (3) Satelited on National Cemetery of the Pacific for day-to-day care
- (4) Satelited on Presidio of San Francisco for day-to-day care
- (5) Belleau Wood-Marine Corps Monument - Aisne Mamme Cemetery
- (6) Satelited on Flanders Field Cemetery for care
- (7) Satellite on Brittany Cemetery for care
- (8) Satelited on Somme Cemetery for care
- (9) Satelited on Aisne Mamme Cemetery for care
- (10) Satelited on Meuse-Argonne Cemetery for care
- (11) Satelited on St. Mihiel Cemetery for care
- (12) Satelited on Normandy Cemetery for care
- (13) Includes 24 Unknowns of World War II
- (14) Satelited on City of Gibraltar for day-to-day care
- (15) Satelited on Washington Office
- (16) Includes 813 non War Dead

FY 1996 VISITORS TO ABMC  
CEMETERIES, MONUMENTS, AND MEMORIALS

<b>U.S. INSTALLATIONS:</b>	<b>TOTAL:</b>	<b>4,932,950</b>	<b>MEDITERRANEAN INSTALLATIONS</b>	<b>TOTAL:</b>	<b>149,390</b>
East Coast Memorial	980,572		Florence Cemetery	36,663	
Honolulu Memorial	3,952,378		North Africa Cemetery	5,840	
			Rhone Cemetery	18,662	
			Sicily-Rome Cemetery	88,225	
				<b>TOTAL:</b>	<b>185,612</b>
<b>EUROPEAN INSTALLATIONS:</b>	<b>TOTAL:</b>	<b>4,289,813</b>	<b>ASIAN INSTALLATIONS:</b>		
Aisne-Mame	36,552		Manila American Cemetery	185,612	
Ardennes Cemetery	144,800				
Britanny Cemetery	140,990				
Brookwood Cemetery	4,084		<b>LATIN AMERICAN INSTALLATIONS:</b>	<b>TOTAL:</b>	<b>28,341</b>
Cambridge Cemetery	215,634		Corozal Cemetery	28,132	
Epinal Cemetery	49,455		Mexico City Cemetery	209	
Flanders Field Cemetery	11,456				
Henri-Chapelle Cemetery	665,075				
Lorraine Cemetery	179,800				
Luxembourg Cemetery	163,224				
Meuse-Argonne Cemetery	95,517				
Netherlands Cemetery	319,170				
Normandy Cemetery	2,162,200				
Oise-Aisne Cemetery	25,475		<b>TOTAL FY 1996 VISITORS:</b>	<b>9,586,106</b>	
Saint Mihiel Cemetery	53,203				
Somme Cemetery	5,458				
Suresnes Cemetery	17,920				

WORLD WAR II MEMORIAL PROJECT  
BACKGROUND and STATUS

President William J. Clinton signed Public Law 103-32 on May 25, 1993, authorizing the American Battle Monuments Commission (ABMC) to establish a World War II Memorial in Washington D.C. or its environs. It will be the first national memorial dedicated to all who served during the war, and will recognize the commitment and achievement of the entire nation.

The first step was to select an appropriate site using an open, cooperative process that followed all of the provisions of the law and all of the procedural steps regarding the placement of memorials in the nation's capital. Following nearly a year of careful consideration, the site recommended by the ABMC was approved by those entrusted by law with protecting and overseeing the use of public space on the National Mall.

Ultimately the merits of nine prominent locations were evaluated before the public agencies responsible for memorial oversight approved the Rainbow Pool, a 7.4 acre rectangular area at the east end of the Reflecting Pool between the Lincoln Memorial and the Washington Monument. The Rainbow Pool location is commensurate with the historical importance and lasting significance of World War II. As the defining event of the 20th Century, World War II is worthy of memorialization on the primary axis of the National Mall. Together, the Lincoln Memorial, Washington Monument and the World War II Memorial will symbolically recognize three of the most important transitions in our nation's history. The Revolutionary War represented by the Washington Monument, the Civil War represented by the Lincoln Memorial, and the Second World War represented by the World War II Memorial as the event that defined our nation as a world leader.

On November 11, 1995, President Clinton dedicated the site in a formal ceremony that concluded the commemorations of the 50th Anniversary of World War II. A plaque currently marks the future location of the World War II Memorial.

On January 17, 1997, President Clinton unveiled the winning design for the Memorial. The winner was selected through a two-stage, open competition modeled on the General Services Administration's Design Excellence Program. The design by Friedrich St. Florian, former dean of the Rhode Island School of Design, and a current Professor was selected from more than 400 submissions in a nationwide design competition. St. Florian's design was selected from among six finalists submissions that included four prominent design firms and a graduate student. The proposed design will now go through the normal Washington memorial review process. Teaming up with St. Florian are George E. Hartman, Hartman-Cox Architects, and Oehme van Sweden & Associates, Inc., both of Washington. Leo A. Daly will be the architect-engineer of record.

The \$100 million memorial will be funded through private donations. However, Congress authorized a total of \$4,767,000 for the memorial during Fiscal Years 1993, 1994, and 1995 from the surcharge proceeds of World War II Commemorative Coin sales. Also, the Department of Defense transferred \$5,000,000 for the memorial in Fiscal Year 1996 from funding authorized to commemorate the 50th Anniversary of World War II. ABMC Commissioners expect that all future funding will come from private contributions.

The American Battle Monuments Commission is working closely with the World War II Memorial Advisory Board to raise funds to meet the planned dedication on Veterans Day in the year 2000.

WORLD WAR II MEMORIAL PROJECT  
FUNDING SUMMARY

((\$000))

	1993	1994	1995	1996	1997	1998	1999	2000	2001
	Actual	Actual	Actual	Actual	Estimated	Estimated	Estimated	Estimated	Estimated

**Revenues & Expenses:**

	1993	1994	1995	1996	1997	1998	1999	2000	2001
	Actual	Actual	Actual	Actual	Estimated	Estimated	Estimated	Estimated	Estimated
<b>Revenues:</b>									
Coin Surcharge Proceeds	\$3,448	\$1,285	\$34	\$0	\$0	\$0	\$0	\$0	\$0
Investment Earnings	4	174	276	356	513	660	2,898	4,548	0
Private Contributions	1	4	8	10	10,000	50,000	43,530	0	0
DoD Transfer	0	0	0	5,000	0	0	0	0	0
<b>Total Revenues:</b>	<b>\$3,453</b>	<b>\$1,463</b>	<b>\$318</b>	<b>\$5,366</b>	<b>\$10,513</b>	<b>\$50,660</b>	<b>\$46,428</b>	<b>\$4,548</b>	<b>\$0</b>

**Expenses:**

Design & Construction *	\$0	\$0	282	\$289	\$3,049	\$4,497	3,500	88,665	0
Contract Services	0	0	177	301	3,520	5,807	4,800	1,400	0
Payroll & Benefits	0	68	58	81	1,035	1,263	1,263	800	400
Travel	0	3	58	4	84	271	271	150	0
Equipment	0	0	18	4	60	18	18	0	0
Office Expense	0	0	4	4	100	100	100	25	0
<b>Total Expenses:</b>	<b>\$0</b>	<b>\$71</b>	<b>\$539</b>	<b>\$943</b>	<b>\$7,848</b>	<b>\$11,956</b>	<b>\$9,952</b>	<b>\$91,040</b>	<b>\$400</b>
<b>Revenue Vs Expense:</b>	<b>\$3,453</b>	<b>\$1,392</b>	<b>-\$221</b>	<b>\$4,423</b>	<b>\$2,665</b>	<b>\$38,704</b>	<b>\$36,476</b>	<b>-\$86,492</b>	<b>-\$400</b>

**Fund Balances:**

Beginning of Year	\$0	\$3,453	\$4,845	\$4,624	\$9,047	\$11,712	\$50,416	\$86,892	\$400
Revenue Vs Expense	3,453	1,392	-221	4,423	2,665	38,704	36,476	-86,492	-400
<b>Total Fund Balance Year End:</b>	<b>\$3,453</b>	<b>\$4,845</b>	<b>\$4,624</b>	<b>\$9,047</b>	<b>\$11,712</b>	<b>\$50,416</b>	<b>\$86,892</b>	<b>\$400</b>	<b>\$0</b>

\* Design & Construction costs (including long term maintenance fund) estimated at \$100 Million.

STATEMENT OF H. MARTIN LANCASTER  
 ASSISTANT SECRETARY OF THE ARMY (CIVIL WORKS)  
 BEFORE THE COMMITTEE ON VETERANS' AFFAIRS,  
 HOUSE OF REPRESENTATIVES  
 ON THE FISCAL YEAR 1998 CEMETIERIAL EXPENSES, ARMY BUDGET  
 FEBRUARY 13, 1997

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

INTRODUCTION

I appreciate the opportunity to appear before the Committee in support of the Fiscal Year 1998 appropriation request for Cemeterial Expenses, Department of the Army. I am appearing on behalf of the Secretary of the Army, who is responsible for the operation and maintenance of Arlington and Soldiers' and Airmen's Home National Cemeteries. Accompanying me are Mr. Thurman Higginbotham, Deputy Superintendent, Arlington National Cemetery, and Mr. Steven Dola, Deputy Assistant Secretary (Management and Budget).

FISCAL YEAR 1998 BUDGET OVERVIEW

The request for Fiscal Year 1998 is \$11,815,000; \$215,000 more than the Fiscal Year 1997 appropriation. The funds requested are sufficient to support the work force, to assure adequate maintenance of the buildings, to acquire necessary supplies and equipment, and to provide maintenance standards expected at Arlington and Soldiers' and Airmen's Home National Cemeteries and include;

- < \$1,175,000 for replacement of the historic Custis Walk;
- < \$810,000 for construction of access roads associated with Columbarium Phase III; and
- < \$200,000 to further expand contracts for enhancing the appearance of the cemetery while implementing government-wide streamlining plans.

The first item is a significant commitment to complete a capital improvement project, which, when completed, will eliminate the heaving and cracks which affect 75 percent of the walkway.

The second item will allow the cemetery to make full utilization of Columbarium Phase III.

The third item continues the initiative begun in Fiscal Year 1996. In Fiscal Year 1996 these contractual services were increased by \$230,000, in Fiscal Year 1997 they were increased by an additional \$165,000, and in Fiscal Year 1998 they will be increased by \$200,000. Additional work will be performed by these contractors that was not done before and total personnel are being reduced from 128, to 121 and 117, respectively.

The funds requested are divided into three programs, Operation and Maintenance, Administration, and Construction. The principal items in each program are as follows:

The Operation and Maintenance Program, \$8,779,000, will provide for the cost of daily operations necessary to support an average of 20 interments and inurnments daily and for maintenance of approximately 630 acres. This program supports 111 of the cemetery's total 117 FTE's. Contractual services, including estimated costs associated with the million dollar grounds maintenance contract, the \$775,000 information and guide service contract, \$410,000 of contract tree and shrub maintenance, and a \$210,000 custodial contract, are estimated to cost \$2,947,000.

The Administration Program, \$599,000, provides for essential management and administrative functions to include staff supervision of Arlington and Soldiers' and Airmen's Home National Cemeteries. Funds requested will provide for personnel compensation, benefits and the reimbursable administrative support costs of the cemeteries.

The Construction Program, \$2,437,000, provides funds as follows: \$1,175,000 to replace the historic Custis Walk, \$810,000 to construct roads that originally were included as part of Phase III of the Columbarium, \$50,000 of minor road repair, \$350,000 for the graveliner program, and \$45,000 to prepare the final design for the Wash Stand/Fuel Island project.

#### FUNERALS

In Fiscal Year 1996, there were 3,325 interments and 1,733 inurnments; 3,500 interments and 1,900 inurnments are estimated in Fiscal Year 1997; and 3,500 interments and 1,900 inurnments are estimated in Fiscal Year 1998.

#### CEREMONIES

Arlington National Cemetery is this Nation's principal shrine to honor the men and women who served in the Armed Forces. It is a visible reflection of America's appreciation for those who have made the ultimate sacrifice to maintain our freedom. In addition to the thousands of funerals, with military honors, held there each year, hundreds of other ceremonies are conducted to honor those who rest in the cemetery. Thousands of visitors, both foreign and American, visit Arlington to participate in these events. During Fiscal Year 1996, about 2,700 ceremonies were conducted and the President of the United States attended the ceremonies on Veterans Day and Memorial Day.

During Fiscal Year 1996, Arlington National Cemetery accommodated approximately 4 million visitors, making Arlington one of the most visited historic sites in the National Capital Region. This budget includes \$35,000 for a study to develop an estimating procedure and reliable estimates of the kinds of visitors that Arlington National Cemetery serves. This increased orientation to our "customers" is consistent with the Government and Performance Results Act and the National Performance Review.

#### CONSTRUCTION PROJECTS

##### New Projects in Fiscal Year 1998

Custis Walk - The Custis Walkway was constructed in 1879 and is 2,500 feet long. Approximately 75 percent of the walkway is affected by heaving and cracks, requiring visitors to exercise additional care while using the walkway. The design for restoration/replace-ment has now been completed using Fiscal Year 1995 appropriations in the amount of \$250,000. Construction funding of \$1,175,000 is included in the Fiscal Year 1998 budget submission.

Columbarium - Columbarium roads associated with the Phase III increment are planned in Fiscal Year 1998 costing an estimated \$810,000.

##### Construction Projects Underway

Columbarium Phase III - On July 1, 1996, construction of one of two courts comprising Phase III of the Columbarium Complex began, bids for construction of the second court were opened on January 23, 1997. Construction funds were appropriated in Fiscal Year 1996 and 1997, respectively. The 11,286 niche combined capacity of the Phase III

increment will bring the total niches in the Columbarium Complex to 31,286. Phase I, completed in 1984, and Phase II, completed in 1991, each provided 10,000 niches. The additional 1,286 niche capacity of Phase III was achieved by increasing the square footage or "foot print" of each of the Phase III courts by 10 percent. In addition to providing more niches, the larger "foot print" permits inclusion of a needed rest room and mechanical/storage area into the North court of Phase III, and makes more efficient use of the site.

#### Recently Completed Construction Projects

**Amphitheater** - The repair of damage done by rainwater leaks at the Amphitheater and restoration of deteriorated marble there which were begun in July 1994 are now complete. The work included replacing waterproofing membranes; cleaning, patching and re-pointing stonework; replacing deteriorated marble and balusters; replacing benches, railings, drinking fountains, trash receptacles, signage and flagstone paving. The Memorial Amphitheater Restoration Project now provides a fitting place for ceremonies where public honor and recognition are accorded national heroes.

**Facilities Maintenance Complex** - A new facility maintenance complex was constructed to replace buildings constructed in the 1930's. The facility maintenance complex consists of work and storage areas for three divisions (Facility Maintenance, Horticulture, and Field Operations), in three separate buildings. There is another building for warehouse operations and a building for the administrative functions associated with all of these operations.

**McClellan Gate** - The work associated with restoration of the McClellan Gate has been recently completed. Work included removal and resetting of stone including some stone replacement, structural repairs, repointing, patching and cleaning of the entire arch, a new concrete ring foundation, new copper roofing and flashing, repair and painting of the iron gate, and new granite cobblestone paving around the arch.

#### MASTER PLAN

The new Master Plan, which currently is undergoing review within the Army Secretariat, will identify projects and policies to respond to the challenges confronting Arlington National Cemetery. These challenges include an aging infrastructure, declining availability of space for initial interment, and the need to preserve the dignity of the cemetery while accommodating substantial public visitation. The future projects envisioned in the master plan will not begin to be implemented until we are into the next century. Projects and policies must be measured against funding to be made available in the budget and appropriations processes. Detailed planning and engineering studies necessary to establish the cost, feasibility, and responsiveness of individual capital projects to the master plan challenges would be programmed and proposed to Congress, after review and consideration by the Administration, at the appropriate times.

#### ARMY - INTERIOR LAND TRANSFERS

Public Law 104-201, the National Defense Authorization Act for Fiscal Year 1997 ("1997 Authorization Act"), which was enacted on September 23, 1996, includes two land transfer provisions in Section 2821 relating to Arlington National Cemetery.

**Section 29 Land Transfer** - The first part of Section 2821 of the 1997 Authorization Act instructs the Secretary of the Interior to transfer to the Secretary of the Army certain lands found in Section

29 of Arlington National Cemetery. The land found in Section 29 is currently divided into two zones: the 12 acre Arlington National Cemetery Interment Zone and the 12.5 acre Robert E. Lee Memorial Preservation Zone. The transfer encompasses the Arlington National Cemetery Interment Zone and the portions of the Robert E. Lee Memorial Preservation Zone that do not have historical significance and are not needed for the maintenance of nearby lands and facilities.

The Secretary of the Interior is to base his or her determination of which portion of the Preservation Zone will be transferred primarily on a cultural resources study that will consider whether archaeological resources are likely to be located on the land, whether portions of the property are eligible for inclusion in the National Register of Historic Places, and whether the property has forest cover that contributes to the setting of the Preservation Zone. The cost of the study, estimated at \$85,000, will be split evenly between the Department of Interior and the Department of the Army. In addition, the Secretary of the Interior will provide the Committee on Armed Services of the Senate and the Committee on National Security of the House of Representatives with environmental and cultural resource information and analysis.

The transfer, which is to be carried out under the Interagency Agreement Between the Department of the Interior, the National Park Service, and the Department of the Army, dated February 22, 1995, is to occur not sooner than 60 days after the Secretary of the Interior has submitted the information and analysis to the Committees. The Secretary of the Interior must provide the information and analysis to the Committees no later than October 31, 1997.

Visitors Center/Old Administration Building - The second part of Section 2821 of the 1997 Authorization Act instructs the Secretary of the Interior to transfer to the Secretary of the Army 2.43 acres of land and the Visitor's Center, which is constructed on the land. In return, the Secretary of the Army will transfer to the Secretary of the Interior .17 acres of land and the Old Administration Building, which is constructed on the site. Section 2821 provides the authority by which this agreed-upon exchange of lands may take place.

#### CONCLUSION

The funds included in the Fiscal Year 1998 budget are necessary to permit the Department of the Army to continue the high standards of maintenance Arlington National Cemetery deserves. I urge the Committee to support this request.

Mr. Chairman, this concludes my remarks. We will be pleased to respond to questions from the Committee.

STATEMENT OF THE HONORABLE SANFORD D. BISHOP, JR  
FY 98 VETERANS AFFAIRS BUDGET  
FEBRUARY 27, 1997

Good Morning, Mr. Chairman, Mr. Evans, members of the Committee, distinguished panelists and guests. It is a pleasure to be here today to hear the testimony of the United States Court of Veterans Appeals and a number of our Veterans Service Organization.

I want to thank Judge Nebeker for his hard work at the Court of Veterans Appeals. The Court, like other entities, is faced with the reality of doing more with less. I understand that the Court is experiencing an increase in the number of appeals, and I am hopeful that we will be able to craft fiscally sound budget solution which will adequately address this issue.

I also want to thank the Veterans Service Organizations for presenting their views and recommendations on the Fiscal Year 1998 budget for Veterans Affairs. I commend you for your efforts in crafting the Veterans Service Organizations' Independent Budget. You have crafted a very good document which addresses major concerns of the veterans community. Additionally, I compliment you on your reverence for humanity and the unifying symbol for which you stand. There are not better words to describe your work than sacrifice, experience, respect, vision, influence, compassion and enthusiasm.

Many of you were present at last committee hearing in which Secretary Brown presented the Administration's Fiscal Year 1998 VA Budget. As you may recall, I expressed concern about various aspects of the budget. I think the Independent Budget is moving in the right direction by recommending increased levels of funding for veterans health programs. While I recognize that we must be more fiscally responsible in tough budgetary affairs, we must be reasonable and equitable in the approach we take in dealing with health problems of our Nation's veterans. I am concerned about the Administration's reliance on enactment of certain legislative proposals to supplant appropriations. Additionally, I believe viable alternatives must be presented to address any shortcomings which may occur if the recommended legislative proposals falter.

The Independent Budget also adequately points out many of the problems which will occur with a number of staff reductions in various Veterans Department agencies. Our ultimate goal must be to ensure that our veterans receive a high degree of care and service. The types of reductions contained in the administration's budget could seriously hamper these efforts. Again, I know that we must make tough fiscal choices. However, we must do so without putting the well-being of those who sacrificed their lives in jeopardy.

As our veterans population continues to age, I am concerned that reductions in grants for state extended care facilities is reduced in the President's budget. This program is very important to many of our older veterans and provides them with a

much needed service. I agree with your conclusion that the funding level should be increased.

The federal budget should target additional funding for improving the veterans education benefit. It is critically important that our veterans have the necessary educational benefits so that they can gain beneficial skills to help them transition more smoothly into the work force. I agree with your assertion that additional funds should be targeted to the veterans education benefit.

During the last Congress, we fought an uphill battle trying to obtain adequate levels of funding for Veterans Affairs. I hope we will be able to agree on an appropriate level of VA funding which will serve the best interests of the veterans population. The Independent Budget provides an additional blueprint from which we can glean information to develop our final Veterans Affairs budget. I look forward to working with all of you to achieve this goal.

Honorable Jack Quinn  
Remarks  
Hearing on the Independent Budget  
February 27, 1996

Mr. Chairman, I am pleased we were able to reschedule the fiscal year 1998 budget testimony of the veterans service organizations. The Independent Budget is an important document to our deliberations on funding for VA programs. I would like to acknowledge the effort that goes into the budget and to assure them we will continue to use it throughout the year.

I am very concerned that the President's budget does not have an increase in the GI Bill benefit level. I know that the Chairman and Ranking Democratic Member have sent a letter to the President offering to work with him to improve the GI Bill. I urge the President to act quickly in this matter.

I am also pleased that for the first time, the Independent Budget addresses funding for the Veterans Employment

and Training Service. Job placement is the only benefit available to every veteran. And at a time when the American industrial base is in the midst of radical change, employment services may be the difference between a veteran taxpayer and a homeless veteran.

We all know that the federal budget is tight and the chances of adding the six billion dollars above what the President has requested as suggested by the Independent Budget are not great. But what I will pledge to you is that we will work with you to make the most of every dollar given to the VA and VETS. As Chairman of the Subcommittee on Benefits I look forward to regular meetings with the veterans service organizations so that together, we can meet America's commitment to its veterans.

SILVESTRE REYES  
16TH DISTRICT, TEXAS  
COMMITTEE ON NATIONAL SECURITY  
SUBCOMMITTEE ON  
MILITARY INSTALLATIONS AND FACILITIES  
SUBCOMMITTEE ON  
MILITARY RESEARCH AND DEVELOPMENT  
COMMITTEE ON VETERANS' AFFAIRS  
SUBCOMMITTEE ON BENEFITS



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February 27, 1997

The Honorable Bob Stump  
U.S. House of Representatives  
Committee on Veterans' Affairs  
335 Cannon House Office Building  
Washington, D.C. 20515

Dear Chairman Stump:

I wish to inform the committee that due to a family emergency I am unable to be present for today's hearing on the Veterans fiscal year 1998 budget. My mother took ill this past Tuesday evening and had to be hospitalized. Consequently, I immediately left for El Paso to attend to her and my family.

Please know that under all other circumstances I would be in attendance, especially as we convene to review the important matters involving the Department of Veterans' Affairs budget. My legislative assistant will be present at the hearing and has been instructed to apprise me of the testimony and all other matters coming before the committee.

Thank you for your consideration, along with that of the other members of the committee.

Sincerely,

A handwritten signature in black ink that reads "Silvestre Reyes". The signature is written in a cursive style with a long horizontal stroke at the end.

Silvestre Reyes  
Member of Congress

SR/mk

FOR RELEASE ON DELIVERY  
Expected at 9:30 A.M. EST  
February 27, 1997

STATEMENT OF  
HONORABLE FRANK Q. NEBEKER  
CHIEF JUDGE, U.S. COURT OF VETERANS APPEALS  
FOR PRESENTATION BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
U.S. HOUSE OF REPRESENTATIVES  
FEBRUARY 27, 1997

MISTER CHAIRMAN AND DISTINGUISHED MEMBERS OF THE COMMITTEE:

On behalf of the Court, I appreciate the opportunity to present for your consideration the fiscal year (FY) 1998 budget of \$9,379,804 for the United States Court of Veterans Appeals.

The Court's total FY 1998 budget request contains the same dollar amount for personnel and operations as in the Court's FY 1997 appropriation. It also includes \$850,804 requested by the Pro Bono Representation Program (Program), which is 121.5% of the \$700,000 appropriated for FY 1997. The Program has provided its own supporting statement for its budget request.

Last year I urged that the Pro Bono Representation Program be authorized and funded outside the Court's appropriation. I outlined the reasons for the Court's concerns with the continued inclusion of the Program's funding in the Court's appropriation. The Court continues to be of the view that such a funding method impermissibly links the Court to one class of litigants, and thereby exposes the Court to an appearance of partiality and a consequent erosion in the public's trust and confidence in the judicial review of veterans' claims. I ask again that the funding for the Program be separated from the Court's appropriation, not only in the budget deliberations in Congress, but in the actual budget enactment.

Notwithstanding these reservations, and consistent with Congress' direction, the Court is forwarding the Program's FY 1998 request for \$850,804 as an appendix to the Court's submission and, consistent with that direction, is including that amount in the Court's total FY 1998 budget request. The Legal Services Corporation administers the grants for the Program and, according to its evaluations, the Program is working the way it should. The Program has provided its own supporting statement for its budget request, which, as noted, represents a 21.5% increase over the \$700,000 appropriated for FY 1997.

The Court has kept a flat budget by continuing a number of cost-saving measures, including a 25% reduction in the budget allotted for travel, with no funding requested for Court hearings outside Washington. Also, as I stated in my testimony last year, the Court now is holding its judicial conference every other year, rather than annually. This event focuses on continuing education for the Court's practitioners and is held locally. Of even more significance, the Court is requesting funding for only 79 full-time equivalent (FTE) positions in FY 1998 which is a voluntary reduction of 2 FTE positions from the FY 1997 authorized FTE level, and matches the FY 1998 FTE target level recommended by the Office of Management and Budget in its implementation of the National Performance Review. The requested 79 FTE positions are required to maintain high-quality service to litigants seeking judicial review, particularly those who come to the Court unrepresented.

As the Court's budget statement illustrates, in a chart the Clerk has compiled, after a drop in number of appeals in FY 1994, the numbers have continued to climb in FY 1995 and FY 1996, and the upward trend seems to be continuing. The number of denials by the Board of Veterans' Appeals, from whose decisions the Court's appeals derive, increased from 6400 appeals in FY 1995 to 10,455 appeals in FY 1996. Furthermore, as noted in the Court's budget submission, the statistics kept by the Board of Veterans' Appeals (Board) on "denials" do not include Board decisions that deny some, but not all, of the benefits sought. The denials in such cases are also appealable to the Court. Thus, the number of pending cases may continue to increase at an even greater rate than is predictable as a set

percentage of the number of full Board "denials." The percentage of unrepresented appeals has fallen from 80% in FY 1995 to 72% in FY 1996. However, this rate remains much higher than the 46% unrepresented civil appeal rate in U.S. courts of appeals. While the Court has, voluntarily, kept pace with the recommendations of the National Performance Review, which propose an 11.5% FTE reduction over six years, further reductions in staff may need to be re-evaluated based on the likelihood of an increased caseload and a percentage of pro se appellants that continues to be relatively high.

It is my understanding that the Independent Budget Veterans Service Organizations (IBVSOs) have reached similar conclusions as to increasing caseload in the chapter on the U.S. Court of Veterans Appeals in their *Independent Budget for Fiscal Year 1998*. The IBVSOs document a presently rising caseload and oppose downsizing of the Court for that reason.

On another matter, I am appending to this testimony a copy of my letter to Chairman Stump emphasizing the importance of passing Title II of the legislative proposal submitted last year to make the Court's retirement/survivor program comparable to the systems of other Article I Courts. As I point out in my letter, the legislative proposal was initially submitted in response to Congressional inquiries regarding the Court's caseload relative to the requisite number of judges on the Court and regarding the comparability of the Court's judicial retirement/survivor program. Following last year's transmittal, there was an increase in the number of notices of appeal filed with the Court, and a consequent increase in the number of pending cases. Some veterans service organizations have either opposed enactment of Title I or, more cautiously, favored a "wait and see" approach to it. I am aware of no negative comments with regard to the largely administrative provisions of Title II.

I ask for your active support in obtaining enactment of Title II to make the Court's retirement/survivor program more comparable with other Article I Court programs. Because of Judge Hart Mankin's death in May 1996, his widow, Ruth Mankin, is now a

survivor under the Court's survivor annuity program. Survivors under the Court's annuity program are at a considerable disadvantage, over time, in comparison to the survivors of other deceased Article I judges covered by the Survivors' Annuity Systems enacted to provide such benefits to them. I ask that you take expeditious action to enact Title II, which is estimated to be without actuarially significant cost impact and without any appropriations impact.

In conclusion, I appreciate this opportunity to present the Court's budget request for fiscal year 1998. On behalf of the judges and staff, I thank you for your past support and request your continued assistance and favorable report to the Appropriations Committee on our budget request. I, or those with me, will be pleased to answer any questions you may have.

FACT SHEET  
UNITED STATES COURT OF VETERANS APPEALS

- Came into being on November 18, 1988, when the Veterans' Judicial Review Act became effective.
- Is a federal appellate court, created under article I of the U.S. Constitution to exercise judicial power of the United States and is not part of VA.
- Is not a trial court that can hear evidence and find fact so as to grant benefits outright.
- Is authorized to have a chief judge and six associate judges.
- Is located at 625 Indiana Avenue, NW, in Washington, DC.
- Began operations on October 16, 1989, when the first two associate judges were sworn in.
- Has jurisdiction to hear appeals from final decisions of the Board of Veterans' Appeals denying claims for veterans benefits.
- Judges of the Court are bound by Code of Conduct for United States Judges and may obtain advisory opinions on the application of the Code from the Judicial Conference Committee on Codes of Conduct.
- Judges of the Court file financial disclosure reports with the Administrative Office of the U.S. Courts.
- Judges of the Court are bound by the provisions of 28 U.S.C. § 372(c), governing judicial discipline and disability. See 38 U.S.C. § 7253(g).
- The Court's budget, by statute, must be included in the budget of the President without review within the executive branch. See 38 U.S.C. § 7282(a).
- May issue decisions by single judge, panel of three judges, or en banc; only three-judge and seven-judge decisions establish precedent binding on the Court and the VA for all similar cases.
- Reviews the record for error in appealed cases to ensure BVA adherence to the Constitution, statutes, and DVA regulations.
- Must, by statute, remand a case to the Board where error is found; only in a few cases does the Court direct grant of the benefits sought.
- Remands about 50% of the cases decided on the merits due to Board error.
- Has an average of over 70% of its appellants file an appeal unrepresented by counsel.

USCVA, 2/27/97

STATEMENT OF  
JOHN C. BOLLINGER, DEPUTY EXECUTIVE DIRECTOR  
PARALYZED VETERANS OF AMERICA  
BEFORE THE  
HOUSE COMMITTEE ON VETERANS' AFFAIRS  
CONCERNING  
*THE INDEPENDENT BUDGET*  
AND THE PRESIDENT'S BUDGET REQUEST TO CONGRESS  
FOR FISCAL YEAR 1998

FEBRUARY 27, 1997

Mr. Chairman, Ranking Democratic Member Evans, and members of the Committee, the Paralyzed Veterans of America (PVA) is honored to be here today on behalf of the *Independent Budget* to present our views on the fiscal needs of the Department of Veterans Affairs (VA) Health Care system. 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 *Independent Budget*. This year will mark the eleventh year of the *Independent Budget*, a budget that addresses the true fiscal and policy needs of the VA. This year, as in past years, PVA has utilized our expertise in the Medical Programs section of the *Independent Budget*, and it is in this area that I will address my remarks.

PVA is disheartened and dismayed over the cuts to VA medical care funding contained in the President's budget for fiscal year (FY) 1998, released on February 6, 1997. The President's budget request is the first in recent history to decrease funding for veterans' health care programs. The President's request of \$16.959 billion is \$54.6 million less than the FY 1997 medical care budget of \$17.008 billion.

This cut in funding for VA medical care, a cut to a level that is proposed to be maintained through the year 2002, will come at a time when the VA faces the daunting prospect of treating an increasingly elderly population of veterans in need of care. In addition, this proposed cut, a cut only magnified by the proposed flat-lining of VA funding through the year 2002, comes during a time when the VA must shift already limited funding from the North and Mid-West to the South and Western areas of our country.

The President's budget purports to increase funding, but only if all the proposed legislation is passed by Congress, and enacted, and only if the estimates are correct. The President's budget relies upon private -sector health insurers to make up for the shortfall in funding that will occur if Congress grants the President's request. The President's budget request assumes that Congress will pass legislation to allow the VA to retain third-party reimbursements and Medicare dollars, a willingness that Congress has not shown in the past.

PVA, and the other *Independent Budget* co-authors, have long championed the idea of outside funding sources, such as reimbursements from private insurers and reimbursements from Medicare, as a supplement to regular appropriations. These outside funding sources should serve as a supplement to regularly appropriated dollars, not as a substitute for regularly appropriated dollars. These supplemental monies, if indeed the President's legislative proposals are enacted, must not serve as a substitute for a lack of fiscal commitment by this Nation to veterans.

If the President's budget request is enacted without the accompanying legislative proposals, this request could violate the provisions of P.L. 104-262, the Veterans' Health Care Eligibility

Reform Act of 1996, which requires the VA to maintain its capacity and current level of services for specialized services, such as Spinal Cord Dysfunction medicine, as of enactment, October 9, 1996. In fact, without enactment of the legislative proposals, the President's request calls for a decrease of \$18 million for the provision of rehabilitative care alone, and estimates that fewer patients will be treated. Even if the legislative proposals are enacted and the estimates for the amount of monies collected are accurate, these retentions will only equal \$14 million for rehabilitative care. The President's request would seem to be a violation, not only of the letter, but of the spirit of P.L. 104-262.

The *Independent Budget* recommends that Congress authorize a \$19.591 billion budget for VA medical care. For the VA just to maintain current services, \$18.044 billion would be necessary, an amount still substantially well above the President's request of \$16.959 billion. The *Independent Budget* recommendation of an additional \$1.55 billion over the estimated current services level is premised upon the additional monies that will be necessary to realize the goals for increasing VA workload, specifically the goal of achieving a 20 percent increase in veterans' workload by the year 2002, enunciated by VA Undersecretary for Health, Kenneth Kizer, M.D..

During the past three fiscal years the VA budget has increased, while workload has remained static, or even declined. Workload has only significantly increased in VA outpatient clinics. The co-authors of the *Independent Budget* have estimated the cost of increasing workload based upon the system's capacity in various care settings. For contracted services this capacity is infinite. VA hospitals, according to occupancy rates for current operating beds, can also handle significant additional workload without augmenting VA's indirect costs (for overhead expenses, training, and other "constant" costs). VA's clinics and nursing homes, according to waiting lists and occupancy rates, are at capacity. Where VA services are at capacity, the VA must create new space and resources to serve veterans. This requires additional indirect costs and additional construction costs for building or leasing space. The *Independent Budget's* recommended medical care and construction budgets reflect these adjustments.

The President has recommended \$234 million for medical and prosthetic research. This represents an unprecedented decrease of \$28 million from FY 1997. At the same time that funding for the National Institutes for Health (NIH) is proposed to be increased by \$340 million there is movement afoot, especially in the Senate, to go even further by increasing NIH funding by 7.5 percent for FY 1998, and to double the NIH budget within five years. The *Independent Budget* recommends an appropriation of \$292 million, an increase of \$30 million over FY 1997. The *Independent Budget* estimates that \$272 million is necessary for current services. The additional \$20 million in the request is to make up for past shortfalls and to assist in transforming VA research efforts into Designated Research Areas of importance to the veteran community in such areas as Spinal Cord Injury research. VA research has suffered years of inadequate funding. If the VA is to meet its duty to veterans, and its duty as outlined in statute, then medical, rehabilitation, and health services research must not be forgotten. If the President's request is honored, the VA research enterprise would suffer a devastating blow directly affecting the present and future quality of care for veterans.

The President's budget requests \$60 million for Medical Administration and Miscellaneous Operating Expenses, a decrease from the \$61 million provided in FY 1997. The *Independent Budget* requests \$64 million. The *Independent Budget* estimates that \$63 million is needed to maintain the level of current services. The additional \$1 million is needed to provide funding for necessary training and education.

The VA medical system must be afforded full and adequate funding during this period of revolutionary changes. With the VA just beginning to operate under an eligibility reform environment, progression of developing efficiencies, and the possibility of attracting and retaining alternative funding streams, the VA will become a more cost effective care-giver. But this will not happen overnight. Now is not the time to slash the budget and consider the job done.

The *Independent Budget* in the past has argued that the VA can realize efficiencies, and ultimately save taxpayer dollars. But with the President's request to cut funding now, cap the budget through 2002, and rely upon un-enacted legislative proposals to somehow "make up the difference" is just far too drastic. We would essentially be forced to perform surgery on the VA before the diagnosis is even completed. We call on Congress to provide the VA medical care system with full and adequate funding, funding that is essential as the VA takes its first steps along the road to remaking itself into a system that can meet the challenges of this decade, and this coming century, and can provide the best health care to veterans, health care that is efficient, yet does not regard saving money at the expense of caring for veterans as its highest calling.

We call on this Committee and this Congress to pass legislation allowing the VA to collect and retain all reimbursements and third-party payments. The VA needs these funds to supplement an adequate core appropriation that fully meets the needs of all veterans who were granted health care service by P. L. 104-262, signed by the President last year. The *Independent Budget* also supports allowing the VA to treat adult dependents of veterans who would bring their insurance dollars and co-payments into the system as well. We support allowing the VA to collect Medicare reimbursements from not otherwise eligible veterans with Medicare coverage. All of these "alternative funding streams" are long-standing recommendations of the *Independent Budget*. It is certainly far from clear as to whether the VA is currently equipped or able to develop the systems to collect all it should from third-parties as efficiently as it could in time for FY 1998 requirements. Even if the full estimate of \$591 million less \$123 million in administrative costs could be collected, this amount would still not be enough given an *Independent Budget* current level of services estimate of \$18.405 billion for FY 1998. Additionally, while we strongly believe that VA care can provide a cost-effective benefit that can save the Medicare trust funds a great deal of money, it will take time for the VA and the Health Care Financing Administration to develop the necessary uniform pricing and billing procedures. These things will take time to implement and to maximize their full potential to the system.

The federal government must not sacrifice VA health care to untried legislative proposals purely to reduce federal expenditures on paper when the health, the well-being, and the lives of veterans are at stake.

Thank you for this opportunity to testify. I will be happy to answer any questions you might have.

Pursuant to House Rule XI 2(g) (4) the following information is provided regarding federal grants and contracts:

Fiscal Year 1995

Department of Justice - Joint venture to produce procedures implementing the Americans with Disabilities Act (ADA) through certification of building codes \$25,000.00

Department of Veterans Affairs - donated space for veterans' representation \$869,519.26

Court of Veterans Appeals, administered by the Legal Services Corporation - National Veterans Legal Services Project \$240,286.

Fiscal Year 1996

General Services Administration - Preparation and presentation of seminars regarding implementation of the Americans with Disabilities Act (ADA) \$25,000

Federal Elections Commission - Survey accessible polling sites resulting from the enactment of the Voting Access for the Elderly and Handicapped Act of 1984, PL 98-435 \$10,000

Department of Veterans Affairs - donated space for veterans' representation \$897,522.48

Court of Veterans Appeals, administered by the Legal Services Corporation - National Veterans Legal Services Program \$200,965.

Fiscal Year 1997

Architectural and Transportation Barriers Compliance Board (ATBCB) - Develop illustrations for an Americans with Disabilities Act (ADA) technical compliance manual \$10,000

Department of Veterans Affairs - donated space for veterans' representation \$224,380.62 (as of 12/31)

Court of Veterans Appeals, administered by the Legal Services Corporation - National Veterans Legal Services Program \$37,125 (as of 12/31).

## CURRICULUM VITA

**John Bollinger**

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 Office: Paralyzed Veterans of America  
 801 18th Street, NW  
 Washington, DC 20006

*Education*

B.A. Economics, Muskingum College, 1968

*Professional Experience.*

1992 - present	Deputy Executive Director Paralyzed Veterans of America
1990 - 1992	National Advocacy Director Paralyzed Veterans of America
1987 - 1990	Associate Director of Legislation Paralyzed Veterans of America
1986 - 1987	Assistant to the Administrator of Veterans Affairs Department of Veterans Affairs
1972 - 1986	Veterans Benefits Department Department of Veterans Affairs

*Organizations*

Trustee - Paralyzed Veterans of America Spinal Cord Research Foundation (SCRF)  
 Board Member - Paralyzed Veterans of America Education and Training Foundation (ETF)  
 Member of Executive Board - President's Committee on Employment of People with Disabilities (PCEPD)  
 Board Member - National Spinal Cord Injury Hotline

*Military*

United States Navy, retired in 1970



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Statement of  
Michael E. Naylor  
AMVETS National Executive Director  
before the  
Committee on Veterans' Affairs  
of the  
U.S. House of Representatives  
on the  
Independent Budget for the  
Department of Veterans Affairs  
for fiscal year 1998

Thursday, February 27, 1997  
Cannon House Office Building  
Room 334

Mr. Chairman, I am Colonel Michael E. Naylon, National Executive Director of AMVETS, The American Veterans of World War II, Korea and Vietnam. We are grateful to you and the committee for this opportunity to testify before you today. Neither AMVETS, nor myself, have received any federal grants or contracts during FY97 or in the previous two fiscal years.

We view the Independent Budget as a factual analysis of the realistic funding required by the Department of Veterans Affairs to adequately carry out the many roles and missions designed to meet the needs of America's veterans. We urge this committee, the Congress and the administration to support the VA's efforts at reorganization and refocusing of its health care delivery system by sparing the agency, and the veteran, from unreasonable reductions in order to balance the budget.

AMVETS' testimony today primarily addresses the National Cemetery System (NCS). America's National Cemetery System (NCS) has a long and proud history of service to America's veterans and their families. Many of the individual cemeteries within the system are steeped in historical memorabilia which represents the very foundation of these United States. The National Cemetery System, its land, its monuments, and the historical interments within are a national treasure that must be protected, maintained, and nurtured.

Unfortunately, despite NCS's continued high standard of service and despite a true need to protect and nurture this national treasure, and despite the administration's proposal for a \$7 million increase in budget authority over FY 97 levels, we feel the system has been and continues to be under funded. The current and future requirements of NCS are simply not being adequately funded to meet the current or anticipated demands.

#### **The System**

The National Cemetery System (NCS) assumed its current posture as an independent benefit provider within the Department of Veterans Affairs pursuant to Public Law 93-43. Its mission is to provide deceased veterans and deceased active duty members of the armed forces, their spouses and certain dependents a last resting place of dignity based on their service to this country. For over 100 years, NCS has performed this mission and to date maintains some 2,148,000 gravesites for veterans and their dependents.

Veterans Service Organizations are concerned with the future of NCS due to the depletion of gravesites available in many of its cemeteries. While some facilities are able to accept the remains of those who chose cremation, the facts are as follows:

- Currently only 57 of the 114 (or 50 percent) national cemeteries remain open with burial plots.
- By the year 2000, it is projected that only 53 cemeteries will be accepting full casket first interments.
- During fiscal year 1996, NCS had approximately 360,000 gravesites available (that is 27,500 less than FY1995), with the ability to add 1.6 million additional grave sites on undeveloped land.

As the veteran population ages, the workload of the NCS will continue to increase in all program areas. Based on the 1990 census, annual veteran deaths are expected to peak at 620,000 in 2008. Given the current and projected death rates in the veteran population, NCS' capability will fall far short of requirements to provide burial spaces for those veterans who seek burial in a national cemetery. A veterans right to burial in a national cemetery was affirmed by public law 93-43, The National Cemeteries Act of 1973. We ask you, the lawmakers, to ensure that the dictates of that law are met, and that burial space is available for those veterans who request it.

It should be noted that historically only about 10% of eligible veterans seek interment in a NCS facility. Despite this seemingly low demand rate, if funding is not forthcoming for new acquisitions and development of existing land, the legal entitlement will be an empty promise, as veterans are denied access based on non-availability.

The non-availability of NCS burial sites is compounded when geographical limitations are considered. An example of geographical limitations is illustrated by the veteran and his family who live in San Francisco, California. The nearest available burial space for that veteran is available at San Jocuquin Valley, approximately 100 miles east of San Francisco. We, the authors of the IB continue to feel it practicable that every veteran have the availability of burial space in a national cemetery or state-supported veterans cemetery within 75 miles of his or her home.

On a more positive note is the projected opening of the new national cemeteries in Dallas, Chicago and Albany. Here again, the need for \$1.8 million activation monies is paramount in FY 1998. The IB also lauds the expansion of the Ft. Sam Houston and Arizona National Cemeteries. The projected funding of \$9.4 million for Fort Sam Houston and \$9.1 million for Arizona will provide burial space for veterans in Texas and Arizona for several decades to come.

#### **NCS Shortfalls**

Prior IB's have been complimentary of NCS's management in spite of the budget shortfall and understaffing they continue to incur. We may only hope they are able to meet future challenges as they face a shortfall of 276 FTEEs (Full Time Employee Equivalents) in fiscal year 1998. NCS has, for too many years, been forced to delay new equipment purchases and maintenance and repair projects, making it difficult to provide basic services at an acceptable level. NCS anticipated that by the end of fiscal year 1994 their equipment replacement backlog would be \$4.8 million. Now, three years later, NCS is looking at an estimated backlog in obsolete equipment and equipment in need of repair of \$6.5 million by the end of fiscal year 1997. This equipment maintenance backlog shortfall of FY 97 is a 35% increase in three short years. The problem continues to compound, and worsen. Less dollars, more deadline equipment, less efficient work, less service to veterans.

#### **Secondary Missions**

The state grant program for veterans cemeteries continues to provide a cost-effective alternative in providing burial space for veterans. The IBVSO's are pleased that in FY 1996 NCS provided grants to 11 states totaling \$7.5 million. One way to ensure that veterans are provided a dignified burial is to ensure

adequate funding of the grants program. We recommend that VA provide at least \$5 million additional in such grants in fiscal year 1998.

NCS is projecting that they will process 351,000 applications for headstones or markers during fiscal year 1998. This, coupled with an estimated request for 250,000 Presidential Memorial Certificates, substantiates the need for improved ADP equipment.

ADP improvements, equipment backlogs on repair, maintenance, new equipment, staff position shortfalls, new and expanded facilities for burials, and the preservation of a national treasure, all require proper funding. The funding comes from the Congress and the Administration. When the veteran was asked to serve, he and she did so willingly, immediately, with pride, and without question. When the veteran or his/her family comes to the NCS to ask for his final entitlement, a dignified burial space, NCS should have the resources to provide that space willingly, immediately, with pride and without question. Not "sorry, no vacancy." The Congress and the president documented, in Public Law 93-43, the American peoples' wish that a veteran be provided a dignified last resting place. The only way to ensure that happening is for Congress to authorize and appropriate the needed resources.

Therefore our recommendations are:

- VA should add at least 60 more FTEEs over the 1997 level to cover incremental workload increases and maintain current services. Although 60 FTEEs are required just to maintain the current line of services, it is important for you to note that there is still a shortfall of nearly 270 FTEEs.
- VA should provide at least an additional \$4 million in funding to reduce equipment backlog.
- The IBVSO's again ask VA to begin a feasibility study to promote a second national cemetery to ease the demand for space at Arlington National Cemetery. While the IBVSOs understand that it is not possible to duplicate the national appeal of Arlington, the VA should pursue a second site of national significance properly promoted and placed. Ft. Myer and Henderson Hall offer potential land mass for expansion of Arlington, as an alternative to this recommendation.
- VA should aggressively pursue an open cemetery in each state.
- VA should actively expand existing national cemeteries wherever possible.
- VA should recommit to a policy of an open national cemetery within 75 miles of 75 percent of America' veterans.
- VA should seek relief from historic preservation requirements at NCS facilities wherever appropriate.

These recommendations cost out at approximately \$85,550,000 which represents a \$1,367,000 increase over the FY98 VA budget request of \$84,183,000.

Mr. Chairman this concludes my statement.



**Michael E. Naylor**  
**AMVETS**  
**National Executive Director**

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Michael E. Naylor assumed his duties as AMVETS national executive director on September 30, 1996. In this capacity, he administers the policies of the nation's fourth largest veterans service organization, supervising its national headquarters operation and providing direction as needed to state and local components.

Prior to joining AMVETS, Mr. Naylor served as director of operations of the National Association of Retired Federal Employees, a Washington-based 501(c) association. His senior management experience also includes serving as office manager of the National Machine Tool Builders Association for 8 years, director of employment at the University of Rochester (N.Y.), manpower administrator of the city of Rochester and director of personnel for the Rochester division of Interstate Brands Corporation.

A retired U.S. Army colonel with 30 years' service, Mr. Naylor held a number of high level positions during his career, most notably in the Pentagon. Here, he was assigned as branch chief for the Army Reserve from 1983 to 1987, after which time he served as Reserve director for the Joint Chiefs of Staff until 1989. Following a year-and-a-half assignment with the U.S. Southern Command in Panama, Colonel Naylor returned to the JCS as senior Reserve director and over the next 5 years developed strategic plans and policy for the Defense Department's deployment of Reserve components in contingency operations.

Mr. Naylor is a graduate of the U.S. Army War College. Among his awards and decorations are the Legion of Merit, the Joint Meritorious Service Medal with oak leaf cluster and the Meritorious Service Medal.

A resident of Reston, Va., Mr. Naylor holds a bachelor of arts degree from John Carroll University in Cleveland and a masters degree in business administration from Marymount University in Arlington, Va. Currently, he is a candidate for a masters degree in public administration from George Mason University in Fairfax, Va.

**AMVETS National Headquarters**  
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STATEMENT OF  
 KENNETH A. STEADMAN  
 EXECUTIVE DIRECTOR  
 VFW WASHINGTON OFFICE  
 VETERANS OF FOREIGN WARS OF THE UNITED STATES

Before the

COMMITTEE ON VETERANS' AFFAIRS  
 UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

DEPARTMENT OF VETERANS AFFAIRS FY '98 BUDGET

WASHINGTON, D.C.

FEBRUARY 27, 1997

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Once again, the VFW is proud to be a co-author of the veterans' *Independent Budget*. As in the past, our contribution lies in the construction portion of this document. Therefore, this statement by the VFW will concentrate on VA's construction program.

Most VA construction activities are funded through the Major Construction appropriation, which finances projects costing \$3 million or more, or the Minor Construction appropriation, which pays for smaller projects. A third appropriation finances the Parking Garage Revolving Fund. Veterans Health Administration (VHA) construction accounts for most expenditures within all three appropriations. VA also provides grants for constructing state extended-care facilities and state veterans' cemeteries.

The creation of VA's Veterans Integrated Service Network (VISN) comes at a time when Congressional appropriations for major construction as well as appropriations for minor construction will be minimal. As VISNs reconfigure programs and shift resources in an effort to attain efficiently integrated networks, the risk of local shortages in service capacity are increased. Therefore, it is critical that VA officials, particularly VISN directors, have maximum flexibility to use construction funds to ensure veterans' optimal access to a full range of services.

VA must continue to plan for a health care delivery system that corresponds to state and private-sector reforms. Perhaps the most difficult problem VA faces in its construction activities is coordinating facility mission and program planning. VHA is retooling the facility development program (FDP) to work within a network environment. Once it understands each facility's program mission, VA should be able to examine a network area's demand and assess how well the area's facilities meet this demand. This will allow VA to begin to capitalize on intra-network sharing opportunities and allocate resources to the Department's and its patients' advantage. FDP has yet to incorporate inter- or intra-network utilization patterns or other sharing opportunities into its construction planning. When determining catchment area service needs, VA models must consider the potential of other community health service providers to meet veterans' needs and work with them to coordinate services most efficiently.

***Priorities for the Fiscal Year 1998 Budget***

The IBVSOs believe that VA's construction program should emphasize expanding primary care access, making facilities more modern and attractive, and increasing long-term care capacity in non-institutional and institutional settings. The need for enhanced outpatient and extended-care facilities and infra-structure improvements has replaced the need for additional hospital beds. Unfortunately, many renovation projects are threatened because costs will exceed the Minor Construction project ceiling of \$3 million. The IB authors recommend the \$3 million ceiling be annually adjusted for inflation.

Prompt expansion of VA's ambulatory care program is crucial if VA is to be an effective care provider. VHA must move as much of its inpatient workload to ambulatory care settings as is appropriate and indications are that this is being done. In 1996, VA increased outpatient visits while at the same time closed hospital beds. However, with this shift to outpatient care,

clinics currently in operation cannot ensure all veterans have accessible care. VHA must open more clinics in areas convenient to veterans, and it must begin extensive primary care outreach through more remote and satellite clinics during this fiscal year and in FY 1998. It should place some primary care clinics contiguous to or within veterans' outreach centers (or vet centers). This can be accomplished by leasing, through sharing agreements, or by contracting for services as these are quicker, less expensive alternatives to new construction. If a veteran user population is small and far from a VA facility, VA should contract with local providers to make care accessible to those veterans at reasonable cost. VA must ensure that these providers meet or exceed VA performance standards and have information systems that can directly interface with VA's. Wherever possible VA should maintain operational control over local clinics, to maintain its identity as a provider for veterans and maximize veterans' access to providers who can best meet their special health care needs. Although the IBVSOs support creating private sector points of entry into the system to meet the needs of veterans remote to VA services, we do not support mainstreaming the system.

To continue to make its unique contributions to the U.S. health care system, VA must provide services in accessible, attractive, and modern care venues. VA has targeted infrastructure needs, such as ensuring patient privacy with telephones for each patient room and private or semi-private bathrooms, as necessary improvements. The IBVSOs believe that this is commendable, but population need and facility mission must determine priorities for remodeling. Not all facilities have the same need for patient privatization, so it should not be a fixed priority system-wide.

#### **Long-Term Care**

The aging veteran population can be expected to place demands on the system that will require rapid expansion of VA long-term care alternatives. Gaps in the care continuum force many veterans into nursing homes prematurely. VA must increase access to community and home-based alternatives for long-term care. In addition, VA must begin to develop additional alternatives to institutional long-term care, such as assisted-living facilities that maximize residents' independence and are less expensive.

A need for increased institutional long-term care also exists. Since the remodeling necessary to convert hospital beds to nursing home care beds can be less expensive than new nursing home construction, VA should convert unused inpatient hospital beds to increase nursing home bed capacity whenever feasible. Other less expensive alternatives should include expanding the state veterans home program and the purchase and conversion of appropriate private-sector community hospitals and DOD facilities vacated due to health care industry downsizing.

#### **VA Management Initiatives**

In recent years, VA significantly reorganized its construction program to streamline operations and to promote a customer service philosophy. In keeping with this philosophy, VA's Office of Facilities Management (FM) worked with the VSOs to address *Independent Budget* recommendations for program improvement. Through this process, FM has set cost-efficiency goals in the areas of seismic and hazard mitigation standards, barrier free design, and facility service life. VA's initiative is encouraging, and the joint effort should serve as a model for resolving medical facility planning issues.

FM has decentralized authority and is focusing on serving its customers in the field. Delegation of authority significantly reduces FM's workload and enables VA to be more responsive to local needs. As a result, VISN directors have more flexibility to initiate infrastructure changes that will allow them to integrate services within their network. The IBVSOs support these changes, which closely mirror initiatives in the Vice President's *National Performance Review*. However, VA should take steps to ensure that uniform standards, which are necessary to manage a national system of health care facilities, are maintained. Support and enhancement of FM's Facilities Quality Office's standards service would help ensure a uniform approach to national system management.

During the fiscal year 1996 reorganization, some planning functions returned to FM. However, implementing network-based facility planning and adjusting the facility sizing model that prioritizes bed and inpatient care rest with the Office of Policy, Planning and Performance (OPPP). This separation of planning functions could lead to conflicting decisions on projects, equipment, or budget issues. While it is too early to determine if the planning realignments and staff reductions have adversely affected project delivery, this should be monitored.

With the decentralization of construction authority, it is critical that a mechanism for stakeholders such as the veteran service organizations be established that would permit early participation in the planning and design process of new construction projects, particularly minor construction projects for which there will likely be no central office oversight. In light of reductions in FM's staff, the IBVSOs strongly urge VA to implement such a protocol to allow local involvement of stakeholders and provide a mechanism of accountability.

The Office of Facilities Management currently supervises nearly 100 major construction projects across the VA with a total dollar value of \$2.7 billion. To manage these projects, FM uses multi-disciplinary teams composed of project managers, architects, engineers, and resident engineers stationed at the construction site. During the past year, in response to the Headquarter's reduction-in-force, FM has expanded its use of contracts with architectural and engineering consulting firms to secure much of the technical support required for construction management and oversight. In addition, FM's four project delivery teams serving VHA have been consolidated to three teams. A single team continues to support the major construction needs of Veterans Benefits Administration and an expanding construction program for the National Cemetery System.

FM has sustained reductions in staff in fiscal year 1996 leaving 170 FTEs to staff operations. While efficiencies gained from staff reductions are encouraged, the IBVSOs believe VA should exercise caution not to reduce staff to a level that jeopardizes research and development of strong facility standards.

As construction requirements of the Veterans Health Administration change from a need for large inpatient facilities to smaller, community-based outpatient clinics that support VHA's needed shift to outpatient care, FM has adopted and greatly expanded the use of alternative construction delivery methods. These include: design-build, use of construction management firms, purchase and hire methods, and contracts with architectural and engineering firms. FM's resident engineers also are increasingly used to assist medical centers with delegated major projects and minor projects as well as to support large lease and enhanced-use activities.

#### ***Customer Service***

The Office of Facilities Management states an abiding commitment to customer service. To honor this commitment, FM is providing a new array of services to the Networks, medical centers and non-VHA customers.

Each of FM's product lines, i.e., major construction, leasing, construction information services, asset and enterprise development, and consulting support now use customer surveys to assess satisfaction with services provided. Customer service standards are in development. In addition, employee's performance plans were revised to contain a heightened emphasis on customer service and specific training was completed to promote behaviors supportive of a customer-focused organization.

FM's Consulting Support Office continues to provide assistance to field facilities. During the past year this FM team provided over 700 architectural and engineering "consult and solve" episodes to more than 120 medical centers. In addition, the group participated in technical assessments of properties of interest to the VA including: the Mather Air Force Hospital and the American River Hospital in Sacramento, CA; Griffis Hospital in Albany, NY; and the Fitzsimmons Army Hospital in Denver, CO.

During the past year FM expanded the use of electronic technology. In May a comprehensive home page was installed on the world-wide web, making FM the first VHA headquarters element to make this technology available to its customers. Anyone with Internet access can query this site to get information related to FM's activities. The home page was cited by the American Institute of Architects as a model for Federal agencies with design and construction programs. In addition, FM doubled the size of its electronic Technical Information Library to make added information available to facility engineers. New products focus on supporting VA's shift from a hospital based system to a primary care environment.

#### ***Streamlining Operations***

Medical administration executives consider most facilities that require more than five years from design to move-in to be obsolete on activation. The fiscal year 1995 budget request incorporated a new process, Expedited Project Delivery, which enables the design team to work without interruption. When fully implemented, this should reduce Major

Construction project development time by two years. The IBVSOs support VA's efforts to reduce the design-to-move-in time line to five years or fewer. Such a reduction will save funds and better serve veterans.

FM has continued to streamline VA's design and construction standards and benchmark them for quality and cost effectiveness against those used by the Army Corps of Engineers and organizations in the private sector such as Kaiser Permanente. Based on this accomplishment and the development of a new system to manage change orders, FM was awarded the prestigious Vice-President's *Hammer Award* in 1996. VA has also developed voluntary guidelines, which replace many previously mandatory VA design and construction requirements. In addition, standards are available electronically nationwide, permitting more timely dissemination of updates.

The IBVSOs applaud these efforts and urge VA to continue to adopt private-sector business practices in its construction programs. VA must continually assess its design process, to eliminate duplicative project review and approval. It can then direct cost savings to other VA functions.

In June 1996, a new Claims and Risk Management Office was established in FM. This new office pulls together individuals with experience in claims analysis, risk management, project scheduling and in providing training in these areas. Since this office was activated it has provided training in claims avoidance, prevention and risk management to network and medical center staff, and resident engineers. It implemented a new Critical Path Method scheduling package and project schedule updating process that will improve efficiency and response times on construction projects at reduced cost. The office also provides expert claims analysis and litigation support to the Office of the General Counsel.

VA must still implement a seamless time line from facility design to construction. Customarily, VA begins facility planning and design with minimal funding. Congress's funding of these projects has been intermittent, causing delays in construction. The IBVSOs recommend that, once Congress authorizes a major project, VA should receive multi-year budget authority for the project's total cost, to preclude delays. This includes approving use of design funds as early as possible. Congress should also guarantee activation funds for staff and equipment once the project is complete.

#### ***Expanded Leasing Authority***

VA has continued to delegate leasing authority to the Networks and medical centers through the "Simplified Lease Acquisition Process" and the "Delegated Authority to Negotiate Leases." To prepare field personnel for acceptance of this additional responsibility a national lease training program was completed in the Summer of 1996.

The IBVSOs applaud such efforts. Expedited lease acquisition provides facility directors greater flexibility and control in meeting their patients' needs for accessible ambulatory care. Leasing space during initial site inspection, rather than delaying the process through formal solicitation of offers, also enable VA facility directors to respond expeditiously to local market conditions.

VAMC directors now have the authority to grant certain leases, licenses, and permits, which allow temporary non-VA use of vacant buildings and land. The directive provides directors with authority to execute leases (for up to three years) and grant licenses and permits (for up to five years) without Central Office approval. This authority enhances VAMC directors' ability to work within the communities in which they serve.

The Office of Facilities Management has greatly expanded the use of VA's enhanced-use leasing authority making it an aggressive asset management tool. The program gives VA leverage in managing capital assets to acquire needed services, facilities, and goods while allowing VA to convert under-used property into productive assets.

The Enhanced-Use Leasing authority allows VA property (buildings or land) to be made available to public or private entities through a long-term (up to 35 years) lease in exchange for "fair consideration". The authority allows VA or non-VA activities that are compatible with VA's mission to be conducted on the leased property. As "fair consideration" for the lease, VA can obtain free or reduced cost facilities, space, services, cash payments, or "in-kind" consideration. This program allows VA to meet facility and service needs that it cannot accommodate within its budget priorities. Caution should be exercised, however, so that enhanced use projects make sense in the context of VA development plans.

Over 80 enhanced-use projects are now ongoing or planned that focus on diverse efforts such as acquiring outpatient facilities, and developing senior housing and assisted living facilities. One such project, in Murfreesboro, Tennessee, proposes to lease its unused property to a firm with the purpose of developing a Continuous Care Retirement Center or an Assisted Living Center for aged veterans, their spouses, and other non-veteran users. In exchange for a long-term, no-cost lease, the developer would finance, construct, operate and maintain the center for the term of the lease. The VAMC would offer a number of services and in exchange receive an enhancement in the way of services, space, facilities and/or discounts for veteran users and their spouses.

An example of how enhanced-use leasing can supplement VHA funding streams is the strategic alliance with the State of Indiana. This project resulted in a long-term lease of the VAMC Indianapolis Cold Spring Division for a rental consideration of \$15.6 million to be held in trust for VA developmental uses.

The IBVSOs strongly support permanent legislative authority for VA's enhanced-use leasing program (currently to expire December 31, 1997) and eliminating the five-projects-per-year limitation. The Enhanced-Use Leasing program is critical to rapidly achieving VA's restructuring goals.

#### ***Independent Budget Funding Recommendations for Fiscal Year 1998***

The IBVSOs believe that VA should use a balanced mix of the facility development options available to meet veterans needs. These include major and minor construction, leasing, and expanding the use of the enhanced-use authority. VA cannot effectively change from an inpatient focused system to a managed care outpatient system without continued improvements in the system's infra-structure. Existing hospitals are aging and were not designed to accommodate modern methods of health care delivery. A progressive needs based construction program is vital to ensuring necessary facility changes. In addition, leasing provides a flexible opportunity to increase points of access for veterans into the system in an expeditious way. Further, the enhanced-use leasing program has proven to be an effective vehicle to leverage VA resources with the private sector to benefit veterans without significant capital commitment by VA.

#### ***Major Construction***

The *Independent Budget* recommends a \$391.5 million Major Construction appropriation for fiscal year 1998. Less funding in fiscal year 1998 would be catastrophic, given the extended replacement cycle for facilities, rapidly changing clinical requirements, and the existing plant's age.

Replacement and modernization costs comprise much of the Major Construction budget. The *Independent Budget* co-authors believe that VA must consider acquisition and conversion projects as alternatives to new construction. Facilities available for acquisition offer VA opportunities to realize substantial savings and activate beds more quickly than "ground-up" construction projects would. VA is, in fact, doing this in some places.

When VA acquires facilities, it needs funds to make them accessible to people with disabilities and to improve infra-structure. The IBVSOs recommend that established priorities dictate replacement and modernization projects that provide natural hazard mitigation and modernize and upgrade the physical plant. Those priorities should carefully assess veterans' needs and the probable effect of changes in local health care markets on the need for facilities missions conversions.

Most of the *Independent Budget* recommendation pertains to leases for outpatient clinics and nursing homes. In these uncertain times, the *Independent Budget* co-authors believe that leasing is a viable alternative to new construction. Leasing offers an affordable, expedient, and flexible solution to VA's immediate need for outpatient and nursing home capacity. The IBVSOs are encouraged by VA facility directors' expanded leasing authority. The *Independent Budget* funding recommendation accommodates the annual cost of leasing seven nursing homes and annual leasing costs for 24 outpatient clinics. Funding for leased clinics complements other *Independent Budget* recommendations to enhance ambulatory care, which include increasing its in-house capacity and offering VA care in remote community settings such as vet centers.

The *Independent Budget* co-authors recommend that some new construction complement leasing and bed conversions, to increase available VA-operated beds for nursing home care. Indeed, the aging veteran population needs more nursing home beds through the

1990s. The *Independent Budget* Major Construction budget includes funding for one new nursing home. VA must also immediately enter into new enhanced-use leases for nursing home beds. This effort, however, will alleviate only some of the actual need for nursing home beds. VA must pursue the IBVSOs' strategy for making nursing home beds available to veterans.

The *Independent Budget* Major Construction proposal includes funding to acquire land for national cemeteries in states that have no available grave sites. Currently 12 states lack a national cemetery. The IBVSOs recommend that VA construct two new national cemeteries annually until the National Cemetery System meets the previously stated goal of at least one open cemetery in each state.

#### **Minor Construction**

The fiscal year 1998 *Independent Budget* recommends a \$299.9 million appropriation for Minor Construction, which funds smaller facility construction projects. The *Independent Budget's* fiscal year 1998 recommendation significantly exceeds the fiscal year 1997 appropriation. The increment requested reflects the IBVSO's growing concern about VA facilities' urgent need for update and repair.

Most VA facilities were constructed during the 1950s, and updating and repair needs are increasing rapidly. Earlier appropriations have fallen far short of addressing these needs. Needs for repairs, beautification, installment of amenities (such as phone lines), and mission conversions should be system-wide priorities, if VA medical centers are to operate successfully in today's health care environment. Of the total Minor Construction appropriation, Congress should allocate \$250 million to these types of projects. Within the allocation, VA should purchase residential sites for compensated work therapy programs. The "Medical Care" section, addresses the need for compensated work therapy programs.

VA should use approximately \$1 million of the Minor Construction account to convert unused and unneeded hospital beds to nursing home care. The National Institute of Building Standards (NIBS) found that remodeling hospital beds to nursing home beds can be less expensive than new construction. Accordingly, the *Independent Budget* co-authors emphasize conversion as the principal means to make nursing home care available to veterans. VA converted 80 beds in fiscal year 1996 and plans to convert an additional 245 beds between FY 1997 and 2000. The IBVSOs recommend that VA convert the beds it planned for fiscal year 1997 and convert six, 30-bed wards in fiscal year 1998. While this strategy represents a tremendous conversion rate, it is the only way VA can keep pace with the demands of the aging veteran community.

VA's initiative to develop additional temporary housing and residential care capacities to accommodate patients needing housing but not acute hospital care while undergoing diagnostic evaluation or treatment must be supported. These types of projects, along with senior housing and assisted living may be best addressed with the Enhanced-Use Leasing program.

The fiscal year 1998 *Independent Budget* recommends \$49 million for existing National Cemetery System construction projects.

#### **Parking Garage Revolving Fund**

The fiscal year 1998 *Independent Budget* recommends a \$1.5 million allocation to this fund, which finances VA facility parking garage construction and operation. Reasonable parking access is essential to patient care. If VA is to compete, veterans need access to parking reasonably near medical facilities. Eventually, parking garage revenues should pay for new projects. Because few revenue-producing projects currently exist, VA needs limited new appropriations. Future funding requirements should diminish.

VA should promote private-sector construction of parking garages through the Enhanced-Use Leasing program. Enhanced-use agreements would allow VA to provide accessible parking to its patients and their families without incurring enormous construction costs. The IBVSOs encourage VA to investigate further utilization of this program to build parking garages where needed.

#### **Grants for the Construction of State Extended Care Facilities**

The state home program greatly enhances VA's extended care workload capacity. At present, there are 83 state homes in 41 states. This appropriation provides grants to help

states acquire or construct state domiciliary and nursing homes for veterans. It also provides grants to expand, remodel, or alter existing facilities, including state home hospital facilities.

The Grants to State Extended Care Facilities benefit both the states and VA. States benefit by receiving Federal money to add nursing home capacity for state residents who have dual eligibility for VA and state programs, such as Medicaid. Under these grants, states are responsible for at least 35 percent of nursing home construction costs. States pay at least 50 percent of treatment costs, which they reimburse on a per diem basis; VA also pays a portion of the per diem cost. States may also retain some of veterans' Social Security incomes to cover their shares of operating costs.

Congress should encourage and fund Grants for the Construction of State Extended Care Facilities wherever states will participate. For fiscal year 1998, the *Independent Budget* recommends an \$80 million appropriation for these grants. This appropriation will fund all state applications for state home programs. The IBVSOs believe this is particularly important with impending block grants and cuts in federal funds to states.

***Grants for the Construction of State Veterans' Cemeteries***

This program makes grants to states to help them establish or improve state-owned veterans' cemeteries. VA anticipates that it will need \$2.5 million to fund program requirements in fiscal year 1998.

***Grants to the Republic of the Philippines***

Grants to the Republic of the Philippines help to replace and upgrade medical equipment and rehabilitate physical plants and facilities. The Veterans' Memorial Medical Center at Manila provides care to U.S. veterans. The facility is now more than 40 years old, so replacement and rehabilitation are major needs. The IBVSOs recommend a grant of \$500,000 for FY 1998.

This concludes my testimony and I will be happy to respond to any questions you may have.

***VFW Representative:*** Kenneth A. Steadman

***Title:*** Executive Director, VFW Washington Office

***Education:*** Bachelors degree in Political Science  
University of Dayton

Masters Degree in International Relations  
Johns Hopkins University

***Employment:*** U.S. Army, 1963-1983

Director of National Security and Foreign Affairs  
the VFW, 1983-1996

\*The VFW is not in receipt of Federal grants or contracts.

**STATEMENT OF  
DAVID W. GORMAN  
EXECUTIVE DIRECTOR, WASHINGTON HEADQUARTERS  
OF THE  
DISABLED AMERICAN VETERANS  
BEFORE THE  
HOUSE COMMITTEE ON VETERANS AFFAIRS  
FEBRUARY 27, 1997**

Mr. Chairman and Members of the Committee:

On behalf of the more than one million members of the Disabled American Veterans (DAV) and its Women's Auxiliary, I am pleased to present DAV's views on the President's fiscal year (FY) 1998 budget request for the Department of Veterans Affairs (VA).

As you know, the combined views of DAV, AMVETS, PVA, and VFW are provided in the *Independent Budget (IB)* we publish each year. The co-authors of the *IB* appreciate the recognition our views have received from this Committee in the past. We hope our analyses of VA's funding needs will be helpful to you. We believe our recommendations accurately reflect the resources necessary to enable VA to provide an acceptable level of benefits and services for our Nation's 26 million veterans and their dependents and survivors.

Because DAV has primary responsibility for the "Benefit Programs" and "General Operating Expenses" (GOE) sections of the *IB*, our testimony will primarily focus on these two areas.

**THE PRESIDENT'S BUDGET**

Of the \$41.1 billion budget authority the Administration requests for VA, \$22.4 billion is for benefit programs. Included in the budget is a proposal to provide a cost-of-living adjustment (COLA), estimated at 2.7%, for compensation and Dependency and Indemnity Compensation (DIC).

The Administration's budget proposes to make permanent several Omnibus Budget Reconciliation Act (OBRA) provisions to achieve cost-savings in benefit programs:

- Permanently round down the COLA for all compensation benefits.
- Permanently limit the monthly pension rate to \$90 for beneficiaries in Medicaid-funded nursing home care.
- Permanently authorize VA to match pensioners' reported income with their Internal Revenue Service (IRS) and Social Security Administration (SSA) income records to identify unreported income and consequent overpayments of pension.
- Make permanent the current 0.75% increase in the fee collected from veterans on non-downpayment VA guaranteed loans.
- Make permanent the current provision allowing inclusion of the expected resale loss in the net value calculation ("no-bid" formula) for home loans.
- Make permanent the current authority to charge a 3% fee for multiple-use home loans with less than 5% downpayment.

The Administration's budget proposes cost-savings through four other legislative changes in the benefit programs:

- Amend the law to prohibit service connection for certain disabilities and deaths related to smoking.
- Repeal the restriction in current law that prohibits, in cases non-judicial foreclosure, collection of loan guaranty debts from Federal salaries and Federal income tax refunds.

- Permanently extend VA's certificate guaranty authority for vendee loans under 38 U.S.C. § 3720(h).
- Increase the vendee funding fee from 1% to 2.25%.

The budget also proposes legislation to extend authority for direct home loans to Native Americans living on trust lands.

Under the Administration's budget, the Veterans Benefits Administration (VBA) would lose 543 FTE (full-time employee(s) or equivalent(s)) from the FY 1997 level, reducing the total from 11,943 to 11,400. In General Administration, there would be an FTE reduction of 71, to 2,292 from 2,363. The reduction in VBA's FTE is to be offset by increased operational efficiency and the impact of various restructuring initiatives designed to improve service to veterans and reduce the overall costs of operation in the future. VBA projects that it will continue its trend of improving its claims processing timeliness and reducing its case backlog in FY 1998. The Board of Veterans' Appeals (BVA or Board) would be authorized 494 FTE for FY 1998, a reduction of 6 FTE from the 500 authorized in FY 1997.

For medical care, the Administration requests \$17.6 billion in budgetary resources, a \$536 million increase over the FY 1997 appropriation. This amount would include an appropriation of \$16.959 billion, \$468 million retained from third-party collections, \$68 million reimbursement from VBA for rating examinations, and \$78 million from sharing and other reimbursements. This assumes legislation allowing VA to retain third-party collections of \$591 million minus \$123 million for the administrative costs for collection. Employment in the Veterans Health Administration (VHA) will decrease by 2,135 to 190,835 FTE. With these resources VHA expects to provide care to 3.1 million unique patients, an increase of 134,914 over FY 1997. Through increased efficiency and with Medicare subvention, VHA's 5-year plan, beginning with FY 1998, includes the goal of reducing the per-patient health care cost by 30%, serving 20% more veterans, and increasing the portion of the operating budget obtained from nonappropriated sources to 10%.

For cost-savings in the medical programs, the Administration's budget would permanently extend three expiring OBRA provisions:

- Authority to collect a \$2.00 pharmacy copayment for certain prescriptions and a \$5.00 and \$10.00 per diem charge for certain nursing home and hospital care.
- Authority to verify income, for medical care purposes, through the IRS and SSA.
- Authority to collect from insurance companies the costs of health care provided to service-connected veterans for nonservice-connected conditions.

A total of \$79.5 million is requested for major construction. Funds are included for structural corrections to the Memphis, Tennessee, Medical Center to meet current seismic standards, beginning development of a new cemetery at Cleveland, Ohio, expansion of the cemetery at Fort Sam Houston, Texas, and additional gravesite development at the National Memorial Cemetery of Arizona.

For various minor construction projects, \$166.3 million is requested. The Administration's budget also proposes legislation to change the definitions of minor and major construction to raise the minor construction range from \$300,000 to a \$500,000 maximum.

The request for the National Cemetery System is \$84.2 million, an increase of \$7.3 million. Fifty-two additional FTE are requested. The Administration is proposing legislation to change the VA role in the cemetery program. Under the proposed plan, VA would discontinue construction of new VA cemeteries after the addition of the Cleveland cemetery. It would make the grant program for construction of state cemeteries more attractive by increasing the Federal share of the construction costs from 50% to 100% and by making initial equipment costs eligible for up to 100% of funding by Federal grant. Thereafter, states would be responsible for the operation expenses.

The DAV appreciates Secretary Brown's continuing advocacy for veterans as seen here in his efforts to obtain a budget that will allow VA to continue to meet its obligations to this Nation's veterans. The DAV appreciates the Administration's proposal to provide a COLA for compensation and DIC. This COLA will offset against the increase in the cost of living incurred by disabled veterans and DIC recipients whose buying power would otherwise be diminished.

However, the DAV opposes the proposal to *permanently* round down the COLAs. With Congress and the Administration working to achieve a balanced budget within the outyears, with a declining veterans' population, and with fiscal uncertainties about the future, making these measures permanent now is premature and unwarranted. For the same reasons, the DAV opposes making the several OBRA cost-savings provisions permanent. If future circumstances should make it necessary, consideration could be given to extension of these measures.

While VA projects that services will not suffer with the recommended staffing reductions in VBA and VHA, the depth of these cuts cause us concern that VA may be overly optimistic, especially considering the already existing strains on the system. The *IB* recommended that staffing levels be maintained at least at current levels for VBA. Additionally, the DAV does not support the Administration's proposal to exclude smoking-related disabilities and deaths from eligibility for service connection. One concern is the fairness of this, given that the harmful effects of smoking were not widely known until more recently. Indeed, the Armed Forces provided free cigarettes to servicemembers in certain circumstances, such as in C Rations issued to many of our combat soldiers. Another concern is that smoking is sometimes the convenient reason given for respiratory disorders and cancers where the etiology is uncertain and where there could have been other factors, either alone or in concert with smoking, that caused the disorder. The proposed legislation could lead to unfair denials of service connection. In any event, from the information provided, the implications of this change cannot be fully understood. If the Committee entertains some action on this proposal, it should first hold hearings so that the reasons for and effects of the measure can be clarified.

The DAV supports the concept of allowing VA to retain and use collections from third parties to strengthen its health care system to permit it to provide more cost-effective treatment to more veterans. However, the Administration's proposal does not direct these collections toward improvement of the efficiency and capacity of VA's health care delivery system, but merely serves to relieve the Government of part of its obligation to provide the resources necessary to care for our Nation's ill and disabled veterans. Funds collected from the private sector and Medicare should not be used to supplant appropriations. Moreover, even with the inclusion of third-party collections in VA's "budgetary resources," health care funding is increased only 5.4% over 5 years. We are concerned that, even with optimum increases in efficiency, this amount will be insufficient to maintain an acceptable level of service. With the effects of inflation, a 5.4% increase over a 5-year period will quite probably not even represent a modest real increase but rather a substantial reduction in health care funding for veterans. In addition, under OBRA, some of the third-party collections have already been assigned to deficit reduction. It would be even more of an inequity if these OBRA funds were to be replaced from elsewhere in VA's budget at the expense of further reducing benefits and services to veterans.

#### **INDEPENDENT BUDGET RECOMMENDATIONS**

In the Benefit Programs section, the *IB* presents some of the authors' priority legislative goals for benefit improvements. Also included is our argument against proposals to means test, eliminate, offset, tax, reduce, and restrict eligibility for disability compensation.

In the GOE section, the *IB* authors have addressed VBA's Business Plan, which, in accordance with the Government Performance and Results Act of 1993 (GPRA), outlines VBA's strategy and associated resource needs for accomplishing its mission of providing benefits and services to veterans and their families in a responsive, timely, and compassionate manner in recognition of their service to the Nation.

**BENEFIT PROGRAMS.** In recognition of the special value of veterans' service in our Armed Forces for the security and defense of our Nation, our citizens take special pride in providing a comprehensive system of benefits to address the needs of veterans and their families. There is an

especially strong sense of obligation to provide indemnification for disability and death resulting from military service. Our Nation's commitment to its veterans has endured periods of economic crisis and has evolved through various military conflicts to the existing system of veterans' programs.

By compensating disabled veterans, by providing rehabilitation, by assisting veterans obtain an education, and by assisting veterans obtain housing, for example, the government also benefits society as a whole. Without this assistance, which helps veterans make the transition into civilian life and makes them competitive with their nonveteran counterparts, more of them would, no doubt, be educationally and economically disadvantaged. Fewer of them would be self-sufficient. Consequently, more of them would depend on public assistance programs, and more might be homeless. The special status accorded veterans also contributes to our national sense of solidarity, patriotism, and pride. We are a Nation that admires and cares for those who sacrifice to preserve our way of life.

The authors of the *IB* appreciate the support veterans receive from this Committee. We are confident that you recognize the value and equities of maintaining our veterans' programs.

These very effective programs need small adjustments and improvements from time to time, however, to remove inequities and make them better serve their intended purposes. The *IB* makes the following recommendations for maintaining or improving the benefit programs:

#### **Compensation**

- A COLA for compensation and dependency and indemnity compensation.
- Reject recommendation to undertake economic validation of the *Schedule for Rating Disabilities*.
- 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.
- Repeal the inequitable requirement that a veteran's military retired pay, based on longevity of service, be offset by an amount equal to his or her disability compensation.
- Enact legislation to remove the requirement that military nondisability separation, severance, or readjustment pay be offset against VA disability compensation.
- 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 a portion of retired pay for more than three years.

#### **Dependency and Indemnity Compensation**

- Repeal the OBRA provision limiting revived DIC eligibility to cases of annulled or voided marriages.

#### **Pension**

- Authorize a VA study to determine if the removal of the presumption of permanent and total disability for pension purposes at age 65 resulted in savings or whether costs of VA examinations and record development outweigh potential savings.

#### **Burial Benefits**

- Amend 38 U.S.C. § 2306 to reinstate former subsection (d), which had provided for reimbursement of the costs of acquiring a headstone or marker privately in lieu of furnishing a Government headstone or marker.

#### **Miscellaneous Assistance**

- Amend Equal Access to Justice Act provisions to permit payment of fees to unsupervised nonattorneys who represent appellants before the Court of Veterans Appeals (CVA or Court).

#### **Readjustment Benefits**

- Adjust the level of the allowance under the Montgomery GI Bill (MGIB) to provide more assistance in meeting the costs of pursuing a course of education.
- Amend the law to permit refund of an individual's MGIB contributions when his or her discharge was characterized as "general" or "under honorable conditions."
- Adjust the benefit rate for the Survivors' and Dependents' Educational Assistance program to correct the lack of cost-of-living adjustments since 1989 and amend the law to provide for automatic annual adjustments indexed to the rise in the cost of living.
- Adjust, to offset decrease in value by inflation, the grant for acquisition of specially adapted housing and the grant for adaptations to housing and provide for automatic annual adjustments indexed to the rise in the cost of living.
- Increase the automobile allowance to 80% of the average cost of a new automobile and amend the law to provide for automatic annual adjustments in the automobile allowance to keep pace with the rise in the cost of living.

#### **Home Loans**

- Enact legislation to authorize adjustable rate mortgages through VA's home loan program.

#### **Other Improvements**

- Remove the 2-year limitation on payment of accrued benefits.
- Enact legislation to require correction of BVA decisions involving clear and unmistakable error.
- Exempt veterans' entitlements from the "pay-go" provisions of the Budget Enforcement Act.

**GENERAL OPERATING EXPENSES.** Just as veterans enjoy a special status and are highly deserving of VA benefits, they are deserving of an effective benefits delivery system to ensure that benefits are dispensed in a manner to be meaningful and fully accomplish their purposes. The GOE portion of the budget covers the administrative costs of delivering VA benefits and services. VBA is responsible for administering VA's nonmedical programs. These are compensation and pension, education, loan guaranty, vocational rehabilitation and counseling, and insurance.

VBA's Business Plan is comprised of its overall direction and policy and its primary goals and strategy for administering all of its benefit programs but also integrates more specific multi-year plans for each of its five component benefit programs, referred to as its five business lines. In addition to serving as VBA's operational "blueprint" for its business processes and reforms, and as its "road map" to achievement of its long-term goals, this comprehensive plan is also intended, under GPRA, to serve as an aid to Congressional oversight and budgetary decisions. To each of the five Business Line Plans—which form the context and specific bases for the Administration's budget request—we added our own recommendations and discussed our concerns where we question or disagree with VBA's approach. The *IB* includes analyses of the activities, performance, and needs of each of the services that administer VBA's business lines as well as two of the functions funded under General Administration, BVA and the Office of the General Counsel (OGC). Although the CVA is not part of VA, the *IB* contains a section on its operations because of its inextricable role and impact in veterans' claims and VA's processes. Overall, we believe that the plan and the budget request are tailored to achieve an optimum level

of services and an optimum use of limited resources. We generally support this plan and, in the *IB*, urged that Congress provide VA with the resources necessary to effectuate its strategy for the timely and efficient delivery of benefits and services. The area of greatest concern continues to be the compensation and pension claims process.

In recent years, VBA has been challenged by increasing claims backlogs and resulting long delays for veterans and other claimants awaiting decisions on claims. With an aging veteran population, the need for prompt service has become greater at a time when, until recently, claims processing times were becoming progressively longer. Backlogs and consequent protracted delays result in increasing numbers of disabled veterans in need of VA assistance dying before that assistance is provided. Other veterans with immediate needs suffer through long delays without their needs being met.

In response to concerns about the quality of its service to its customers, VA established a Business Process Reengineering (BPR) Office in November 1995 and the BPR team issued a report of its findings and recommendations in August 1996. These recommendations were incorporated in Compensation and Pension Service's (C&P's) Business Line Plan. This plan includes measures to correct the following five core problems identified in the BPR study: inadequate communications and outreach; lack of individual accountability; emphasis on production and timeliness instead of quality; inadequate information technology support for process; and complexity of rules and regulations.

The plan acknowledges that poor quality and the resulting necessity to rework claims is the primary problem accounting for the overload on the system. The plan builds on the strengths of the current successful hearing officer program—personal interaction and more thorough review. The current “assembly line” process is replaced with a new integrated claims process that allows direct interaction between the veteran and a more highly skilled and trained adjudication team, with one person on the team responsible for ensuring satisfactory completion of all actions related to the claim. A separate post-decision review process will allow a dissatisfied claimant prompt access to remedial action and a “second look” by a hearing officer, (redesignated post-decision review officer). The post-decision review officer will have authority to (1) change the decision on the basis of the current record, if warranted, (2) undertake additional action toward favorable resolution, or (3) prepare the case for BVA review if revision of the decision or further action is not indicated. Quality—and thus efficiency—and customer service will be the primary goals, supported by training and a certification process and better quality review and accountability mechanisms. We believe that the Business Line Plan for C&P presents a solid, well-reasoned, and well-supported strategy for resolving the problems that have for the past several years plagued VBA and have been at the center of attention of the Congress, VA, and the veterans' community.

From our knowledge of VBA's operations and our review of VBA's Business Plan as included in VA's budget submission, the four veterans organizations co-authoring the *IB* present the following added recommendations for the activities funded under the GOE appropriation:

#### **Compensation and Pension**

- Congress should endorse and support C&P's BPR plan as set forth in its GPRA Business Line Plan. Congress should provide VA with the resources necessary to accomplish all components of this plan, namely funding for training and associated personnel costs, information technology improvements, and other related costs. However, Congress should reject recommendations that VA revise its rules to negate the Court's enforcement of claimants' rights as contained in current rules. Congress should, through its oversight functions, closely scrutinize VA rulemaking to ensure that it is not undertaken to erode or undermine rights VA claimants currently enjoy and to ensure that VA does not continue to make rules without involving its customers.
- Should it become necessary to protect VA claimants' procedural rights, as have been provided in long-standing VA regulatory provisions, Congress should codify into statute provisions which VA shows an intent to rescind, and Congress, if necessary,

should amend the Secretary's general rulemaking authority to require means for public participation in rulemaking that impacts upon VA customers.

- Congress should enact the legislative changes recommended by C&P to carry out simplification of VA programs, namely, de novo review authority for Post-Decision Review Officers and pension simplification.
- C&P's Business Line Plan should be revised to include more concrete, defined strategies for obtaining improvements in quality of decisionmaking, namely through performance standards that focus primarily on quality criteria. To obtain quality in decisionmaking, VA must install an effective quality assurance infrastructure, VA must have quality measurement criteria that correspond to the requirements of law for a complete and legal adjudication, and VA must have a means for effective enforcement of quality and performance standards among its decisionmakers through an accountability process that includes strong incentives for quality work and strong disincentives for noncompliance with quality standards.
- VA should promptly institute an aggressive new training program to instruct adjudicators on the mandatory nature of case law and in its use and applicability. This training should be complemented by a process incorporating a chain of accountability for proper and legal claims decisions, with monitoring for compliance and quality control, along with studies of appellate decisions to identify problem areas. Management should take necessary steps to bring about a renewed institutional and individual adjudicator commitment to VA's fundamental guiding principles for the administration of benefits, such as broad and liberal application of the law, resolution of reasonable doubt, and award of all benefits to which entitlement may be established.
- To confront rating boards with the reality of their errors, to instruct them in proper interpretation and application of law, to provide data to measure performance and enforce accountability, and to aid in identifying areas where training is most needed, BVA decisions should specify regional office errors accounting for the different outcome on appeal or necessitating remand.
- If VA fails to voluntarily revise the manner in which BVA decisions are written, Congress should amend 38 U.S.C. § 7104(d) to expressly require that the Board specify the basis for affirming the decision of the agency of original jurisdiction or specify the errors accounting for the Board's reversal or remand.

#### **Education**

- Congress should provide Education Service the resources necessary to improve accessibility, services, accuracy, and efficiency as envisioned in its GPRA Business Line Plan.

#### **Loan Guaranty**

- Congress should provide the resources necessary for Loan Guaranty to fulfill the service goals in its Business Line Plan, including the information technology improvements shown to be essential to the plan; however Congress should not reduce Loan Guaranty's FTE authorization below current levels inasmuch as staffing reductions are incompatible with the planned improvements for customer service under GPRA and are indeed essential to maintaining current levels of service quality and timeliness.

#### **Vocational Rehabilitation and Counseling**

- To prevent further strains on Vocational Rehabilitation and Counseling Service (VR&C) and reversal of recent gains, current FTE levels should be maintained until the effects of reorganization can be evaluated as to staffing needs. Subsequently, staffing considerations should include a plan to return to full use of in-house counseling and routine rehabilitation services because they are more cost effective than contract services.

- VBA should include VR&C's immediate and future needs in its development of automated support systems.
- Disabled Veterans Outreach Program specialists employed at the local Job Service Office should be part of the case management system for vocational rehabilitation.
- The vocational rehabilitation Design Team should promptly finalize its report and forward it to the Under Secretary for Benefits and to the Secretary, if appropriate, for implementation.

### Insurance

- Insurance Service should be provided the resources necessary to fulfill its customer service goals.

Because of changes in VA's accounting methodology beginning with the FY 1997 budget, Veterans Services is no longer funded as a separate entity under the budget structure. Its functions are viewed as support and are considered overhead expenses, which are apportioned among VBA's business lines. Nonetheless, even with the changes in accounting methodology and the consolidation of functions, Veterans Services remains a discrete operational entity within VBA. Given the necessity for personnel devoted solely to dissemination of general benefits information and assistance across the varied benefits programs at various field and satellite locations, it seems apparent that VA will find it necessary to retain a service dedicated to those purposes. We believe that Veterans Services is a vital part of VBA's benefits delivery system, and we discuss it separately in the *IB* because of its importance. Our recommendation for Veterans Services is:

- VA and Congress should continue to recognize that a strong and viable Veterans Services component within VBA is essential to the satisfactory delivery of veterans' benefits, and Congress should provide Veterans Services with the resources necessary for it to perform all of the many important tasks with which it has been charged.

Similarly, funding for information technology is no longer separated from the VBA's product lines under the current budget structure. Again, because of the importance of this program, the *IB* includes separate discussion and a recommendation for this component of VBA's operations;

- Congress should provide funds to maintain VBA's existing data systems while new systems are phased in; Congress also should provide all funding necessary to meet VBA's future responsibilities and to implement its new business processes.

From its analysis of the processes, performance, and needs of BVA and OGC, the *IB* provides several recommendations. Two recommendations aimed at improving the Board's operations and decisions:

- Congress should earmark sufficient funding for BVA training programs.
- VA should change 38 C.F.R. § 19.5 to properly instruct that BVA is bound by VA manuals, circulars, and other directives issued by VA.

Given OGC's workload, the *IB* includes the following recommendations for additional personnel to meet OGC's needs:

- OGC should be authorized 12 additional FTE for Professional Staff Group VII to handle the increase in workload.
- OGC should be authorized 10 additional FTE for its alternative dispute resolution program.
- OGC should be authorized 15 additional FTE for procurement and leasing functions to minimize VA's liability and reduce litigation and claims costs.

**COURT OF VETERANS APPEALS.** Last year, there was some consideration of reducing the number of judges on the Court. Such action would be inadvisable for several

reasons, including the increasing rate of appeals in the last year. The four veterans organizations presenting the *IB* oppose any reduction in the number of judges on the Court.

One of the problems the Court has faced since its inception is a large pro se docket. Approximately 74% of appellants before the Court are unrepresented when they file their appeals. That figure is reduced to 50% through the efforts of the Pro Bono program. The *IB* authors support continuation of this program. The *IB* recommends:

- Legislation to codify into law the Veterans Consortium Pro Bono program.
- Appropriation of adequate funds to operate the program.

The Court seeks improvement in its retirement and survivor program to make it comparable to other Article I courts. Also, regarding its retirement plan, the Court seeks early retirement provisions for associate judges to avoid retirement of all judges near the same time, when their terms expire. We understand that the Court has corresponded with the Committee on the details of these proposals. The DAV supports these changes.

The Court has also proposed legislation to rename it "The United States Court of Appeals for Veterans Claims." This would make the Court's name consistent with that of other Article I Courts. The DAV supports this proposal.

#### **CONCLUSION**

This concludes the DAV's testimony on the FY 1998 budget. We appreciate the opportunity to present our views on this most important matter, and we thank this committee for its continuing support of this Nation's disabled veterans.



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The DAV: a nonprofit  
 organization of more  
 than one million  
 wartime disabled vets

## F A C T S H E E T

### **BIOGRAPHICAL INFORMATION**

#### **DAVID W. GORMAN**

Executive Director, Washington Headquarters  
 Disabled American Veterans

David W. Gorman, a combat-disabled Vietnam veteran, was appointed Executive Director, Washington Headquarters for the million-member Disabled American Veterans (DAV) in 1995. He works at DAV National Service and Legislative Headquarters in Washington, D.C., where he has held management responsibilities since 1981.

Mr. Gorman attended Cape Cod Community College until entering the U.S. Army in 1969. He was seriously wounded by a Viet Cong land mine explosion while on patrol in the central area of South Vietnam. His wounds required the amputation of both of his legs.

Discharged from the Army in 1970, Mr. Gorman immediately joined the DAV and is currently a life member of the DAV's National Amputation Chapter and of Chapter 12 in Rockville, Md.

Mr. Gorman, became a professional DAV National Service Officer in 1971, rising to the post of supervisor of the DAV's Providence, R.I., office in 1972.

In 1975, Mr. Gorman was assigned to the DAV National Appeals Staff, which represents veterans in claims before the Department of Veterans Affairs (VA) Board of Veterans Appeals (BVA) in Washington, D.C. BVA is the highest level of appeal in the VA claims processing system. In 1981 he was promoted to supervisor of the DAV National Appeals Staff.

In 1981, Mr. Gorman assumed management duties in the DAV's National Service Program at DAV National Service and Legislative Headquarters. He was promoted to Assistant National Legislative Director for Medical Affairs in 1983 and to Deputy National Legislative Director in 1994.

The father of four children, Mr. Gorman lives in Germantown, Md.

DAV

*Motto: "If I cannot speak good of my comrade, I will not speak ill of him."*

DISABLED AMERICAN VETERANS

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**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.

**STATEMENT OF JOHN R. VITIKACS, ASSISTANT DIRECTOR  
 NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION  
 THE AMERICAN LEGION  
 BEFORE THE  
 COMMITTEE ON VETERANS' AFFAIRS  
 UNITED STATES HOUSE OF REPRESENTATIVES  
 ON  
 FISCAL YEAR 1998 VA BUDGET  
 FEBRUARY 27, 1997**

Mr. Chairman and Members of the Committee:

The American Legion appreciates the opportunity to present its views on the Administration's proposed budget for the Department of Veterans Affairs (VA) for Fiscal Year 1998.

For Fiscal Year (FY) 1998, President Clinton requests approximately \$41.1 billion for the programs and operations of the Department of Veterans Affairs. The proposal reflects an increase of \$1.7 billion in budget authority over the FY 1997 budget. The proposal provides for certain programs and functions as follows:

**FISCAL YEAR 1998  
DEPARTMENT OF VETERANS AFFAIRS BUDGET PROPOSAL**

	<u>Proposed FY 1998</u>	<u>American Legion Recommendations</u>
Medical Care	\$17.6 billion	\$18.2 billion
Medical Research	\$234 million	\$280 million
Construction		
Major	\$79.5 million	\$225 million
Minor	\$166.3 million	\$200 million
State Home Grants Program	\$ 41 million	\$ 75 million
National Cemetery System	\$ 84.2 million	\$ 80 million
Veterans Benefits Administration (GOE)	\$885.2 million*	\$840 million

\* Veterans Benefits Administration (GOE) funding for FY 1998 includes \$68 million transferred from the medical care appropriation for C&P medical exams.

The Administration's VBA-GOE FY 1998 budget proposal will result in an overall reduction of 543 Full Time Employees (FTE).

**MEDICAL CARE**

The American Legion commends the Department of Veterans Affairs for striving to maintain a consumer centered health care system. The Veterans Health Administration (VHA) is a recognized leader in the nation's health care delivery network and must maintain its capacity to provide timely, quality and comprehensive health care.

The sufficiency of the Administration's FY 1998 budget proposal for VA medical care is linked to uncertain assumptions. For the period FY 1998-2002, the budget recommends no increase in discretionary appropriations for VA medical care. Instead, the Administration theorizes that the Veterans Health Administration will withstand this condition by way of enhanced efficiencies and by recovering specific non-appropriated revenues through third party billings.

The  
American  
Legion



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February 13, 1997

Honorable Bob Stump, Chairman  
House Veterans Affairs Committee  
335 Cannon House Office Building  
Washington, DC 20515

Dear Mr. Chairman:

The American Legion has not received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the subject of today's hearing, the VA Fiscal Year 1998 Budget

Sincerely,

John R. Vitikacs, Assistant Director for  
Resource Development  
National Veterans Affairs and  
Rehabilitation Commission

**JOHN R. VITIKACS  
ASSISTANT DIRECTOR FOR RESOURCE DEVELOPMENT  
NATIONAL VETERANS AFFAIRS AND  
REHABILITATION COMMISSION**

Mr. Vitikacs' service with The American Legion commenced on November 1, 1982. He was assigned as a Field Service Representative with the National Veterans Affairs and Rehabilitation Commission (VA&R). Assuming new responsibilities in January 1990, John applied his Field Service experience in the capacity of Resource Development Specialist, preparing Congressional testimony on a wide variety of veterans' related legislation. In April 1993, he was promoted to the position of Assistant Director for Resource Development.

Mr. Vitikacs' duties with The American Legion include oversight of Veterans Health Administration medical care programs, medical construction, the National Cemetery System, State veterans' programs, and Department of Veterans Affairs budgetary analysis.

John was born in Frederick, Maryland on September 10, 1952. He graduated from Brownsville Area High School, Brownsville, Pennsylvania in May 1970. He served on active duty in the U.S. Army from June 1970 until June 1973. He received training as a combat intelligence analyst at Fort Holabird, Maryland, and served a tour of duty with the 525th Military Intelligence Group, MACV Headquarters, Saigon, Vietnam. Upon completion of his Vietnam service until discharge, he was assigned to Supreme Allied Headquarters Europe, Brussels, Belgium as a personnel security analyst. Mr. Vitikacs' military decorations include the Bronze Star Medal (meritorious), Army Commendation medal, and Good Conduct Medal.

Mr. Vitikacs obtained a Bachelor's Degree in Public Administration from George Mason University in Fairfax, Virginia and a Graduate Certificate in Legislative Affairs from George Washington University, Washington, DC. He belongs to American Legion Post #364, Woodbridge, Virginia.



**Non Commissioned Officers Association of the United States of America**

225 N. Washington Street • Alexandria, Virginia 22314 • Telephone (703) 549-0311

**STATEMENT OF**

**LARRY D. RHEA**

**DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS**

**BEFORE THE**

**COMMITTEE ON VETERANS AFFAIRS**

**U. S. HOUSE OF REPRESENTATIVES**

**ON THE**

**FISCAL YEAR 1998 BUDGET**

**FOR THE**

**DEPARTMENT OF VETERANS AFFAIRS**

**FEBRUARY 27, 1997**



**NCOA**

**Non Commissioned Officers Association of the United States of America**

225 N. Washington Street • Alexandria, Virginia 22314 • Telephone (703) 549-0311

**DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS**

The Non Commissioned Officers Association of the USA (NCOA) does not currently receive, nor has the Association ever received, any federal money for grants or contracts. All of the Association's activities and services are accomplished completely free of any federal funding.

The Non Commissioned Officers Association of the USA (NCOA) appreciates the opportunity to appear today and testify on the Administration's budget proposal for the Department of Veterans Affairs for Fiscal Year 1998. The Association thanks the Distinguished Chairman for your invitation and trusts that our testimony will be helpful in the deliberations undertaken by the Full Committee.

Generally, it is NCOA's impression that the VA Budget proposed for FY 98 has received a mixture of reactions. While some concerns have been expressed on specific areas, it is NCOA's impression that the most common reaction has been along the lines that this budget represents "the best we can do" within the prevailing budgetary climate.

The Administration has described the veterans budget as "historic and innovative." It certainly is that Mr. Chairman; however, the "innovative" trend set forth in this budget is deeply troubling to NCOA on several fronts.

In NCOA's view, the out year trends are innovative in one tragic respect - relying on states and the private sector to fulfill in the future what should be federal responsibilities. Arguably, there are probably many things done by the federal government that are more appropriately state and private sector responsibilities. NCOA respectfully submits that taking care of the needs of the Nation's warriors and providing a proper, eternal resting place are not among them.

When taken in its entirety, the Administration's budget starts veterans down a path that is fraught with even more uncertainty than under current conditions. NCOA trusts that the Committee will examine very closely the implications of this budget in the out-years. NCOA requests that we not take steps in FY98 which could produce disastrous results and from which recovery would be very difficult, if not impossible.

In NCOA's view, it is the philosophy behind the FY98 veterans budget that troubles this Association as much or even more than the dollar numbers in the various line items. In this regard, the Association's testimony today departs from traditional budget statements. Rather than a discussion of the numbers, NCOA will highlight three areas of the budget - health care, education and the National Cemetery System - which we believe reveal a troubling, philosophical future path that NCOA believes is wrong and should be avoided.

**VETERANS HEALTH ADMINISTRATION**

NCOA is pleased that the Administration included in its budget proposal a request for legislative authority to collect and retain MEDICARE payments for those MEDICARE-eligible veterans treated by VA. The Administration is also seeking authority to retain within the VA health care system the money recovered from the private insurance of veterans or other third-party payers.

NCOA has previously advocated both of these initiatives and supports the Administration's request for MEDICARE reimbursement and retention within VA of third-party recoveries. The Association requests that the Committee makes these issues a priority during this session. In NCOA's view, MEDICARE reimbursement and allowing VA to retain third-party collections are the next common sense steps that should be taken in VA health care.

Although NCOA has previously advocated the above two proposals, the Distinguished Chairman knows that this Association has done so very guardedly. Over the past several years as the issue of MEDICARE subvention gained momentum, NCOA expressed concern and fear that appropriations would eventually be reduced with the influx of MEDICARE dollars into VA. The VA medical care budget for FY98 and the out years is ample evidence that NCOA's worse fears were more than justified.

As you also know Mr. Chairman, NCOA has never had great confidence in any of the estimates on third-party insurance recoveries from so called high-income, non-service connected veterans. Somehow though, it seems we have reached the point where many believe that high-income, non-service connected veterans are going to suddenly, and in great numbers, rush to the VA for their health care. The overlooked fact is that these veterans could be going to the VA right now but they are not and we have yet to ask the question - Why?

Although allowing VA to retain third-party recoveries is important, NCOA is not convinced that action alone will magically attract these veterans. We must keep in mind that these non-service connected veterans, who have been labeled high-income, have a choice of providers. NCOA believes that it is important to keep in mind also that these veterans are the lowest priority for care within VA. It is unreasonable to believe that these individuals are going to wait several days, or even weeks, for a VA appointment when they can, in many cases, visit a private physician in a matter of hours if not

Immediately. The Administration's estimates on third-party recoveries have to be recognized for what they are. It is foolish in NCOA's view, to base much of the future for VA health care on guess work.

In complete candor Mr. Chairman, the budget before you puts the future of VA health care in a crap shoot. There is no other way for NCOA to describe the Administration's proposal. If MEDICARE and third-party recoveries are less than expected, the Administration does not have an alternate plan. Even if the recoveries meet the Administration's estimates, VA health care cannot survive an estimated 12% reduction in appropriations during the next five years.

NCOA has consistently held that MEDICARE reimbursement and third-party insurance retention was the infusion of money needed to help: (1) offset the rising medical care costs for an aging veteran population; (2) allow VA to treat more needy veterans; and, (3) allow VA to maintain specialized services. NCOA viewed these two initiatives as a means to help VA reclaim ground that has been lost to insufficient appropriations for several years now. **NCOA has never considered Medicare subvention and third party billing as a replacement for appropriated funds and will never support such a proposition.**

Whatever hope we have for the enormous change underway in the Veterans Health Administration, the Administration's proposal is a sure prescription for failure. Reducing or flat-lining medical care appropriations is precisely what is not needed at this critical juncture.

If the Administration's health care proposal represents "innovation", then NCOA wants no part of it. NCOA has been down an identical path with the beneficiaries of the DOD medical system. The entire message of this budget to any veteran who might seek VA health care in the future can be summarized as follows: it will be there if you find a way to pay for it. Somewhere out in the future if the Administration's budget is enacted, the result for veterans will be much like the result for beneficiaries of the DOD system - the core federal obligation will eventually be dishonored. In NCOA's view, if there is to be a future for VA health care that is reasonably stable and certain, it is clearly up to Congress to provide the appropriated funds needed to fulfill what is, and will forever remain, a federal obligation.

Now that the initial steps on eligibility reform have been taken with the passage of last year's measure, NCOA believes it is time for the Committee to consider a group of "forgotten veterans" - the military retired ones. Even with the passage of last year's legislation, the majority of medical care provided by the VA will continue to be provided for non-service connected conditions and without cost to the

individual veteran. VA continues to routinely waive co-payments for non-service connected treatment even when third-party insurance is involved except for the military retired veteran.

Mr. Chairman, this Committee is concerned with several issues relating to equity in VA health care, for example: equity in the allocation of resources to hospitals; and, ensuring that the quality and level of care is equitably provided to veterans across the nation. The issue regarding military retired veterans and VA is also a matter of equity. NCOA believes the Committee's budget deliberations provide an opportunity to address this issue and do the right thing for these veterans. Military retirees are veterans and now is the time for the Committee to take action to grant these veterans, equal, cost free access to a VA system that is, after all, theirs too.

### EDUCATION BENEFIT

As the Distinguished Chairman and Members know, veteran education has been one of NCOA's passions for many years. For that reason, the Association is thoroughly insulted with the "non proposal" for veterans education in the President's budget. Education benefits in every other area of the Federal Budget trend upward to record levels - except for veterans.

Mr. Chairman, if the Administration's federal budget represents historic, innovation in veterans post-service education, then NCOA will again say that we want no part of it. In a federal budget which proposes a record \$51 billion for education, not one cent is targeted for improvement of the veteran education benefit. The Administration's unspoken message on veteran education is much like that on the future of VA health care - If you want post-service education, find a way to pay for it yourself. In NCOA's view, for any Administration to propose record levels of spending on education while excluding the veteran benefit is utterly and completely shameful.

In his State of the Union address, the President launched an education crusade in the context of national security. Included in the Administration's budget are education incentives and give aways for just about everybody except the men and women who have in fact provided for the nation's security. In plain language Mr. Chairman, the Commander in Chief of Education went AWOL on his military members and veterans.

Mr. Chairman and members of the Committee, we need to fix the conversion opportunity for those VEAP participants not included in last year's legislation. Also, NCOA implores you to do your best to increase the basic benefit of the Montgomery G.I. Bill. If anything is going to be done on the veteran education benefit, it is up to this Committee to do it and NCOA believes your budget discussions provide such an opportunity. It is sad, and painfully apparent to this Association, that the initiative will not originate with the Administration.

### NATIONAL CEMETERY SYSTEM

As the Chairman and Members of the Committee now know, the FY98 budget proposal reflects a major change in long-standing government policy for the National Cemetery System. After completion of the Cleveland National Cemetery, the Administration wants to end altogether the construction of new VA national cemeteries. Whether intended or not, this proposal on the future of the National Cemetery System conveys a strong philosophical statement to veterans.

Despite the offer by the Administration to front the initial construction and equipment costs for state veterans cemeteries, the statement to veterans in this budget is that VA wants "out of the cemetery business." In the past NCOA has supported the state cemetery grant program because appropriations have not been sufficient to expand the capacity of the national system to meet the needs of veterans. Never once though did NCOA look upon the state veteran cemetery grant program as a replacement for the national system - an alternative to supplement the national system, yes - but as a replacement for the national system, no!

As the Committee knows, veteran deaths are expected to increase during the next five years with a peak in the year 2008. Likewise, interments in National Cemeteries are expected to increase as is the total number of graves maintained. According to the Administration, the change proposed in the FY98 budget would "position VA to meet future requirements."

In NCOA's view, the budget and the proposal regarding cemeteries clearly does not position VA to meet future requirements. Under the proposal, if future veteran burial requirements are met, it will be the states, not VA, fulfilling the need. NCOA is unaware of any evidence that would lead us to reasonably believe that states are willing to fully take that responsibility in the next ten to fifteen years.

The proposal, if anything, is full of hope - a hope that states will take up the Administration's offer. If the states do not, to the extent needed to meet future requirements, this budget provides no other alternative - national cemetery construction will end - and, that thought is disturbing to NCOA.

Under the Administration's proposal, a historic federal responsibility would now shift to the veterans themselves. If the proposal is enacted, the burden is then on veterans to lobby Governor's and State legislatures for burial space and perpetual maintenance. What happens Mr. Chairman when the proposal is enacted and the states don't step forward to meet the need? What happens in the future when a state cannot properly fund maintenance and replacement equipment costs?

In NCOA's view, providing a lasting, eternal tribute to the Nation's veterans has been and always will remain a federal responsibility. NCOA sincerely asks the Committee to look closely at the long-term implications of this proposal - not only in terms of appropriations but also in terms of the moral principle this Nation once held sacred.

## CONCLUSION

NCOA has addressed in general terms only three areas of the VA budget proposal. There are other areas of the budget proposal which also cause concern to this Association. NCOA notes that the overall level of full-time employees continues to shrink as demand for health care and services rise. Medical and prosthetic research funding drops \$37 million from the FY97 level and we must recognize the impact this will have on patient care. At any given time, 75-80% of researchers are physicians who also have a direct responsibility for patient care. The budget also proposes to make permanent several OBRA-93 provisions which, in NCOA's opinion, ignores past efforts of veterans to do their part in balancing in federal budget.

As indicated earlier, and maybe even more so than the numbers in this budget, the philosophical trend portrayed therein is deeply disturbing - a gradual lessening of historical federal responsibility. Veterans are being told to find a way to pay for health care because appropriations are going to go down. Record levels are proposed to be spent on education but nothing is included for veterans. As harsh as it may sound, veterans are even being told to find a way to bury their dead.

NCOA sincerely hopes that this Committee will look closely at the long term implications of this budget. There has been a lot of talk about bridge building lately. Let us not rush to dismantle some of those which should be considered sacred.

Thank you.



*Vietnam Veterans of America, Inc.*

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*A Not-For-Profit Veterans Service Organization Chartered by the United States Congress*

Statement of

**VIETNAM VETERANS OF AMERICA**

Presented By

**KELLI R. WILLARD WEST**  
DIRECTOR OF GOVERNMENT RELATIONS

Before The

**House Committee on Veterans' Affairs**

Regarding

*FY 1998 Department of Veterans Affairs Budget*

February 27, 1997

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Attachments:

    Biography -- Kelli Willard West, Director of Government Relations

    Funding Statement -- February 27, 1997

### Introduction

Mr. Chairman and members of the committee, Vietnam Veterans of America (VVA) is pleased to present our views and recommendations on the Fiscal Year 1998 Department of Veterans Affairs (VA) and collateral agency budget proposals. Since this is our first opportunity to appear before the 105th Congress, we wish to extend a special welcome to the new members of the Committee. Veterans have been well served by the dedicated bipartisan leadership of this committee through the years. We look forward to working with each of you.

As we examine the FY 98 proposed budget, Mr. Chairman, it becomes more and more evident that VA must update its business practices -- particularly in the area of health care -- in order to survive the current fiscal climate. VVA would again like to commend your leadership in the passage of the Veterans Health Care Eligibility Reform Act of 1996. We firmly believe that this legislation will be instrumental in providing VA with the tools to both improve services to veterans and to sustain the integrity of the VA health-care system.

VVA has been encouraged by the spirit of cooperation expressed by the 105th Congress and the Administration. The budget battles of the past two years did very little toward providing better service and cost-accountability to veterans or to the general public. And in a number of cases the very partisan bickering was quite-damaging. The veterans who depend upon VA to process benefits claims and provide health-care services cannot afford to have further government shutdowns which delay services and increase already appalling backlogs.

VVA pledges to you our commitment to work in good faith toward improving services to our nation's veterans in the most cost-effective manner possible. And we urge the members of this committee to continue the fine tradition of bipartisanship, and to exert leadership among your colleagues to keep veterans issues above the fray of partisan politics. Our nation's 27 million veterans deserve no less for their patriotic sacrifices.

### Overview of the VA FY 1998 Budget Request

Recognizing fiscal realities, VVA acknowledges that we cannot depend upon more and more appropriations for veterans programs. When nearly every other agency in the federal government is being affected by budget cuts and every conceivable interest group in the nation is crying out against diminishing services, it is unrealistic to assume that veterans and veterans programs will be immune. The veterans community is not unwilling to make adjustments.

However it must be noted that veterans have repeatedly made sacrifices for budgetary purposes throughout the last two decades. Access to health-care services have been progressively squeezed, so that very few of our nation's veterans can even get into the door. Even service-connected disabled veterans are turned away from a host of services they should rightfully receive. Outside of the veterans advocates who sit on this committee, very few members of Congress have an understanding of the services VA does -- and more importantly does not -- provide. Many still believe that any veteran can get any services from the VA, which is simply not true. In fact, only ten percent of the total veteran population even tries to obtain VA health care.

Recognizing these fiscal realities, the veterans community no longer expects nor demands that the VA be all things to all veterans. VA cannot provide health care and benefits to all 27 million veterans. Frankly, not all of these veterans want or need comprehensive services from VA. We do, however, expect VA to maintain a range of necessary services for a core group of the most deserving and needy veterans. And Congress must provide an appropriate level of funding to carry out this principle mission.

### VA's Health-Care Proposals

Much credit must be given to the far-sightedness demonstrated by Secretary Brown and Dr. Kizer for changing the direction of the VA health system. As VVA has stated in the past, without the dramatic changes now underway, the VA system would be doomed to failure, through being eclipsed by national health care trends and private sector innovations. Change -- especially rapid change -- is often unpopular and disruptive to stakeholders.

The reengineering of the VA health-care system from one of highly centralized command and control, to a more streamlined, decentralized VISN model is a giant and sometimes traumatic step.

And the shift from a convoluted, often arbitrary funding allocation system to the logical, easily explained Veterans Equitable Resource Allocation (VERA) system is likely to raise concerns from the minority who benefited unfairly from the previous system. But not taking these steps would have jeopardized the very survivability of the VA health-care system.

The VA's formula for the budgetary foundation is predicated on moving aggressively toward a goal over the next five years of reducing per-patient cost for health care by 30 percent, serving 20 percent more veterans, and increasing the percentage of the operating budget that is obtained from non-appropriated sources to 10 percent of all medical care funding. While controversial and difficult to achieve this plan is logical and deserves our consideration. VVA is favorably disposed, in particular, to the concept of providing incentives for VA to compete for health care dollars -- improving services for all veterans in order to attract paying customers is the inevitable outcome.

VVA agrees with the objective and supports the enactment of legislation to permit VA to retain third-party reimbursements and Medicare payments. The current system which requires most insurance and copayment revenue to be directed to the Treasury in effect robs one group of veterans in order to pay for services to another group. This is because each dollar spent on discretionary-category veterans cannot be spent on care for a service-connected disabled or indigent veteran.

VVA is pleased that the Administration has embraced the long-held view of the veterans community that VA should retain these non-appropriated monies not only to recoup its expenditures on discretionary-category veterans, but also to supplement infrastructure and overhead which will benefit core group veterans. Without bringing alternative revenue sources into the VA system, it questionable that the U.S. can sustain the veterans health-care system. Without additional monies, many veterans may be denied services by an ever-shrinking VA health system.

At the same time, VVA is cautious about the health care proposals in the President's budget because they seem extraordinarily optimistic. Given the fact that nowhere near 10 percent of VA's health care budget is currently being collected by MCCR (and routed to the Treasury), it seems unlikely that the incentives, appropriate billing mechanisms, and customer base can be generated quickly enough to meet these targets. Based upon the President's budget proposal, if VA fails to meet these collection targets there could be a significant shortfall in the medical-care accounts. If these legislative provisions are not enacted in a timely manner, the net impact could be a catastrophic shortfall of health care services for America's veterans in the amount of \$468 million.

And if we generously assume that the system is ready for this monumental shift, VA would obviously have to be very aggressive in collecting payments from veterans and their insurance companies. A wholly dollar-driven health-care system has proven problematic for private-sector HMOs in many cases, with complaints from consumers about restricted services. We already hear anecdotal information about VA inappropriately billing service-connected veterans. How can we assure that a VA driven by the bottom line will not further put the squeeze on core-group veterans -- who are VA's primary mission -- in pursuit of paying customers? Will access to the resource-intensive specialized services -- which are, again, part of VA's core mission -- be jeopardized by the almighty dollar?

VVA insists that protections be incorporated into any authorizing legislation (for retention of third-party and Medicare dollars) to ensure that Congress does not subsequently reduce the VA's budget and appropriation by the amount of its receipts. Additionally, it is critical that the federal appropriation be maintained at a level high enough to sustain services to core-group veterans. Service-connected and indigent veterans are the federal government's responsibility -- not insurance companies. With the veterans population aging, it is unlikely that a projected flatline appropriation over five years can maintain even current services.

VVA urges this committee, in its authorizing role, to work very closely with the appropriators to ensure that funding for VA health care is maintained at an appropriate level to ensure services for core-group veterans and specialized programs such as PTSD and Substance Abuse units. VVA further urges this committee to be very aggressive in conducting oversight of the very dramatic changes underway within the VA health-care system. These innovations are critical for the future improvement and viability of the system, but many of our nation's disabled and indigent veterans

cannot afford to gamble with its future -- the VA is the safety net for thousands of at-risk veteran patients who rely upon its PTSD programs and substance abuse treatment, as well as programs for the homeless and the seriously mentally ill. Careful monitoring of quality and access by Congress will be critical to ensuring that the veterans community -- your constituents and ours -- are not inadvertently harmed by this transition.

#### **Homeless Veterans**

We are encouraged that the committee has indicated in its oversight plan, that it will conduct a very necessary evaluation of how funds are used and allocated to provide assistance for homeless veterans. Public and private studies suggest that more than one-third of our nation's homeless are veterans -- some 270,000 veterans are homeless on any given night. Thousands of these former soldiers are experiencing severe problems including PTSD, substance abuse, or serious mental illnesses. Some of these conditions are directly attributable to their military service, though many do not know they may be entitled to VA benefits, have not applied, or have claims pending.

Despite these abhorrent statistics, the Department of Housing and Urban Development (HUD) controls over 75 percent of the appropriated discretionary dollars allocated for the homeless each year. Yet HUD fails to assure that state and local communities who are awarded over \$1 billion [each year??] respond to "veterans specific" needs in the homeless population. VVA supports legislation which will soon be introduced by Representative Jack Metcalf to correct this inequity. Additionally, VVA urges this committee to ensure that VA's homeless programs are not adversely effected by tight budgets. Investing in comprehensive programs to assist homeless veterans to be reintegrated into society is a win-win proposition. Many of these men and women are ready and able to work and contribute back to the community as tax-paying citizens; they simply need a helping hand -- not a handout.

#### **Compensation and Pension Innovations Needed**

The Veterans Benefits Administration (VBA) has not been innovative enough in changing its inefficient procedures for processing claims. Excessive delays and backlogs continue to plague the system, sometimes forcing veterans to wait years for resolution of their claims. Part of this situation, as VVA has noted in other forums, is a general problem of performance quality at the initial decision-maker level -- rating specialists. Congress should require VBA to review decisional data from Hearing Officers, Board of Veterans' Appeals, and Compensation & Pension Service (administrative reviews) to determine which rating specialists repeatedly make the same types of errors. This data should be used for retraining, as well as performance evaluations and appropriate personnel actions.

Given the downsizing already undertaken by VBA in the past two years, and the need to retrain and improve services, VVA believes it is not appropriate to further cut staffing and budgets at this time. Though there is a temptation to give the agency a slap on the wrist, so to speak, for poor performance. Imposing further resource restrictions, however, will not accomplish the desired service improvements -- and ultimately veteran claimants will suffer from longer delays. Additionally, VBA computerization/automation programs should be closely monitored and held to task. There are opportunities to improve efficiency and quality of claims adjudications through these innovations. But, as GAO and the committee have already evaluated, we cannot depend upon this for short-term efficiencies because these programs have been ill-planned and have shown little results.

#### **Court of Veterans Appeals**

VVA applauds the decision by the Chief Judge to withdraw the Court's proposal to downsize, because of the courts increasing caseload. VVA opposed this recommendation when it was originally put forward last year, in part because there was a surge in appeals on the horizon due to increased production of decisions at the Board of Veterans' Appeals. VVA urges full funding for the court in order to assure the most timely decisions possible of veterans appeals.

#### **Research on Persian Gulf Illnesses and Agent Orange**

VVA firmly believes that additional funds should be directed toward independent research on Agent Orange, as well as Persian Gulf illnesses. VVA believes the structure set forth within the Agent Orange Act of 1991, wherein the National Academy of Sciences (NAS) provides independent

analysis of scientific literature on Agent Orange/dioxin, has provided significant improvement in the fairness and scientific basis upon which compensation determinations are made. But because there continues to be disagreement over whether certain conditions are related to exposure, it is critical that more research be done by independent scientists to allow the NAS reviews to provide more conclusive determinations. More research on Persian Gulf illnesses is clearly needed as well.

VVA does not aim to propose that VA compensate veterans for conditions that are clearly not related to their military service. In cases where the scientific data presents an unclear determination of exposure and risk, however, the benefit of the doubt must go to the veteran. In order to more conclusively determine what conditions are and are not related to service in Vietnam or in the Persian Gulf, VVA suggests that additional government-funded, independently conducted research be done on these issues. With Agent Orange, we continue to propose research on the Vietnamese population which presents an ideal laboratory. This committee's support for such research would be instrumental in assuring that veterans get answers to the questions that have plagued them since leaving the battlefield; we urge you to support an earmarked funding.

#### **Veterans Employment & Training Service**

The Veterans Employment & Training Service provides a key mission to American veterans -- not only those leaving the armed services, but also to older veterans in the midst of career transitions. Through the Local Veterans' Employment Representative (LVER) and Disabled Veterans' Outreach Program (DVOP) programs, VETS has a local presence in the State Employment Security Agencies and is able to assist hundreds of thousands of veterans to get jobs each year, as well as to promote veterans as good employees among the employer communities. In addition, VETS has enforcement authority under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). We anticipate that VETS will be tasked with similar enforcement authority with passage of the Veterans' Employment Opportunities Act of 1997 (H.R. 240).

VVA advocates full funding of VETS programs in FY 1998. We have noted improved accountability of these programs under General Taylor's leadership. And VETS is working hard to adapt to the changing environments of "One-Stop Career Services" among employment agencies, as well as technology innovations. VVA also recommends funding of the Homeless Veterans Reintegration Project at the authorized level of \$10 million, because finding jobs is frequently the highest priority for assisting homeless veterans.

#### **Savings from Gardner Repeal**

VVA remains firmly committed to working to recoup the \$510 million Gardner repeal funds which were in excess of the PAYGO requirements for the spina bifida benefits package included in H.R. 3666, the FY 1997 VA, HUD and Independent Agencies Appropriation bill. We believe there is sufficient time to work with the Budget and Appropriations Committees before the enactment date of the Gardner repeal on October 1, 1997.

VVA is adamant that these savings should be redirected to veterans programs rather than going to the U.S. Treasury for general deficit reduction. CBO estimated the savings of the Gardner fix at \$705 million, while the spina bifida benefit was costed at \$195 million -- leaving \$510 million of excess spending potentially available for veterans programs. We are hopeful that the Veterans' Affairs Committees will support this strategy and work with us to recoup these funds.

#### **Stand-Alone Veterans Appropriations Subcommittee**

As we stated last year, VVA supports a reorganization of the Appropriations Committees to create a separate subcommittee to deal exclusively with funding for veterans programs both within and outside the Department of Veterans Affairs, including VETS at the Dept. of Labor, and Transition Assistance Program (TAP) within the Dept. of Defense. This could be done without increasing the total number of subcommittees, and in fact could result in improved efficiency by eliminating overlapping jurisdictions and functions.

The aim would be to create greater accountability and funding integrity through closer coordination of authorized missions and budget functions. The VA, HUD and Independent Agencies Appropriations Subcommittees currently juggle funding for the conflicting and demanding needs of

more than 21 separate agencies. Formation of a separate subcommittee for the Department of Veterans Affairs and related program spending would also eliminate the serious perennial problem of how to balance the extreme mismatch between VA's high annual outlay rates, with the low outlays but large budget authority levels of HUD and other agencies. The VA, HUD & Independent Agencies Subcommittee has not been able to withstand the competing pressures and meet the essential spending needs of America's 27 million veterans.

In addition to the obvious advantages for assuring fairness and balance in protecting vital veterans programs, this proposal would assure greater accountability and better management efficiency for Congress. While VVA does not offer this suggestion as the panacea for the budgetary challenges facing VA and the veterans community, it still is a practical and easily understood partial solution and clearly a significant step in the right direction.

#### **Conclusion**

This is a challenging time for the veterans community. Fiscal considerations are forcing the VA to develop new ways of doing business -- in many cases improving services while enhancing efficiency. Yet veterans are very cautious, because they have seen budget-driven changes in the VA restrict services through the years. While these budget proposals frequently look good on paper and VA has done a very good job of selling the plan, there are no guarantees that health-care funding will increase to meet the changing needs of the veterans population or even inflation. Quite often the plans and commitments made at VA Central Office are interpreted and implemented quite differently in the field.

VVA agrees with the overall objectives of developing alternative funding streams for VA to supplement the federal appropriation. But we strongly recommend that both fiscal and legislative protections be put in place at the outset, to ensure that there will be no shortfall of funding in FY 1998, nor in the out years. Additionally, the fiscal incentives for VISN directors must include some protection for VA's core mission of providing specialized care to veterans. Addressing these concerns is critical to ensuring a smooth transition toward the VA of the future.

VVA urges this committee to work closely with your respective leadership and your colleagues on the Budget and Appropriations Committees to assure an appropriate level of funding for VA and other veterans programs. Also, the veterans community must work collaboratively with the House Ways and Means, Senate Finance, House National Security, and Senate Armed Services Committees to achieve the legislative language necessary to make these proposals work effectively. Rest assured that we have heard your message about helping to educate your colleagues who do not sit on this committee. And we will work collaboratively with you to achieve these objectives.

Thank you for the opportunity to present VVA's views on the FY 1998 budget. This concludes our statement. We would be pleased to respond to any questions.



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*A Not-For-Profit Veterans Service Organization Chartered by the United States Congress*

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Kelli Willard West joined the VVA government relations department in 1993, after serving in the U.S. House of Representatives as Legislative Assistant to Representative Dave Nagle from her home state of Iowa. As VVA Legislative Assistant and subsequently Deputy Director for Government Relations, her areas of responsibility included health care, Agent Orange, PTSD and related issues. In October 1995, she was promoted to her current position as Director of Government Relations.

West is responsible for coordinating VVA government relations and legislative activities; advising VVA leaders on strategy; overseeing and training VVA's nationwide network of legislative coordinators in support of national VVA advocacy goals; and keeping the general VVA membership informed through reports in *The VVA Veteran*.

Kelli received her B.A. in Global Studies from the University of Iowa. She resides in Washington, D.C., with her husband Rich, who is a graduate student at American University.

### **VIETNAM VETERANS OF AMERICA, INC. Funding Statement February 27, 1997**

The national organization Vietnam Veterans of America, Inc. (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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# Independent Budget for Veterans Programs

Promises to keep...



Fiscal Year  
**1998**  
Executive Summary

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A special thanks to the many others from the veterans community who contributed to the development of this document.

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## Prologue

**F**OR THE 11TH YEAR, AMVETS (American Veterans of World War II, Korea and Vietnam), Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars of the United States join to present a budget based on achieving our policy objectives for veterans' programs in the next fiscal year.

Through the years, the *Independent Budget* has become a consensus document outlining the four coauthors' policy priorities for Department of Veterans Affairs (VA) programs in the next year. More than 50 additional organizations endorse the Independent Budget's guiding principles. The coauthors are proud to continue the tradition of working together to address issues of greatest importance to the veterans and organizations we represent.

These veterans service organizations (VSOs) were chartered by Congress to represent veterans. We are the veteran community's voice. Veterans, as the primary consumers of health care in the Veterans Health Administration (VHA) and of other VA benefits and services, should be involved in planning the administration and delivery of these services. While VSOs were asked to participate in working groups and panels looking into VHA restructuring, management in the new Veterans Integrated Service Networks (VISNs) has tended to circumvent this buy-in process for our groups, veterans, and others, such as volunteers, employees, and academic affiliates—those who will be most affected by the planned changes. Instead, network managers fall back on the predictable formula of calling veterans' groups and others to the table at the last minute to present leadership's decisions. Last-minute information does not equate to meaningful involvement in the decisionmaking process and does not produce the same result. Both the quality of plans and veterans' acceptance of these plans suffer without real consumer input.

Understandably, with shifting power structures VSOs' relationships with VA have changed. VSOs initially embraced most of the concepts set forth in VHA's *Vision for Change*. This document called for patient-centered care, local decisionmaking, and some programmatic changes in focus. Since the plan's implementation, however, VSOs have failed to see some core VHA system values translated to the network level. VHA's commitment to special programs makes an outstanding case in point. While VA Headquarters seems genuinely committed to preserving the integrity of special programs, some networks seem intent on toying with these programs because of their costs. When significant changes are planned, network managers are genuinely surprised to meet resistance from those served by the programs.

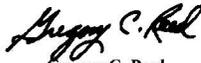
As with medical benefits, the system for delivering nonmedical benefits and services to veterans and their families is the subject of much study and debate. The VSOs who work within that system and are intimately familiar with its level of performance, its strengths, and its weaknesses are responsible, in large part, for heightening attention to its needs. While various components within the Veterans Benefits Administration (VBA) are serving their customers well despite heavy workloads and reduced resources, virtually all who are familiar with the claims adjudication process agree that this area is not functioning satisfactorily. VSOs are in the best position to understand veterans' needs and expectations and how VA can improve its services to veteran consumers.

VSOs are not guardians of the status quo. We realize that VA health care must change to ensure its place in a rapidly evolving health care environment. In this *Independent Budget*, we promote initiatives we believe can help VA provide efficient, high-quality care for veterans. We feel certain that our ideas would preserve VA as a unique resource for veterans' health care and thereby allow it to survive ephemeral changes in its environment. Similarly, veterans' benefits delivery must improve to ensure veterans are well-served into the next century.

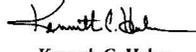
Veterans are not only the system's consumers—we are its advocates, its volunteers, and its reason for being. Unless it accounts for our preferences and unique needs in the future, VA could and should close its doors.



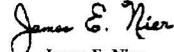
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## Introduction

Efforts to reduce health care costs are dramatically transforming the way health care is delivered in the United States. Health care systems are operating under tight budgets—and the Department of Veterans Affairs' (VA) medical system is no exception. Along with the challenge of working in a more austere budget environment, VA is reorganizing into health networks administered at the local level. VA administrators are making many much-needed structural and operational changes to improve the quality and efficiency of VA health services. Nevertheless, the four veterans service organizations that are coauthors of the *Independent Budget (IB)* (the IBVSOs) fear that VA's attempts to be cost-effective may in some cases be taking precedence over efforts to provide high-quality care to veterans. We are especially concerned about the future of VA's specialized programs, which serve many of our Nation's most vulnerable veterans.

Specialized services are an integral part of VA's mission. From VA's inception, Congress has recognized the Department's unique potential to serve as a national leader in the research and treatment of specialized services. Because of the prevalence of certain chronic and disabling conditions among veterans and VA's strong medical, research, and teaching missions, VA has developed unparalleled expertise and resources to provide certain specialized services. VA's prosthetic services, blind rehabilitation, spinal cord injury care, and mental health services, including treatment for posttraumatic stress disorder, are largely unmatched in excellence and not widely available in the private sector.

Last year, the 104th Congress and the Clinton administration took an important step toward protecting specialized services in the VA medical system by passing Pub. L. 104-262. The law requires VA to maintain its capacity to provide specialized services within distinct facilities or programs. It also directs VA to establish a strategic plan for veterans who rely on these special programs. Through this statute, Congress heightened its commitment to the

oversight of these programs and reaffirmed their importance in the VA medical system.

The new law also includes changes to VA's complicated and outdated eligibility rules—some that the *Independent Budget* has advocated for more than a decade. Veterans will have increased access to outpatient and preventive care. VA administrators will no longer be compelled to admit veterans to the hospital for services that would be more appropriately provided in an outpatient setting. As a result, VA will be able to provide veterans with more convenient, high-quality, and cost-effective care. The law also fulfills another long-standing *IB* objective: It gives veterans with catastrophic disability who are not otherwise eligible for care high priority for VA services. These veterans and their families will no longer be forced to drain their savings before gaining access to the VA medical system.

The IBVSOs—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars of the United States—and the more than 50 organizations that endorse the *IB* thank Congress and President Clinton for enacting this important legislation. Early on in the formulation of the bill, the *IB* coauthors, as well as most other veterans service organizations (VSOs), supported the legislation as a starting point for future reforms. While the coauthors agreed with the Congressional Veterans Affairs Committees that eligibility reform could take place within a budget that supported "current services," we did not necessarily agree that the amounts enacted in law were sufficient to bring about other desired changes. Therefore, this *IB*, as in past years, calls on Congress to provide full funding to maintain appropriate levels of care (see table 1).

The IBVSOs recognize that the bill's path to enactment was not an easy one, in light of past opposition from organizations such as the Congressional Budget Office and the General Accounting Office. These groups feared that more veterans would come to VA as a result of improved access to services and that VA could not afford the cost of new users. We commend

TABLE 1

### VA Appropriations by Account (dollars in thousands)

	FY 1997 APPROPRIATION	FY 1998 IS CURRENT SERVICES LEVEL	FY 1998 IS RECOMMENDED APPROPRIATION	FY 1998 IS RECOMMENDED BUDGET AUTHORITY
<b>GENERAL OPERATING EXPENSES</b>				
General Operating Expenses	827,584	851,382	853,808	853,808
Office of the Inspector General	30,900	31,789	31,789	31,789
National Cemetery System	76,864	79,075	85,550	85,550
<b>TOTAL GENERAL OPERATING EXPENSES</b>	<b>\$935,348</b>	<b>\$962,246</b>	<b>\$971,147</b>	<b>\$971,147</b>
<b>BENEFITS PROGRAM</b>				
Compensation, Pension, and Burial Benefits	19,424,259	19,735,043	19,735,043	19,735,043
Readjustment Benefits	1,377,000	1,366,000	1,366,000	1,366,000
Veterans Insurance & Indemnities	38,970	51,360	51,360	51,360
Veterans' Job Training Fund	0	0	0	0
Veterans Housing Benefit Program	503,756	352,884	352,884	352,884
Direct and Other Loan Program Accounts	622	633	633	633
Native American Veteran Housing Loan Program Account	205	515	515	515
<b>TOTAL BENEFITS</b>	<b>\$21,344,812</b>	<b>\$21,506,435</b>	<b>\$21,506,435</b>	<b>\$21,506,435</b>
<b>MEDICAL PROGRAMS</b>				
Medical Care	17,013,447	18,043,558	19,590,764	23,820,609
Medical & Prosthetic Research	262,000	272,460	292,460	292,460
Medical Admin and Miscellaneous Operating Expenses	61,207	62,991	63,591	63,591
Health Professions Educational Assistance Programs	0	15,000	15,000	15,000
<b>TOTAL MEDICAL PROGRAMS</b>	<b>\$17,336,654</b>	<b>\$18,394,009</b>	<b>\$19,961,815</b>	<b>\$24,191,660</b>
<b>CONSTRUCTION PROGRAMS</b>				
Construction, Major Projects	218,758	391,499	391,499	391,499
Construction, Minor Projects	175,000	299,900	299,900	299,900
Parking Garage Revolving Fund	12,300	1,500	1,500	1,500
Grants for Cons. of State Vet. Cemeteries	1,000	2,500	2,500	2,500
Grants for Cons. of State Extended Care Facilities	47,397	80,000	80,000	80,000
Grants to the Republic of the Philippines	0	500	500	500
<b>TOTAL CONSTRUCTION PROGRAMS</b>	<b>\$454,455</b>	<b>\$775,899</b>	<b>\$775,899</b>	<b>\$775,899</b>
<b>TOTAL VA PROGRAMS</b>	<b>\$40,071,269</b>	<b>\$41,638,589</b>	<b>\$43,215,296</b>	<b>\$47,445,141</b>

Congress for its foresight and willingness to look beyond this and other ill-founded assumptions.

Although the eligibility reforms in Pub. L. 104-262 will help VA gain tremendous cost-efficiencies, veterans' advocates remain concerned about VA's future financial stability. Deep budget cuts in some parts of the country have led VA health care administrators to lay off large numbers of health care workers and cut important programs. Reductions in the number of health care workers have resulted in greater delays in care.

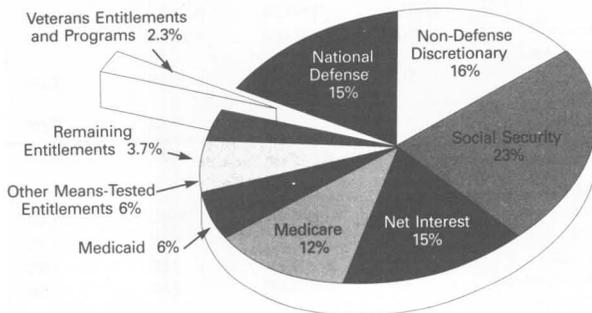
Both Democrats and Republicans have pledged not only to eliminate the deficit in the next 6 years, but also to lower taxes. Thus, the reelection of President Clinton and the return of the Republican majority in Congress put added pressure on VA to deliver high-quality services with fewer resources. With balancing the budget as a top priority and Federal entitlement programs such as Social Security and Medicare difficult to cut or downsize, Federal policymakers might have

little choice but to look to discretionary funds—including those that support the VA medical system—to trim government spending. It is important to note, however, that veterans entitlements and programs are a very small percentage of federal government spending (see chart 1) and that VA already has contributed significantly to reducing the federal deficit (see chart 2).

The IBVSOs are especially concerned about the future of VA's special programs as restructuring progresses within the 22 Veterans Integrated Service Networks (VISNs). Although the IBVSOs continue to support VA's restructuring goals and advocate for operational changes within VA's medical system, we fear that efforts to be cost-effective may be overriding efforts to provide high-quality care. Some of our most vulnerable (and expensive-to-treat) veterans—those with severe physical disabilities (spinal cord dysfunction, amputations, or blindness), mental illness, or

CHART 1

### VA Programs as a Percentage of Total Federal Government Spending in FY 1998

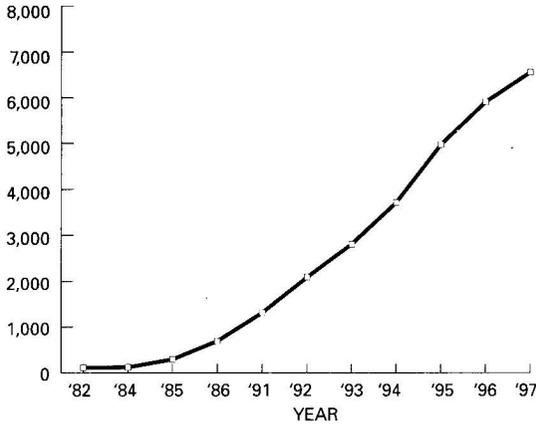


*Note: Numbers do not add due to rounding.*

Sources: Budget of the U.S. Government, VA FY 1998 Budget Submission

## VA's Cumulative Contribution Towards Deficit Reduction

(in millions)



Source: Budgets of the U.S. Government.

chronic disease—must not be the most adversely affected by restructuring under limited budgets.

As part of its reorganization, VA is moving to a capitation system to guide its budget allocations to the VISNs. The IBVSOs are similarly concerned about the impact of capitation on specialized programs and believe that steps must be taken to ensure that perverse incentives created by capitation do not drive management decisions. Capitation rates for veterans who rely on special programs must be high enough to provide those veterans with the full continuum of specialized services to meet their needs. They also must be high enough to ensure that local managers have no incentive to abandon the excellent programs that support veterans with special needs. As VA makes this transition, health outcomes must be closely

monitored to ensure that veterans with special needs are receiving appropriate care.

Like their peers in the private sector, network managers will have to decide how to use limited dollars to provide the most care to the greatest number of veterans. Unfortunately, in the quest to be cost-effective, some administrators are making the same decisions that their peers in the private sector once made: They are limiting care for users with a high level of need and targeting for savings the special, but expensive, programs that have become the heart of VA's health care system.

Other VA administrators, however, like many private sector managers, have learned that exchanging breadth of coverage for depth of coverage does not work. They understand that limiting access to services for individuals with chronic conditions only increases ultimate costs and that

preventing secondary conditions is the most effective cost-savings method. As a result, they are now implementing disease management strategies that identify individuals with certain chronic conditions who are most likely to use their services and are building special programs for them. High-quality private sector providers realize that mainstream systems do not work effectively for individuals who need rigorous case management to ensure that their chronic conditions are controlled and to avert unnecessary acute episodes of care.

All VA health care administrators must learn to capitalize on the programs they already have in place. The IBVSOs believe that, while managers may want to reevaluate some aspects of service delivery for specialized programs, improving quality of care rather than achieving cost-savings should be the reason for reform. While some initiatives may produce cost savings, savings should not be the primary motivation for changing the way care is delivered.

Representatives of all VA stakeholders—especially veterans who use the VA medical system—should be involved in decisions affecting the way VA care is delivered. Without input from veterans who use the system, VA will fail to achieve one of its most important goals: a patient-centered system. A truly patient-centered VA would listen and respond to the needs and concerns of veterans, and give veterans and other stakeholders an integral role in VA's continuous planning process.

The veterans community will see many changes in the future of the Veterans Health Administration (VHA) under reorganization and reforms brought about by Pub. L. 104-262. Exactly how VA—and, for that matter, any health system—will look in several years is unclear because health care is changing so rapidly. Nevertheless, whatever VA's future holds, specialized services should and must be an important part of the Department in the 21st century.

While VHA continues its reorganization under tight budgets, it must pay careful attention to how its veterans with special health care needs are affected and take steps to ensure that specialized services—the shining jewel of VA—are not jeopardized through efforts to achieve cost-efficiency.

Congress has fashioned a range of nonmedical benefits and services to meet various needs of veterans and eligible family members. As circumstances warrant or new needs arise, these benefits are adjusted to better serve their intended purpose and to improve their effectiveness.

The IBVSOs have played a central role in defining the shape these programs should take and in identifying needed changes. Unfortunately, some changes in recent years were not for improvement but for budgetary purposes. The IBVSOs believe that no group is on the whole more deserving of assistance than those who have made personal sacrifices in our Nation's defense. It has therefore been our position that veterans' programs should always be viewed as a priority for government funding.

Compensation for service-connected disability is VA's core benefit. Unlike the tidal wave of changes that have taken place in health care, the nature of compensation and its delivery have remained unchanged. However, large claims backlogs and resulting long delays in claims processing in recent years have brought the system under much scrutiny from within and without. The IBVSOs have been at the forefront in pressing for changes. A sincere effort to identify the sources of the problems and their solutions has been channeled through various commissions and studies.

While these initiatives were well-intentioned, the direction some have taken is cause for concern. They have departed from the singular objective of improving delivery of compensation to veterans and have gone so far as to recommend fundamental changes in the nature and purpose of compensation, including a more restrictive and burdensome process for veterans, as ways to make the administration of benefits easier for VA.

The IBVSOs have maintained that the source of the problem is simply high error rates necessitating multiple decisions or administrative actions to accomplish what should have been accomplished in the initial decision. In the *Independent Budgets* for the last 2 years, we have supported that view with detailed analysis and citation of data. We have recommended a course of action to remedy the problem. During that same period, VA's own in-house experts were conducting an objective and introspective internal study of the problem. The findings and recommendations from that study closely parallel those of the IBVSOs. The Veterans Benefits Administration (VBA) has incorporated the recommendations, known as its Benefits Process Reengineering (BPR) plan, in its strategic plan under the Government Performance and Results Act of 1993 (GPRA), which forms the basis for its budget request for fiscal year 1998.

## INTRODUCTION ▶

Although in the past the IBVSOs have been dissatisfied with VA's efforts to improve claims processing, we believe that, in its BPR plan, VA has been objective and candid in its self-assessment and has formulated a good general blueprint for correcting the identified deficiencies. We support the concept of the plan and believe that its singular goal is truly to improve service to VBA's customers. On the other hand,

we adamantly oppose other approaches that would "solve" the problem by reducing veterans' rights and thereby lessening VA's responsibilities. Through its BPR plan, VBA has embarked on a course the Congress and the other stakeholders have strongly urged. The IBVSOs submit that Congress must now provide VA with the resources necessary to accomplish the plan.

# Summary of Recommendations

## Benefits Programs

### A. Compensation, Pensions, and Burial Benefits

- ▶ Enact a cost-of-living adjustment (COLA) for compensation and for dependency and indemnity compensation (DIC).
- ▶ Maintain VA's discretion to adopt or revise the *Schedule for Rating Disabilities*.
- ▶ 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 circumstance necessitating convalescence.
- ▶ Repeal the requirement that a veteran's military retired pay based on longevity be offset by an amount equal to his or her disability compensation.
- ▶ Remove the requirement that military nondisability separation, severance, or readjustment pay be offset against VA disability compensation.
- ▶ Provide for an exception to the 3-year limitation on amendment of tax returns in the cases of erroneous taxation of disability severance pay or retroactive exemption of more than 3 years and discontinue the withholding of taxes from disability severance pay.
- ▶ Repeal the Omnibus Budget Reconciliation Act of 1990 provisions limiting revived DIC eligibility to cases of annulled or voided marriages.
- ▶ 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.

- ▶ 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.

### B. Miscellaneous Assistance

- ▶ Permit payment of Equal Access to Justice Act (EAJA) fees to unsupervised nonattorneys who represent appellants before the U.S. Court of Veterans Appeals (CVA).

### C. Readjustment Benefits

- ▶ Adjust the basic Montgomery GI Bill (MGIB) allowance to a level that provides veterans more assistance in meeting the costs of pursuing a course of education.
- ▶ Permit refund of an individual's MGIB contributions when his or her discharge was characterized as "general" or "under honorable conditions."
- ▶ Adjust the benefit rate for the Survivors' and Dependents' Educational Assistance program to correct for the lack of COLAs since 1989 and provide for automatic annual adjustments indexed to the rise in the cost of living.
- ▶ Adjust the amount of the housing and adaptation grants to offset losses in their value due to inflation and provide for automatic annual adjustments indexed to the rise in the cost of living.
- ▶ Increase the automobile allowance to 80% of the average cost of a new automobile.
- ▶ Provide for automatic annual adjustments in the automobile allowance indexed to the rise in the cost of living.

## SUMMARY OF RECOMMENDATIONS ▶

**D. Home Loan Programs**

- ▶ Authorize adjustable rate mortgages through VA's home loan programs.

**E. Other Suggested Benefit Improvements**

- ▶ Remove the 2-year limitation on payment of accrued benefits.
- ▶ Require correction of Board of Veterans' Appeals (BVA) decisions involving clear and unmistakable error.
- ▶ Exempt veterans' entitlements from the "pay-go" provisions of the Budget Enforcement Act.

**F. Opposition to Benefit Reduction or Elimination**

- ▶ Reject means testing of VA disability compensation.
- ▶ Retain compensation for partial disabilities with low ratings.
- ▶ Reject offsets of VA disability compensation by amounts received in Social Security payments.
- ▶ Reject taxation of veterans' benefits.
- ▶ Reject arbitrary across-the-board cuts in the payments of compensation and pensions.
- ▶ Reject restriction of compensation payment through imposition of a strict performance-of-duty standard for service connection.

**General Operating Expenses****A. Veterans Benefits Administration****1. Compensation and Pension (C&P)**

- ▶ Appropriate funds necessary to implement the C&P Service's Business Process Reengineering plan, including personnel training and improvements in information technology. Reject recommendations that VA negate the Court's rulings by revising its current rules. Ensure that VA rulemaking does not erode or undermine claimants' rights.
- ▶ Should it become necessary to protect VA claimants' procedural rights, codify into law provisions that VA shows an intent to rescind. Congress, if necessary, should amend the Secretary's general rulemaking authority to

require means for public participation in rulemaking that impacts upon VA customers.

- ▶ Enact the legislative changes recommended by the C&P Service needed to simplify VA programs, namely, de novo review authority for Post-Decision Review Officers and pension simplification.
- ▶ The C&P Service should revise its Business Line Plan to include more strategies for improving the quality of decisionmaking, including the development of performance standards and the implementation of a quality assurance infrastructure.
- ▶ Institute a program to train adjudicators on the mandatory nature of case law and in its use and applicability. Include a process that accounts for proper and legal adjudications, monitors compliance and quality control, and identifies problem areas of appellate decisions.
- ▶ Specify, in BVA decisions, regional office errors resulting in reversal or remand.
- ▶ If VA fails to voluntarily revise the manner in which Board of Veterans' Appeals decisions are written, Congress should amend 38 U.S.C.A. § 7104(d) (West 1991) to expressly require that the Board either specify the basis for affirming the decision of the agency of original jurisdiction or the errors accounting for the Board's reversal or remand.

**2. Education**

- ▶ Appropriate funds for the Education Service to improve accessibility, services, accuracy, timeliness, and efficiency as envisioned in the GPRA Business Line Plan.

**3. Loan Guaranty Service**

- ▶ Appropriate funds for Loan Guaranty Service to fulfill the goals in its Business Line Plan, including the information technology improvements.
- ▶ Maintain the current level of full-time employee equivalents (FTEEs) for the Loan Guaranty Program.

**4. Vocational Rehabilitation and Counseling (VR&C)**

- ▶ Maintain current FTEE levels until the effects of reorganization on staffing needs can be

evaluated. Include a plan to return to full in-house counseling and routine rehabilitation services.

- ▶ Include VR&C's immediate and future needs in the development of automated support systems.
- ▶ Utilize Disabled Veterans Outreach Program Specialists employed at the local job service office in the case management system for vocational rehabilitation.
- ▶ Finalize the Design Team report and forward it to the Under Secretary for Benefits and the Secretary for implementation, if appropriate.

#### 5. Insurance

- ▶ Appropriate funds necessary for the Insurance Service to fulfill its customer service goals.

#### 6. Veterans Services

- ▶ Appropriate funds to enable Veterans Services to perform its assigned tasks.

#### 7. Information Technology

- ▶ Appropriate funds to maintain VBA's existing data systems while new systems are implemented.
- ▶ Appropriate funds for the development of information technology.

### B. General Administration

#### 1. Board of Veterans' Appeals (BVA)

- ▶ Earmark sufficient funding for BVA training programs.
- ▶ Change 38 C.F.R. § 19.5 to mandate that BVA is bound by VA manuals, circulars, and other directives.

#### 2. General Counsel

- ▶ Authorize 12 additional FTEEs for professional staff group (PSG) VII to handle the increased workload.
- ▶ Authorize 10 additional FTEEs for the Alternative Dispute Resolution Program.
- ▶ Authorize 15 additional FTEEs for procurement and leasing functions to minimize VA's liability and reduce litigation and claims costs.

### 3. Courts of Veterans Appeals (COVA)

- ▶ Enact legislation to codify the establishment of the Veterans Consortium Pro Bono Program.
- ▶ Appropriate adequate funds to operate the Veterans Consortium Pro Bono Program.

### *Veterans' Employment and Training*

#### A. U.S. Department of Labor: Veterans' Employment and Training Programs

- ▶ State in employment and training authorization legislation that veterans' readjustment is a National priority.
- ▶ Set levels of service that may be quantified based on local veterans' need.
- ▶ Clearly specify in Department of Labor (DOL) policy eligible veterans' priority for services in DOL programs, including displaced workers.
- ▶ Develop veterans labor market statistics to determine levels of need for local planning purposes.
- ▶ Legally define the Local Veterans Employment Representatives' (LVERs) monitoring, oversight, and coordinating role over all one-stop Career Center activities and give the LVERs authority for ensuring that veterans receive priority services in one-stop Career Centers.
- ▶ Clearly specify in law and DOL policy that state and local governments must provide veterans priority services in one-stop Career Centers.
- ▶ Establish uniform national veterans' employment and training reporting requirements.
- ▶ Review Veterans Employment and Training Services (VETS) Federal employee staffing patterns in light of the changing role of the Director and Assistant Director of Veterans Employment and Training (DVETS and ADVETS).
- ▶ Appropriate funds for the Homeless Veterans Reintegration Programs (HVRP).
- ▶ Increase funding for the Transition Assistance Program (TAP).

## SUMMARY OF RECOMMENDATIONS ▶

- ▶ Provide adequate funding for the National Veterans' Training Institute (NVTI).

**B. Veterans' Preference in Federal Civil Service**

- ▶ Maintain veterans' preference principles and ensure that the system provides meaningful monitoring and oversight for uniform implementation of the law.
- ▶ Ensure that the development of veterans' preference policy oversight and monitoring is not jeopardized by reduced Office of Personnel Management (OPM) staff, decentralized personnel functions, and contracted out services previously provided by OPM.
- ▶ Require that OPM maintain passover and medical unsuitability decisionmaking at the OPM level.
- ▶ Reduce the number of noncompetitive and accepted appointing authorities and maintain a central authority to enforce uniform personnel policies on the various agencies.
- ▶ Establish a complaint process for veterans illegally denied employment that would allow for appeals ultimately to the Federal courts. Establish legal remedies that would provide the veteran all benefits of employment as though the original error had not been committed.
- ▶ Amend title 5 U.S.C. to provide for affirmative action to be taken among the top equally qualified candidates and to require that disabled veterans be selected for promotion.

**National Cemetery System**

- ▶ Appropriate \$85.6 million for the National Cemetery System (NCS) in fiscal year (FY) 1998.
- ▶ Add at least 60 more FTEEs to cover incremental workload increases and maintain current services.
- ▶ Provide at least \$4 million in additional funds to reduce equipment backlog.
- ▶ Conduct a feasibility study to promote a second national cemetery to ease the demand for space at Arlington National Cemetery.

- ▶ Ensure that each state has an open cemetery.
- ▶ Expand existing national cemeteries wherever possible.
- ▶ Recommit to a policy of an open national cemetery within 75 miles of 75 percent of America's veterans.
- ▶ Seek relief from historic preservation requirements at NCS facilities wherever appropriate.

**Medical Programs****A. Medical Care**

- ▶ Divert resources from inpatient to noninstitutional care.
- ▶ Ensure that efforts to gain cost savings do not take priority over efforts to improve health care quality.
- ▶ Develop a patient-centered approach to delivering health care services.

**Creating a Health Care Continuum****1. New Eligibility Reform Law**

- ▶ Give current VA users priority in enrollment as long as VA can ensure access for veterans with service-connected conditions for any condition.
- ▶ Aggressively recruit current system users for enrollment, particularly those who are most at risk of being left out, including severely disabled veterans, veterans with mental illness, and homeless veterans.
- ▶ Define a nonservice-connected catastrophically disabled veteran, for the purposes of determining their priority for VA health care, as an individual who merits a rating of 100% under VA's *Schedule for Rating Disabilities*.
- ▶ Define "capacity" as the capability to contain and provide services to a certain patient population.
- ▶ Provide women veterans with access to the full range of maternity services.
- ▶ Provide access to fertility treatment for veterans whose problems are service-related.

- ▶ Include veterans service organizations (VSOs) and other VA stakeholders in the VA reorganization planning and decisionmaking process.
- 2. Access**
- ▶ Create points of access to ensure that VA is able to provide accessible primary care services.
  - ▶ Use vet centers as points-of-entry into the VA medical care system.
  - ▶ Add funds to support training for emerging clinical roles.
- 3. Primary and Preventive Care**
- ▶ Implement primary care and case management programs to improve the management, coordination, and continuity of care.
  - ▶ Broadly define "medical services" to give veterans access to a wide array of in- and outpatient services, including primary and preventive care.
  - ▶ Fund programs that enhance primary and preventive care.
- 4. Acute Care**
- ▶ Divert resources from inpatient to noninstitutional care.
  - ▶ Align missions of VA hospitals within the VISN reorganization. Consolidate and improve resource allocation as necessary.
  - ▶ Develop hospital admission, utilization, and length of stay criteria and clinical practice guidelines to assist clinicians with medical decisionmaking.
  - ▶ Set standards for appropriate lengths of stay (if any) for pre-admission procedures for surgery and annual physicals. Schedule patients with appropriate providers before they are admitted or to preclude admission.
  - ▶ Implement a system for consistent and routine home follow-up or telephone contact with patients.
  - ▶ Establish discharge planning programs to ensure appropriate follow-up that utilizes community services and assesses functional, psychological issues.
- ▶ Allocate more resources for hospital-based home care and systematic outpatient follow up.
  - ▶ Develop and utilize telemedicine devices to reduce travel and improve access to care.
  - ▶ Utilize lodging alternatives when appropriate to avoid hospital admission.
  - ▶ Increase VA hospital patients treated from 834,511 in FY 1996 to 934,652 in FY 1998 (cost: \$811.1 million).
  - ▶ Increase outpatient care staff visits from 28.4 million in FY 1996 to 31.8 million in FY 1998 (cost: \$275.1 million). Increase fee outpatient visits from 1.1 million in FY 1996 to 1.2 million in FY 1998 (cost: \$50.7 million).
- 5. Intermediate (Subacute) Care**
- ▶ Examine the types of patients treated in intermediate care beds and restructure resources to care for these patients in the most effective settings for their conditions.
  - ▶ Increase capacity to provide temporary lodging and residential care to accommodate patients needing housing but not acute care while undergoing diagnostic evaluation or treatment.
  - ▶ Expand VA domiciliary care capacity and accommodate an average daily census (ADC) of 6,164 in VA's own programs in FY 1998 and 6,650 in FY 2001 (cost: \$34.7 million in FY 1998).
- 6. Home- and Community-Based Care**
- ▶ Allow VA to determine how much community nursing home funding to divert to non-institutional care settings.
  - ▶ Develop standards for appropriate use of hospital-based home care (HBHC) programs.
  - ▶ Operate 84 HBHC programs by FY 1998 (cost: \$5.9 million).
  - ▶ Operate three new VA adult day health care programs (a total of 16 programs) by FY 1998 (cost: \$5 million).
  - ▶ Increase the number of contracted adult day health care programs from 83 in FY 1996 to 93 in FY 1998 (cost: \$1.3 million).
  - ▶ Expand the community residential care program to accommodate an ADC of 10,416

## SUMMARY OF RECOMMENDATIONS ▶

in FY 1998 and an ADC of 11,160 by 2001 (cost: \$1.7 million in FY 1998).

- ▶ Establish three assisted living facilities by FY 1998.

### 7. Nursing Homes and Other Long-Term Care Institutions

- ▶ Work incrementally toward accommodating 16 percent of VA's market share by 2005.
- ▶ Implement VA's planning goal for a nursing home workload distribution of 40 percent in community homes, 30 percent in VA homes, and 30 percent in state nursing homes.
- ▶ Increase VA nursing home ADC from 13,642 in FY 1996 to 15,279 in FY 1998 (cost: \$138.3 million).
- ▶ Increase state home nursing home ADC from 12,518 in FY 1996 to 14,020 in FY 1998 (cost: \$24.4 million).
- ▶ Increase community nursing home ADC from 7,414 in FY 1996 to 8,304 in FY 1998 (cost: \$66.3 million).
- ▶ Operate 20 new respite care programs (a total of 152) by FY 1998 (cost: \$2.9 million).
- ▶ Expand the VA hospice program by creating community-based programs with existing hospital-based home care teams (cost: \$0).

### Contracting

- ▶ Develop a system to monitor care delivered by contract organizations to ensure that veterans receive high quality care.
- ▶ Ensure that contracting options do not jeopardize programs that currently have enough patients to maintain quality of services.

### Creating An Adequate Funding Stream for VA Health Care

- ▶ Authorize VA to collect and retain Medicare reimbursement for certain veterans. Authorize VA to initiate a multi-year pilot project to assess the feasibility and cost-effectiveness, both to VA and Medicare, of collection and retention of Medicare reimbursement.

- ▶ Allow VA to retain funds from "lower-priority" veterans' private insurance.
- ▶ Allow VA to treat dependents with private insurance or Medicare and retain the funds.
- ▶ Privatize most medical care cost recovery efforts.
- ▶ Implement systems that will ensure efficient collection operations.

### Ensuring Efficiency to Meet Program Needs

#### 1. Sharing

- ▶ Make VA specialized services available to military beneficiaries with adequate CHAMPUS reimbursement as long as no veterans are displaced.
- ▶ Capitalize on opportunities to collaborate with the military for joint purchasing, consolidating lab services, creating clinical practice guidelines, providing discharge physicals to determine veterans' compensation for disability, and developing medical technology, such as telemedicine and informatics.

#### 2. Resource Allocation

- ▶ Ensure appropriate implementation of the Veterans Equitable Resource Allocation system, adjusting the system as problems are identified.

#### 3. Consolidations and Integrations

- ▶ Include stakeholders in the decisionmaking process to identify best possible solutions and to engender support for consolidations.

### Pharmacy

- ▶ Enforce VA regulations that require provision of medically necessary OTC products to eligible veterans.
- ▶ Ensure broad participation of VA stakeholders including VSOs in the development, implementation, and annual review of the national formulary.

- ▶ Continue to consolidate mail service pharmacies and streamline the handling process for pharmacy products.

### **Special Programs**

#### **1. Homelessness**

- ▶ Provide rigorous case management and follow-up care after veterans' discharges from VA's homeless programs.

#### **2. Posttraumatic Stress Disorder (PTSD)**

- ▶ Continue a strong, accessible PTSD program, with services tailored to meet individual veterans' needs.

#### **3. Care for the Seriously Mentally Ill**

- ▶ Create home and community alternatives to institutionalization.
- ▶ Do not deinstitutionalize patients where no community resources exist to serve them.
- ▶ Make every possible effort to discharge these veterans into stable, supported environments, with detailed plans to monitor their progress and provide aftercare in the community.
- ▶ Develop adequate housing alternatives, sheltered work or activity environments, and care management to ensure that mentally ill individuals function at the highest possible levels.

#### **4. Substance Abuse**

- ▶ Ensure veterans' access to the panoply of services, in medical care, counseling, housing, vocational training, and income support, that respond to their particular needs.
- ▶ Assign a care manager to each patient, to develop goals for the individual, coordinate benefits and services, monitor the patient's progress, and revise the treatment plan when necessary.
- ▶ Ensure that a strong aftercare program is in place for each patient.

#### **5. Blind Rehabilitation**

- ▶ Cultivate more visual impairment services team coordinators, to develop alternative access to training.

- ▶ Maintain expertise in rehabilitation, orientation, and mobility.
- ▶ Augment professional staff who have training in low-vision aids and devices.

#### **6. Persian Gulf Veterans Programs**

- ▶ Continue efforts to uncover and treat the cause or causes behind Persian Gulf Syndrome.

#### **7. Preservation Amputation Care and Treatment (PACT)**

- ▶ Invest PACT teams in outreach and patient education for high-risk VA users.

#### **8. Prosthetics and Orthotics**

- ▶ Appropriate funds to meet the new demand likely to arise from increased access to prosthetics and orthotics.
- ▶ Ensure that VHA Headquarters (VHA-HQ) monitors the use of prosthetic funds.
- ▶ Ensure that the quality of equipment is not sacrificed by efforts to achieve cost savings.
- ▶ Ensure that quality, not cost, is the major determinant of assessing bids for contracts.
- ▶ Ensure that PSAS funds are not diverted to an extent that jeopardizes efficiency.
- ▶ Tailor equipment for personal use, subject only to clinical judgment and patient preference, to meet the needs of each patient.

#### **9. Spinal Cord Dysfunction Medicine**

- ▶ Fund a Geriatric Research, Education and Clinical Center (GRECC) devoted to investigating the consequences of aging with a spinal cord injury (SCI) and the special treatment needs of veterans with such injuries (cost: \$3 million).
- ▶ Shift resources to outpatient care and coordinate VA and community resources to serve patients in their homes and communities.
- ▶ Develop alternative care settings to meet these veterans' needs optimally.
- ▶ Assess assisted living arrangements, personal assistants, hospital-based home care, and other options to determine, with the patient, which care best meets an individual's needs.

## SUMMARY OF RECOMMENDATIONS ▶

- ▶ Ensure that basic SCI care is available to veterans close to home.
- ▶ Assure high-quality care through a cadre of health professionals trained in spinal cord medicine.
- ▶ Monitor care to ensure optimal quality, performance, patient satisfaction, and outcome.
- ▶ Develop information systems to monitor care and target problem programs.
- ▶ Strive to achieve standards, set by the Commission on Accreditation of Rehabilitation Facilities (CARF), in all VA rehabilitation programs.
- ▶ Establish an interdisciplinary team approach to managing multiple sclerosis (MS) care in VA.
- ▶ Implement at least two regional centers for MS that coordinate all VA MS programs, develop care standards, establish in-service education and training programs, and pursue MS-related health services research.

**Human Resources**

- ▶ Include staff in the VA reorganization planning and decisionmaking process.
- ▶ Develop a clear and systematic approach to employee reductions.
- ▶ Establish and implement performance indicators and operating criteria for the allocation of personnel.
- ▶ Ensure that staff reorganizations preserve the quality of VA services and help VA to achieve necessary shifts in care delivery.

**1. Nurses**

- ▶ Continue to monitor the implementation of amendments to the Nurse Pay Act and problems in salary compression and pay retention.
- ▶ Recruit nurse practitioners to supplement primary and preventive VA providers.

**2. Physicians**

- ▶ Reprogram staff requirements to emphasize primary and preventive care needs.

- ▶ Offer generalist "retraining" to specialists as a recruitment tool.

**3. Dentists**

- ▶ Continue to strengthen VA-dental school affiliations and seek opportunities for sharing resources and facilities with dental schools.
- ▶ Provide 50 dental residency stipends.

**4. Physician Assistants**

- ▶ Take steps to ameliorate retention problems and to improve recruitment of physician assistants by implementing more competitive salaries.

**5. Education and Training**

- ▶ Initiate and expand programs to train students and medical students in primary care specialties.
- ▶ Maintain competitive stipends to attract medical residents and other trainees.
- ▶ Offer tuition reimbursement programs to students in return for service at VA. (See Educational Loan Repayment Program.)

**VA Volunteer Programs**

- ▶ Designate a staff person to be responsible for recruiting volunteers, developing volunteer assignments, and maintaining a program that formally recognizes volunteers for their contributions.
- ▶ Develop new volunteer assignment plans to respond to the increasing need for volunteers in outpatient clinics.
- ▶ Develop, retain, and implement alternate outpatient activities for volunteers and encourage local volunteers to participate.

**B. Medical and Prosthetic Research**

- ▶ Appropriate total funding of \$272 million. Include \$20 million more to launch the Designated Research Areas (DRAs) initiative and support existing statutory research earmarks. The total research appropriation recommendation for FY 1998 is \$292 million. Funding should be allocated as follows: \$200 million for Medical Research; \$31 million for

Rehabilitation Research; \$41 million for Health Services Research and Development; and \$20 million for the DRA initiative.

- ▶ Broaden the definition of research.
- ▶ Create 13 DRAs, as recommended by the Veterans Health Administration Research Realignment Advisory Committee.
- ▶ Give VA clear authority to develop private-public partnerships, including partnerships with for-profit medical entities.

### **C. Medical Administration and Miscellaneous Operating Expenses (MAMOE)**

- ▶ Appropriate \$ 63.6 million and 610 FTEEs (the FY 1997 staffing level) to ensure that VHA-HQ can provide the necessary leadership and guidance in VHA reorganization.
- ▶ Appropriate \$600,000 to ensure that VHA-HQ has adequate training funds to support new staff activities and roles.
- ▶ Ensure that staff have skills needed to perform the duties of their jobs.
- ▶ Ensure that authorized funds for miscellaneous contracts, personal service contracts, and increased tuition facilitate staff development for VA transition.
- ▶ Develop systemwide guidelines, practice parameters, performance standards, outcome measures. Criteria for Potential Realignment, and other policy based on current practice.

### **D. Educational Loan Repayment Program**

- ▶ Authorize the VA Educational Loan Repayment Program to replace the Health Professionals Educational Assistance Program.
- ▶ Appropriate \$15 million to help VA recruit clinicians in high demand positions.

## **Construction Programs**

### **A. Management Recommendations**

- ▶ Incorporate inter- and intranetwork utilization patterns into construction planning to optimize resource sharing.

- ▶ Monitor the impact of organizational changes on project development time and operational efficiency.
- ▶ Establish a formal mechanism to involve local stakeholders in planning and designing new projects, particularly Minor Construction projects.
- ▶ Provide permanent authority for the Enhanced-Use Leasing Program and eliminate the five-projects-per-year cap.
- ▶ Expand access to primary and preventive care, through leasing, sharing agreements, or contracting for these services.
- ▶ Consider acquisition and conversion as alternatives to new construction whenever possible.

### **B. Major Construction**

- ▶ Appropriate \$391.5 million for Major Construction projects, including leases that exceed \$300,000 for outpatient clinics and nursing homes.
- ▶ Identify replacement and modernization projects that provide natural hazard mitigation and modernize and upgrade the physical plant according to established priorities.
- ▶ Open 24 new clinics through lease arrangements in areas that are convenient to veterans.
- ▶ Construct three assisted living facilities and one new VA nursing home.
- ▶ Open seven new nursing home facilities through leasing arrangements.
- ▶ Appropriate funds to construct four new outpatient facilities. Consider sites adjacent to or within veterans' outreach centers.
- ▶ Increase nursing home bed capacity, primarily by converting unused inpatient hospital beds where feasible or by leasing.
- ▶ Appropriate funds to acquire land for national cemeteries in states with no available grave sites.
- ▶ Construct two new national cemeteries annually until the National Cemetery System meets previously stated goals of a minimum of one open cemetery in each state.

## SUMMARY OF RECOMMENDATIONS ▶

**C. Minor Construction**

- ▶ Appropriate \$299.9 million for Minor Construction projects.
- ▶ Raise the \$3 million cost limitation for Minor Construction projects to a level that keeps pace with inflation.
- ▶ Develop alternatives to nursing homes, such as affordable assisted-living residential complexes that maximize independence.
- ▶ Convert six 30-bed wards to nursing home care.
- ▶ Develop temporary housing and residential care capacity that will accommodate patients' housing needs while they are undergoing diagnostic testing and treatment but do not require acute hospital care.
- ▶ Appropriate \$49 million for existing National Cemetery System construction projects.

**D. Parking Garage Revolving Fund**

- ▶ Provide \$1.5 million for this fund.
- ▶ Promote private-sector construction of parking facilities through the Enhanced-Use Leasing program.

**E. Grants for the Construction of State Extended Care Facilities**

Provide \$80 million for these grants, to fund a portion of pending applications for the state home programs.

**F. Grants for the Construction of State Veterans Cemeteries**

Appropriate \$2.5 million to fund VA-anticipated program requirements.

**G. Grants to the Republic of the Philippines**

Appropriate \$500,000 to meet the Manila facility's repair and renovation needs.

## Legislative Initiatives

### VA Medical Programs

**Reform eligibility for VA health care benefits.** Require VA to provide the full continuum of VA health care services, including readily accessible outpatient and long-term care, to Core Group veterans. The IBVSOs define the Core Group as service-connected veterans of all disability ratings, low-income veterans, catastrophically disabled veterans, and those described in special categories in Title 38, U.S. Code. Public Law 104-262 eases access to outpatient and preventive care and is an important first step to providing more convenient, high-quality, and cost-effective care to veterans. However, the law does not change access to nursing home, domiciliary, and long-term care for veterans for treatment of service-connected disabilities.

**Ensure adequate congressionally appropriated support for Core Group veterans' health needs.** Ensure that Congress maintains its commitment to cover the cost of VA services for Core Group veterans by providing full funding from a mandatory spending account.

**Allow VA to retain third-party reimbursement.** Allow VA to retain third-party payments for treatment of veterans in the Medical Care account. The ability to retain third-party reimbursements from all veterans would encourage a strong cost-recovery effort. It would also increase access to VA services for higher-income veterans when they or a third-party payer can cover the cost of VA care.

**Authorize treatment of adult dependents of veterans when they or a third-party payer can cover the cost of VA care.** Adult dependents of veterans should be able to choose VA where space and resources exist to serve them. Authorizing VA to treat adult dependents does not constitute a new entitlement to VA health care. Rather, it gives VHA an opportunity to use some resources more efficiently in exchange for a new source of revenue and allows dependents to use VA health

care under certain conditions, so as to ensure that veterans always have priority to treatment. VA would retain the funds for treatment of adult dependents in the Medical Care account.

**Authorize VA to collect and retain Medicare reimbursement for certain veterans.** VA should be authorized to initiate a multi-year pilot project to assess the feasibility and cost-effectiveness (both to VA and Medicare) of collection and retention of Medicare reimbursement. VA would only collect and retain Medicare payments for treatment of non-Core-Group veterans and all Medicare-eligible dependents. VA would retain the Medicare funds in the Medical Care account. VA would continue to cover the costs for treatment of Core Group veterans and therefore would not collect Medicare payments for these veterans. VA should be allowed to compete with private-sector Medicare providers by offering HCFA discounted rates (as long as rates cover the cost of care provided).

**Allow a portion of reimbursements to remain in the VA facilities that provide treatment.** Allow individual medical facilities to retain a specific share of reimbursements they collect, to encourage initiative and growth. Allow the rest to be distributed, through a centralized decisionmaking process, to areas where high-priority needs exist.

**Expand VHA's authority to allow them to provide procreative services and pre- and post-natal care.** Include in the VA definition of "medical services" those services designed to overcome service-connected and nonservice-connected disabilities affecting procreation. VA should offer pre- and post-natal care in its women's health care programs to Core Group veterans.

**Grant carry-over authority for medical care funding.** Allow VA to carry over to the following year funds not spent by the end of the fiscal year.

## LEGISLATIVE INITIATIVES ▶

**Shield VA from the impact of sequestration.** Legislatively provide total exemption from sequestration for VA medical care appropriations.

**Eliminate arbitrary restrictions on full-time employee equivalents.** Grant VA medical center directors the discretion to hire necessary staff within funds available to their centers, including retained third-party funds.

**Expand the definition of research to allow nonprofit research corporations to accept and expend funds for educational activities that benefit their affiliated VA medical centers.** This would give VA and VA personnel access to the substantial amount of private funding available for continuing medical education.

### Veterans' Benefits

**To keep pace with inflation, compensation must be adjusted at least annually.** Cost-of-living adjustments for all categories of disability compensation and Dependency and Indemnity Compensation rates must be sufficient to offset the rise in the cost of living.

**Exempt VA benefits from the "pay-go" provision of the Budget Enforcement Act.** Allow Congress to base new benefits on their merit, rather than arbitrary budget rules.

**Oppose the taxation of VA benefits.** Seek legislation expressly exempting VA benefits from any form of taxation.

**Remove the 2-year limitation on payment of accrued benefits.** Correct the injustice that occurs when delays or errors by VA defer a claim determination for more than 2 years and the claimant's death intervenes before the eventual favorable decision and benefits payment. Repeal 38 U.S.C. § 5121 (a) and authorize award of all retroactive benefits due to the beneficiaries entitled under section 5121 (a)(1)-(4).

**Seek legislation to provide for correction of "clear and unmistakable error" occurring at the Board of Veterans' Appeals.** This would allow a claimant to challenge an otherwise final Board decision on the basis of clear and unmistakable error, to require the Board to decide the question and correct the error where found, and to allow

a claimant to seek judicial review of the Board's finding of no clear and unmistakable error.

**Authorize increased compensation based on a temporary total rating for hospitalization or convalescence, effective on the hospital admission date or the date of treatment or surgery that necessitates convalescence.** Seek legislation to exempt temporary total ratings from 38 U.S.C. § 5111, to guarantee veterans the compensation needed to offset the total disability during the first month in which temporary total disability occurs and to remedy the current law's inequitable delay in payment and adverse economic effects.

**Correct the inequity that exists in the requirement that reduces military retired pay by an amount equal to disability compensation received.** Allow full military retired pay based on longevity with concurrent receipt of full VA disability compensation on the principle that these two benefits are not duplicative, but are based on different entitling factors.

**Remove the requirement that military nondisability separation, severance, or readjustment pay be offset against VA disability compensation.** Veterans earn compensatory pay for injuries incurred through service to their country. They earn military pay through employment. Therefore, compensation as a result of one's military service should not be offset against VA disability compensation.

**Remove the 3-year limitation on the time for amending tax returns.** Enact legislation authorizing veterans to file amended federal income tax returns for periods preceding the last 3 years. This will allow veterans to recover taxes incorrectly withheld from disability severance pay more than 3 years earlier and claim tax exemptions, based on VA disability ratings or corrected military records, that should result in retroactive disability pay or compensation.

**Allow reinstatement of survivor benefits eligibility to veterans' spouses who have remarried and then ended these subsequent marriages.** Congress should repeal the Omnibus Budget Reconciliation Act of 1990 provisions limiting revived DIC eligibility to cases of annulled and voided marriages. Widows and widowers of Central Intelligence Agency employees recently received this reinstatement of

eligibility. Congress should provide the same benefit to veterans' surviving spouses.

**Permanently authorize VA's home loan programs to provide adjustable rate mortgages.** This will afford veterans and active-duty military personnel the same financing option available to many other home buyers.

**Provide necessary appropriations to fund all projected rehabilitation revolving fund loan applications.** Once veterans' entitlement to rehabilitation services is determined, funding must be available immediately to meet the needs veterans and their counselors identify during initial evaluations. These programs are designed to make veterans optimally productive and independent.

**Compensate non-pay training and work experience for vocational rehabilitation in the private sector.** Allow private-sector non-pay work experiences to augment federal, state, and local programs as authorized settings for vocational rehabilitation.

**Expand the case management system for vocational rehabilitation to include Disabled Veterans Outreach Specialists employed at local job service offices.** These individuals play a central role in the successful rehabilitation of veterans.

**Adjust monetary assistance for purchase of an automobile (and adaptive equipment) for certain veterans.** Increase the monetary assistance to veterans for purchase of automobiles from \$5,500 to \$17,376, 80% of the average cost of a new car (in 1996, \$21,720). This is a one-time grant for which a limited number of service-connected veterans are eligible. Also, provide for annual cost-of-living adjustments in the automobile grant.

**Refund an individual's Montgomery G.I. Bill (MGIB) contributions when discharge was characterized as "general" or "under honorable conditions."** Allow for the refund of an individual's MGIB contributions when his or her discharge was characterized as "general" or "under honorable conditions."

**Increase MGIB allowance.** The basic MGIB allowance should be adjusted to a level that provides veterans more assistance in meeting the costs of pursuing a course of education.

**Adjust Chapter 35, Title 38 U.S.C. benefits and provide for annual cost-of-living adjustments.** Adjust the benefit rate for the Survivors' and Dependents' Educational Assistance Program to reflect cost-of-living adjustments since 1989. Also, provide for annual cost-of-living adjustments for these educational assistance benefits.

**Adjust housing and adaptation grants and provide for annual cost-of-living adjustments.** Seek legislation to adjust the amount of the housing and adaptation grants to offset effects of escalating costs.

**Allow VA to reimburse veterans or their families for headstone or marker purchases.** Congress should amend 38 U.S.C. § 2306 to reinstate former subsection (d), which had provided for reimbursing the cost of acquiring a headstone or marker privately, in lieu of furnishing a government headstone or marker.

## General Operating Expense

**Provide de novo review authority for Post-Decision Review Officers.** Seek legislation to authorize de novo review by independent post-decision review officers who will be responsible for working with the claimant and taking appropriate actions to ensure that a correct decision is made on the claim for benefits or services.

## Employment and Training Service

**Rescind the residency requirements for Director and Assistant Directors of Veterans Employment and Training.** These positions are the only government jobs requiring the applicant to be a bona fide resident of the state for at least 2 years.

**Amend Chapter 42, Title 38, U.S.C. § 4212 to include federal grantees (with awards of \$25,000 or more) under the Affirmative Action Provisions.** Current law only covers certain federal contractors. We believe other recipients of federal financial assistance should be required to take affirmative action to employ and advance in employment certain covered veterans.

## LEGISLATIVE INITIATIVES ▶

Provide an appeal process for veterans who believe their veterans' preference or affirmative action rights have been violated. This would require amendments to both titles 38 and 5 U.S.C.

Amend the definition of disabled veterans for affirmative action purposes. Current law defines a disabled veteran as one who has a service-connected disability of 30% or more for affirmative action. We believe it should be changed to 10% or more.

### The Court of Veterans Appeals

Provide Pro Bono Program funding in a separate line item. This valuable program affords those veterans who otherwise could not afford it with legal representation in pursuing their appeals.

Allow for payment of Equal Access to Justice Act (EAJA) award to nonattorney representatives. Seek legislation to allow for the payment of EAJA awards to nonattorney representatives resulting from the successful challenge of agency policies, procedures, and regulations before the Court as authorized by EAJA.

### Construction Programs

Relieve VA from federal acquisition regulations, to allow more cost-effective construction projects. Federal regulations, as well as VA's self-imposed regulations, increase costs of VA construction by as much as 5 percent, according to the National Institute of Building Sciences.

Increase the cap on Minor Construction projects. Congress last increased the Minor Construction cost limitation (from \$2,000,000 to \$3,000,000) in fiscal year 1991. The account currently covers construction projects whose costs are estimated to range from \$750,000 to \$3,000,000. Inflation has eroded construction dollars' purchasing power since then and VA has delegated more authority to the field. For FY 1998, Congress should adjust the Minor Construction cap to incorporate inflation costs since fiscal year 1991 and to provide VA field managers more discretion in designating high priority projects.

Eliminate the Minor Miscellaneous Construction and include funding for such projects under the appropriate VA medical program accounts. VA currently funds minor miscellaneous projects from \$150,000 to \$750,000 from the Minor Miscellaneous account. This proposal would authorize Network Directors to use the Minor Miscellaneous account to meet the needs of their catchment areas as specified in their strategic business plans.

### The Role of the Veterans Service Organizations

Establish a mandatory advisory role for the VSOs. Enact legislation requiring that VA include VSOs on all commissions, committees, or boards involving VA policy and planning efforts that affect VA missions. It is particularly important to include veterans service organizations on veterans integrated service networks (VISN) management advisory councils as VA transitions to network management and resource allocation. Communication with veterans and their advocates is critical to successful major system reform. Most of the major VSOs have already provided VA network directors with a protocol for identifying local contacts.

**AMVETS**

4647 Forbes Boulevard  
Lanham, MD 20706  
301-459-9600

**DISABLED AMERICAN VETERANS**

807 Maine Avenue, S.W.  
Washington, D.C. 20024  
202-554-3506

**PARALYZED VETERANS OF AMERICA**

801 Eighteenth Street, N.W.  
Washington, D.C. 20006  
202-872-1300

**VETERANS OF FOREIGN WARS  
OF THE UNITED STATES**

200 Maryland Avenue, N.E.  
Washington, D.C. 20002  
202-543-2239

**WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES**  
**CHAIRMAN STUMP TO DEPARTMENT OF VETERANS AFFAIRS**

**QUESTIONS FROM CHAIRMAN BOB STUMP**

Question 1: For purposes of this question, please assume the following scenario: the Department must rely on Medical Care appropriations alone for the period FY 1998 through 2002. Such appropriations are frozen at FY 1997 funding levels, but the Department could not retain any new third-party collections' revenues or Medicare revenues. Assuming this scenario, please provide program resource data to include workload (for VA and non-VA facilities) and FTEE projections and the assumptions underlying such data. To the extent possible, please array such data so as to provide revised charts for pages 2-39 through 2-43, 2-45-49 of volume 2 of the Department's five-volume budget submission for Fiscal Year 1998.

Answer: The attached charts (Attachment 1) reflect the committee's scenario for the budget year and provides an approximation of impact. These estimates were generated by simply using national averages of past resources and workload. They do not reflect the actual outcomes and efficiencies that would result through Network planning and implementation.

In summary, based on this existing model, VA would not be able to treat 105,000 veterans in 1998, with an even more severe impact in the outyears. This straight-line funding level obviously means we would not be able to go forward with our plans of 30-20-10 if these new revenues are not approved.

	1998	1999	2000	2001	2002
Shortfall (\$000)	(\$648,985)	(\$1,319,015)	(\$2,027,789)	(\$2,696,992)	(\$3,475,791)
Unique Individuals	(105,423)	(214,265)	(329,400)	(438,108)	(564,618)
Inpatients Treated	(35,421)	(69,220)	(102,325)	(130,858)	(162,159)
Outpatient Visits	(1,179,000)	(2,304,000)	(3,406,000)	(4,356,000)	(5,398,000)
FTE	(6,643)	(12,983)	(19,192)	(24,546)	(30,417)



## Program Resource Data

Unique Patients by Patient Care Group					
Patient Care Group	1997			1998 Estimate	Increase/ Decrease
	1996 Actual	Budget Estimate	Current Estimate		
Basic care.....	2,793,824	2,704,431	2,790,113	2,689,961	(100,152)
Special care.....	143,176	154,151	146,887	141,616	(5,271)
Total.....	2,937,000	2,858,582	2,937,000	2,831,577	(105,423)

Basic Care category consists of veterans whose health care needs can be met with standard benefits, while the Special Care category consists of veterans with health care needs in excess of the standard benefit. Special Care category patients are those with severe mental illness, spinal cord injury, extensive long term care and transplant needs.

Medical Care Number of VA Installations					
	1997			1998 Estimate	Increase/ Decrease
	1996 Actual	Budget Estimate	Current Estimate		
Veterans Integrated Service Networks.....	22	22	22	22	0
VA hospitals.....	173	173	173	173	0
VA nursing homes.....	133	135	135	135	0
VA domiciliaries.....	40	39	40	40	0
Outpatient clinics.....	398	404	428	428	0

Summary of Workloads for VA and Non-VA Facilities					
	1996 Actual	1997		1998 Estimate	Increase/ Decrease
		Budget Estimate	Current Estimate		
<b>Acute hospital care:</b>					
Average daily census.....	13,948	13,214	12,266	10,251	(2,015)
Patients treated.....	621,495	606,210	575,334	520,254	(55,080)
Length of stay in FY 1/.....	8.2	8.0	7.8	7.2	(0.6)
<b>Rehabilitative care:</b>					
Average daily census.....	1,642	1,473	1,516	1,255	(261)
Patients treated.....	18,625	18,018	18,021	16,302	(1,719)
Length of stay in FY 1/.....	32.3	29.8	30.7	28.1	(2.6)
<b>Psychiatric care:</b>					
Average daily census.....	11,037	11,760	10,357	8,596	(1,761)
Patients treated.....	177,287	188,000	172,624	156,105	(16,519)
Length of stay in FY 1/.....	22.8	22.8	21.9	20.1	(1.8)
<b>Nursing home care:</b>					
Average daily census.....	33,733	36,604	35,182	34,448	(734)
Patients treated.....	82,390	83,038	86,091	83,966	(2,125)
Length of stay in FY 1/.....	149.9	160.9	149.2	149.7	0.5
<b>Subacute care:</b>					
Average daily census.....	5,085	4,726	4,369	3,600	(769)
Patients treated.....	32,691	28,000	28,605	25,763	(2,842)
Length of stay in FY 1/.....	56.9	61.6	55.7	51.0	(4.7)
<b>Residential care:</b>					
Average daily census.....	9,319	9,163	9,612	9,548	(64)
Patients treated.....	28,036	24,460	29,142	28,604	(538)
Length of stay in FY 1/.....	121.7	136.7	120.4	121.8	1.4
<b>Total inpatient facilities:</b>					
Average daily census.....	74,764	76,940	73,302	67,698	(5,604)
Patients treated.....	960,524	947,726	909,817	830,994	(78,823)

1/ Similar to fiscal year obligations, length of stay reflects only days of care generated in that fiscal year.

Summary of Workloads for VA and Non-VA Facilities (continued)					
Medical outpatient visits (000)	1996	1997		1998	Increase/ Decrease
	Actual	Budget Estimate	Current Estimate	Estimate	
<b>Outpatient Visits 1/:</b>					
Staff.....	28,360	30,260	29,209	28,936	(273)
Fee.....	935	1,060	935	900	(35)
Readjustment counseling.....	760	751	767	759	(8)
Total.....	30,055	32,071	30,911	30,595	(316)
<b>Staff and fee outpatient dental program</b>					
	1996	1997		1998	Increase/ Decrease
	Actual	Budget Estimate	Current Estimate	Estimate	
Staff examinations.....	234,968	220,000	235,000	233,000	(2,000)
Staff treatments.....	152,373	150,000	150,000	148,500	(1,500)
Fee cases.....	16,647	17,000	16,500	15,900	(600)
<b>CHAMPVA workloads</b>					
	1996	1997		1998	Increase/ Decrease
	Actual	Budget Estimate	Current Estimate	Estimate	
Inpatient census.....	150	150	150	144	(6)
Outpatient claims.....	822,637	850,000	822,637	788,916	(33,721)

1/ Outpatient visits reflect a revised method of accounting in this request. The 1997 Budget Estimate was adjusted to account for this change.

<b>Medical Care</b>					
<b>Summary of Obligations by Activity</b>					
(dollars in thousands)					
	1996	1997		1998	Increase/ Decrease
	Actual	Budget Estimate	Current Estimate	Estimate	
Acute hospital care.....	\$5,584,433	\$5,539,509	\$5,418,390	\$5,002,001	(\$416,389)
Rehabilitative care.....	400,093	321,867	399,390	363,290	(36,100)
Psychiatric care.....	1,600,741	1,709,625	1,627,915	1,485,183	(142,732)
Nursing home care.....	1,646,252	1,846,882	1,820,136	1,902,694	82,558
Subacute care.....	567,389	762,532	519,692	470,716	(48,976)
Residential care.....	259,616	282,185	284,695	300,122	15,427
Outpatient care.....	5,504,543	5,849,481	6,281,535	6,858,827	577,292
Miscellaneous bene. & svcs.....	718,333	656,326	726,354	698,753	(27,601)
CHAMPVA.....	91,456	106,040	91,553	88,074	(3,479)
<b>Total obligations.....</b>	<b>\$16,372,856</b>	<b>\$17,074,447</b>	<b>\$17,169,660</b>	<b>\$17,169,660</b>	<b>\$0</b>
Less reimbursements.....	(74,600)	(66,000)	(75,000)	(143,000)	(68,000)
Unobligated balance expiring.....	14,174				
Unobligated balance available (SOY).....	(500,893)	(500,893)	(731,213)	(650,000)	81,213
Unobligated balance available (EOY).....	731,213	500,893	650,000	568,787	(81,213)
<b>Total appropriation.....</b>	<b>\$16,542,750</b>	<b>\$17,008,447</b>	<b>\$17,013,447</b>	<b>\$16,945,447</b>	<b>(\$68,000)</b>

Comparative Employment Ratios					
	1996 Actual	1997		1998 Estimate	Increase/ Decrease
		Budget Estimate 1/	Current Estimate		
Staffing ratios (FTE/Census):					
Acute hospital care.....	4.87	4.49	4.99	5.40	0.41
Rehabilitative care.....	3.49	3.45	3.53	3.85	0.32
Psychiatric care.....	2.28	2.04	2.31	2.53	0.22
Nursing home care.....	0.58	0.55	0.58	0.58	0.00
Subacute care.....	1.89	2.47	1.92	2.20	0.28
Residential care.....	0.40	0.38	0.40	0.41	0.01
FTE/1,000 patients treated:					
Acute hospital care.....	109	98	106	106	0
Rehabilitative care.....	307	282	297	296	(1)
Psychiatric care.....	142	128	139	139	0
Nursing home care.....	237	245	238	237	(1)
Subacute care.....	295	417	294	307	13
Residential care.....	132	141	133	136	3
FTE/1,000 visits.....	1.9	1.9	2.0	2.1	0.1

1/ Restated based upon new display format.

Payroll Analysis			
Fiscal Year	Personal Services Obligations (dollars in thousands)	Personal Services per FTE	Percentage Increase/ Decrease
1983.....	\$5,016,477	\$26,583	
1984.....	5,275,245	27,697	4.19%
1985.....	5,615,266	28,970	4.60%
1986.....	5,776,292	29,705	2.54%
1987.....	6,052,013	31,122	4.77%
1988.....	6,433,497	33,197	6.67%
1989.....	6,782,103	35,360	6.52%
1990.....	7,278,063	37,550	6.19%
1991.....	7,925,079	40,413	7.62%
1992.....	8,783,205	43,958	8.77%
1993.....	9,415,673	46,036	4.73%
1994.....	9,872,846	48,424	5.19%
1995.....	9,987,439	49,826	2.90%
1996.....	10,104,034	51,775	3.91%
1997 Estimate...	10,337,261	54,695	5.64% 1/
1998 Estimate...	10,056,224	55,705	1.85%

1/ Larger than expected increase due to buy-out and decline in staffing.

Employment Analysis					
	1996 Actual	1997		1998 Estimate	Increase/ Decrease
		Budget Estimate	Current Estimate		
FTE by type:					
Physicians.....	11,891	11,479	11,512	11,056	(456)
Dentists.....	906	897	877	836	(41)
Registered Nurses.....	37,187	36,380	35,999	34,818	(1,181)
LPN/LVN/NA.....	22,033	22,416	21,328	20,137	(1,191)
Non-physician providers.....	3,157	3,012	3,055	3,139	84
Health techs/allied health.....	38,640	37,505	37,405	36,473	(932)
Wage board/P&H.....	29,109	29,324	28,169	26,204	(1,965)
All other.....	52,230	49,987	50,655	47,865	(2,790)
Total.....	195,153	191,000	189,000	180,528	(8,472)
FTE by activity:					
Acute hospital care.....	67,902	59,596	61,175	55,311	(5,864)
Rehabilitative care.....	5,724	5,111	5,344	4,832	(512)
Psychiatric care.....	25,162	24,108	23,944	21,716	(2,228)
Nursing home care.....	19,567	20,398	20,494	19,932	(562)
Subacute care.....	9,634	11,722	8,399	7,919	(480)
Residential care.....	3,700	3,465	3,864	3,876	12
Outpatient care.....	56,906	60,562	59,653	61,165	1,512
Miscellaneous bene. & svcs.....	6,416	5,891	5,985	5,635	(350)
CHAMPVA.....	142	147	142	142	0
Total.....	195,153	191,000	189,000	180,528	(8,472)
FTE by function:					
Direct care.....	142,232	138,548	137,747	132,976	(4,771)
Support.....	27,443	26,978	26,578	24,823	(1,755)
Engineering and environmental mgmt.....	24,043	24,087	23,285	21,483	(1,802)
All other.....	1,435	1,387	1,390	1,246	(144)
Total.....	195,153	191,000	189,000	180,528	(8,472)

1/ Restated based upon new display format.

Patient Resource Data					
	1996 Actual	1997		1998 Estimate	Increase/ Decrease
		Budget Estimate 1/	Current Estimate		
Average obligation/patient day:					
Acute hospital care.....	\$1,093.92	\$1,143.27	\$1,210.25	\$1,336.86	\$126.61
Rehabilitative care.....	665.74	595.14	721.78	793.08	71.30
Psychiatric care.....	396.27	396.50	430.63	473.36	42.73
Nursing home care.....	133.34	137.87	141.74	151.33	9.59
Subacute care.....	304.87	440.29	325.89	358.23	32.34
Residential care.....	76.12	84.05	81.15	86.12	4.97
Average obligation/patient treated:					
Acute hospital care.....	\$8,985	\$9,096	\$9,418	\$9,615	\$197
Rehabilitative care.....	21,482	17,759	22,162	22,285	123
Psychiatric care.....	9,029	9,053	9,430	9,514	84
Nursing home care.....	19,981	22,182	21,142	22,660	1,518
Subacute care.....	17,356	27,125	18,168	18,271	103
Residential care.....	9,260	11,493	9,769	10,492	723
Obligation per visit:					
Outpatient visit (staff & fee).....	\$187.90	\$186.02	\$208.38	\$229.88	\$21.50

1/ Restated based upon new display format.

<b>Education and Training Summary</b>					
<b>VHA Health Professions Education</b>					
(dollars in thousands)					
	1996 Actual	1997		1998 Estimate	Increase/ Decrease
		Budget Estimate	Current Estimate		
<b>Obligations by Health Professions Program:</b>					
Physician Residents and Fellows.....	\$349,061	\$388,702	\$383,875	\$383,875	\$0
Associated Health Residents & Students.....	40,203	40,817	43,923	43,923	0
<b>Subtotal.....</b>	<b>\$389,264</b>	<b>\$429,519</b>	<b>\$427,798</b>	<b>\$427,798</b>	<b>\$0</b>
<b>Obligations by Support Account:</b>					
VAMC Instructional Support.....	\$231,647	\$252,719	\$241,077	\$241,077	\$0
VAMC Resident Administrative Support.....	123,791	134,065	128,803	128,803	0
<b>Subtotal.....</b>	<b>\$355,438</b>	<b>\$386,784</b>	<b>\$369,880</b>	<b>\$369,880</b>	<b>\$0</b>
<b>Total Obligations.....</b>	<b>\$744,702</b>	<b>\$816,303</b>	<b>\$797,678</b>	<b>\$797,678</b>	<b>\$0</b>
<b>Health Professions Individuals Rotating Thru VA:</b>					
Physician Residents & Fellows.....	32,612	34,260	32,612	31,117	(1,495)
Medical Students.....	20,011	21,349	20,011	20,011	0
Nursing Students.....	27,194	25,882	27,194	27,194	0
Associated Health Residents & Students.....	27,096	27,212	27,096	26,184	(912)
<b>Total.....</b>	<b>106,913</b>	<b>108,703</b>	<b>106,913</b>	<b>104,506</b>	<b>(2,407)</b>
<b>Health Professions Paid Positions:</b>					
Physician Residents & Fellows.....	9,063	9,063	8,881	8,474	(407)
Associated Health Residents & Students.....	2,901	2,901	3,208	3,100	(108)
<b>Total.....</b>	<b>11,964</b>	<b>11,964</b>	<b>12,089</b>	<b>11,574</b>	<b>(515)</b>
<b>Employee Education</b>					
(dollars in thousands)					
	1996 Actual	1997		1998 Estimate	Increase/ Decrease
		Budget Estimate 1/	Current Estimate		
<b>Obligations:</b>					
Continuing Education of VAMC Staff.....	\$122,994	\$132,472	\$127,735	\$127,735	\$0
Employee Education System.....	24,920	19,886	21,994	21,994	0
<b>Subtotal.....</b>	<b>\$147,914</b>	<b>\$152,358</b>	<b>\$149,729</b>	<b>\$149,729</b>	<b>\$0</b>
Administrative Trainees.....	6,265	6,573	8,294	8,294	0
<b>Total Obligations.....</b>	<b>\$154,179</b>	<b>\$158,931</b>	<b>\$158,023</b>	<b>\$158,023</b>	<b>\$0</b>
<b>Number of Participants.....</b>	<b>196,316</b>	<b>250,800</b>	<b>196,316</b>	<b>189,322</b>	<b>(6,994)</b>

1/ President's budget estimates are revised based on new definition of employee education costs.

Obligations by Object (dollars in thousands)					
	1996 Actual	1997		1998 Estimate	Increase/ Decrease
		Budget Estimate	Current Estimate		
<b>10 Personal services &amp; benefits:</b>					
Physicians.....	\$1,679,032	\$1,670,380	\$1,701,958	\$1,654,454	(\$47,504)
Dentists.....	98,117	101,889	101,326	97,835	(3,491)
Registered nurses.....	2,324,345	2,382,412	2,373,597	2,334,267	(39,330)
LPN/LVN/nursing asst.....	756,111	808,883	777,178	746,449	(30,729)
Non-physician providers.....	236,399	233,057	241,448	252,494	11,046
Health techs/allied health.....	1,806,294	1,828,520	1,854,034	1,835,174	(18,860)
Wage rate/P&H.....	1,022,237	1,073,857	1,042,825	986,665	(56,160)
Administration.....	2,022,734	1,976,431	2,085,060	1,992,111	(92,949)
Perm. change of station.....	13,199	17,700	14,000	13,540	(460)
Employee comp. payments.....	145,566	145,835	145,835	143,235	(2,600)
Subtotal.....	10,104,034	10,238,964	10,337,261	10,056,224	(281,037)
<b>21 Travel and transportation of persons:</b>					
Employee.....	30,628	51,365	51,365	51,528	163
Beneficiary.....	108,227	114,834	117,834	126,871	9,037
Other.....	42,493	51,875	45,875	49,207	3,332
Subtotal.....	181,348	218,074	215,074	227,606	12,532
22 Transportation of things.....	24,613	30,128	30,128	30,653	525
<b>23 Communications, utilities &amp; other rent:</b>					
Rental of equipment.....	32,048	39,460	33,460	34,092	632
Communications.....	136,876	158,208	156,208	159,881	3,673
Utilities.....	263,831	261,530	278,530	290,181	11,651
GSA basic space rental.....	23,362	25,344	24,966	24,997	31
Other real property rental.....	55,375	52,510	62,792	64,774	1,982
Subtotal.....	511,492	537,052	555,956	573,925	17,969
24 Printing and reproduction.....	12,882	16,695	14,695	14,865	170
<b>25 Other services:</b>					
Outpatient dental fees.....	12,145	13,270	13,245	13,401	156
Medical and nursing fees.....	274,802	274,646	288,554	291,636	3,082
Repairs to equipment & furniture.....	92,334	104,930	96,930	99,067	2,137
M&R contractual services.....	55,959	71,915	58,915	60,814	1,899
Contract hospitalization.....	142,874	173,142	150,080	150,667	587
Community nursing homes.....	338,450	346,736	324,736	349,591	24,855
Repairs to prosthetic appliances.....	42,211	39,551	46,551	50,249	3,698
Personal services contracts.....	53,856	120,641	60,641	62,191	1,550

Obligations by Object (continued)					
(dollars in thousands)					
	1996 Actual	1997		1998 Estimate	Increase/ Decrease
		Budget Estimate	Current Estimate		
<b>25 Other services (continued):</b>					
House staff disbursing agreements.....	\$277,272	\$314,034	\$311,962	\$319,108	\$7,146
Scarce medical specialists.....	103,659	108,641	118,641	130,365	11,724
Other contractual services.....	602,857	580,621	678,961	737,269	58,308
CHAMPVA.....	85,047	98,158	85,047	81,568	(3,479)
Subtotal.....	2,081,466	2,246,285	2,234,263	2,345,926	111,663
<b>26 Supplies and materials:</b>					
Provisions.....	92,491	102,033	95,033	96,605	1,572
Drugs & medicines.....	1,157,708	1,331,084	1,350,211	1,448,182	97,971
Blood and blood products.....	37,925	41,113	39,113	39,956	843
Medical and dental supplies.....	455,917	514,690	479,690	490,559	10,869
Operating supplies.....	228,516	317,674	262,881	270,865	7,984
M&R supplies.....	87,178	122,179	94,530	97,292	2,762
Other supplies.....	100,802	126,146	111,146	116,811	5,665
Prosthetic appliances.....	262,195	272,652	285,652	297,211	11,559
Subtotal.....	2,422,732	2,827,571	2,718,256	2,857,481	139,225
31 Equipment.....	632,804	482,753	566,917	557,247	(9,670)
<b>32 Lands and structures:</b>					
Non-recurring maintenance (NRM).....	184,155	235,653	256,017	261,822	5,805
Capital leases.....	2,900	0	0	0	0
Subtotal.....	187,055	235,653	256,017	261,822	5,805
<b>41 Grants, subsidies and contributions:</b>					
State home.....	207,487	232,209	232,209	235,014	2,805
Homeless Grants.....	6,069	7,244	7,244	7,364	120
Subtotal.....	213,556	239,453	239,453	242,378	2,925
43 Imputed interest.....	874	1,819	1,640	1,533	(107)
Total obligations.....	16,372,856	17,074,447	17,169,660	17,169,660	0
Less reimbursements.....	(74,600)	(66,000)	(75,000)	(143,000)	(68,000)
Lapse.....	14,174				
Unobligated balance available (SOY).....	(500,893)	(500,893)	(731,213)	(650,000)	81,213
Unobligated balance available (EOY).....	731,213	500,893	650,000	568,787	(81,213)
Total appropriation.....	16,542,750	17,008,447	17,013,447	16,945,447	(68,000)

Question 2a: Please provide the methodology, data, and underlying assumptions by which you projected MCCR collections of \$591 million in FY 1998 and increases of more than \$75 million annually.

Answer: We estimate that receipts net of administrative costs from MCCR activities would increase \$75 million per year. Historical recovery performance is considered, along with a current environmental assessment. The third party methodology is based on historical patient workload within patient categories (In Patient, Out Patient) determined by patient age, eligibility status and bed section for care (OP care being treated as two bed sections, billable and non-billable). The current environmental factors include the change to primary care in the VHA clinical care system, eligibility reform, the fact the Networks would get to keep collections, and changes in the private insurance industry payment practices. The specific initiatives to ensure this goal is met are discussed in the following question.

Question 2b: Please discuss in detail each of the proposed changes VA will make in the MCCR process to improve insurance identification, enhance billings, etc., and the extent to which each proposed change has been tested and fully evaluated.

Answer: The chart below describes the proposed changes VA will make to increase recoveries. We expect the incentive that will be created by allowing networks to retain collections to be the greatest catalyst of increased receipts. At this time, however, we cannot predict the exact dollar impact of this incentive.

### Initiatives for Increasing Revenues for Medical Care

Initiative	Description	Projected Recovery
<i>Insurance Identification (Pre-registration, HCFA Match)</i>	<p><b>Pre-registration:</b> Involves contacting patients scheduled for outpatient visits to remind the patients of their appointment and to update patient information. \$6.4 million was recovered from insurance from 10 medical centers in one year. Assuming average recoveries of \$500,000 per each of 150 medical centers, \$75 million in new revenues could be generated.</p> <p><b>HCFA Match:</b> Approximately 5% of the Medicare eligible population possess third party primary, full coverage, reimbursable insurance as a result of their full time employment or the employment of a spouse. MCCR is pursuing a match of Medicare and VA records to identify primary payer data. If the estimate is correct and VA mirrors the private sector, potential recoveries from this group may total between \$60 to \$97 million.</p>	<p>\$75 million</p> <p>\$60 to \$97 million</p>
<i>HCFA Medicare Remittance Notices</i>	<p>Since VA presently cannot receive reimbursement from Medicare for eligible veterans, MCCR has not been able to submit claims to Medicare Supplemental insurers similar to those of Medicare providers that have an accompanying remittance notice from a Medicare Fiscal Intermediary or Carrier. Certain payers are with holding payment of Medicare Supplemental claims. HCFA and VA are negotiating an agreement to allow VA to utilize existing Medicare contracts to obtain the remittance notices to satisfy payer requirements. A one time recovery of \$42 million in outstanding unpaid claims and a recurring annual \$8 million in additional revenue are expected as a result of this contract and change in processing.</p>	<p>\$42 million (one time)</p> <p>\$ 8 million (recurring)</p>

Initiative	Description	Projected Recovery
<i>Utilization Review</i>	In FY 1995, approximately \$159 million in non-Medigap inpatient claims and \$44 million in non-Medigap outpatient claims were denied by payers. Utilization review staff, familiar with third party criteria, such as admissions, lengths of stay, discharges, pre-certification, continued stay reviews, etc., could negotiate payments for many of the denied claims. UR staff have recovered as much as \$400,000 per medical center in previously denied claims. If we assume a possible average success rate of between \$100,000 and \$200,000 for each of the 150 medical centers, recoveries from proper training and assignment could amount to between \$15 and \$30 million.	\$15 to \$30 million
<i>Universal Billing (TRICARE, Sharing, etc.)</i>	As a consequence of P.L. 104-262, eligibility reform legislation, expanded sharing contracts, including support of TRICARE is expected to result in \$25 million in new revenues annually.	\$25 million
<i>SC / NSC Documentation &amp; Billing</i>	Approximately 3.3% of service connected inpatient care and 2.5% of service connected outpatient care for adjunct conditions is inappropriately being coded as treatment for adjudicated service connected care. Properly coding this care as adjunct and billing insurance carriers will result in an additional \$11 million per year.	\$11 million
<i>Salary &amp; Benefit Offset</i>	An IG audit determined that by referring delinquent patient copayment and means test debt for salary and benefits offset, an additional \$3 million in revenues can be recovered. The MCCR program currently utilizes IRS offset for delinquent debt and is implementing referral of debt over 90 days old to the Debt Management Center in St. Paul.	\$ 3 million
	<b>Annual Total</b>	<b>\$239 to \$291 million</b>
<i>Point of Service Contracts</i>	In order to remain competitive, traditional HMO's recently began offering their enrollees the option of obtaining health care outside the HMO network. The enrollees agree to bear larger copayments and providers receive reimbursements that are less than customary and usual. Aggressive identification and recovery from these HMO plans will be pursued.	Undetermined
<i>Network Incentives</i>	Network retention of revenues recovered will result in better managed local recovery efforts.	Undetermined
<i>Restructuring Reimbursement Rates</i>	Restructure reimbursement rates to more accurately reflect the costs related to the actual services provided; and facilitate new revenue streams from public and private health insurance programs such as Medicare, Medicaid, CHAMPUS, and Sharing agreements. Initially a DRG rate schedule will be developed for inpatient care, to be used with an automated multiple rate schedule pricer in Integrated Billing. Outpatient procedure rates are planned in late FY 1998.	Undetermined
<i>AICS</i>	Increases efficiency, reducing program costs to identify, bill and collect the cost of outpatient care services. Implementation of Primary Care Management module has been completed. Training on scanning and scheduling changes continues. Implementation of Version 3.0 is scheduled in Spring 1997.	Human Resources dedicated to Increased Insurance Identification Initiative.

For each such change, please quantify, to the extent possible, its anticipated fiscal impact.

Answer:

Initiative	Projected Recovery
Pre-Registration	\$75 Million
HCFA Match	\$60-\$97 Million
HCFA Remittance Notices	\$42 Million (\$8 Million recurring)
Utilization Review	\$15 to \$30 Million
Universal Billing (TRICARE, Sharing)	\$25 million
SC/NSC Documentation	\$11 Million
90-Day Referral (Salary and Benefit Offset)	\$3 Million
<i>Range of Increase in Recoveries</i>	<i>\$237-\$289 Million</i>
Point of Service	undetermined
Network Incentives	undetermined

Question 2c: In light of the changing environment within which such collections would occur and the untested nature of some or all of the proposed changes in the MCCR process, please indicate (i) whether the budget's collection targets for FY 1998 and the out years are best described as "highly reliable," "reasonably reliable," "relatively speculative," "highly speculative," or "arbitrary," and (ii) the basis for that characterization.

Answer: Short Term, these estimates are "reasonably reliable". Long Term, they are less reliable, but not speculative by our definition. These are the best estimates VA is able to provide given the fast-changing trends in workload and mode of treatment. In developing estimates, MCCR contracted with the Center for Health Care Quality, Outcomes, and Economic Research, Bedford, MA. With their assistance, MCCR has refined its projection methodology, and in the next few months will be reassessing the environmental effects which are constantly changing. The basis for the characterization of "reasonably reliable" is that we have confidence in our experience and track record. The MCCR Strategic and Business Plan is an indication of the sophistication our organization has achieved.

Question 3: Please provide a copy of the most recent MCCR Strategic Direction and Business Plan.

Answer: Attachment 2 is an updated Medical Care Cost Recovery Strategic Direction and Business Plan.



**Executive Summary Update**

March 7, 1997

This update provides current perspective on the challenges facing the MCCR Program, and on the responses to those challenges, i.e., the initiatives undertaken to meet the ambitious recovery goals we are committed to achieve. Since the initial publishing of the MCCR Strategic Direction and Business Plan in Spring 1996, rapid changes are occurring in the scope and potential impact of the challenges. The challenges are:

- To respond to external changes in the health insurance industry, most particularly in the changes to claim payment practices.
- To participate in and support VHA's change to a primary care model and overall changes in its method of doing business, the 30-20-10 proposals set forth by the Undersecretary for Health. MCCR must continue to develop recovery process efficiencies, and improve the documentation of care provided in order to sustain present levels of recovery and support VHA by attaining aggressive increases in recoveries by FY2002. The Automated Information Collection System (AICS) has been implemented.
- To develop a Medical Reimbursement Rates structure which truly reflects the VHA cost of doing business.

The Strategic Direction and Business Plan offers significant detail and overviews of MCCR activities. MCCR is moving on several fronts to ensure continued increases in our revenue collected from insurance companies for health care provided to veterans. We have a variety of initiatives underway that will: increase the number of veterans that we identify as having insurance; decrease program operating costs; and develop billing rates that reflect our true cost of doing business. At the same time, we will use a health care consulting firm to assist us in determining whether we can collect more funds by continuing our in-house efforts, or whether we could more effectively increase collections through the use of private sector billing and collection services.

The chart on the following page provides an updated description of the initiatives MCCR has undertaken in order to accomplish our recovery goals, and the estimated recoveries associated with each initiative:

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## Medical Care Cost Recovery Strategic Direction & Business Plan 1996

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### Section 1: Overview

**Purpose of the Plan.** The purpose of this plan is to clearly and logically present the integrated strategy, current implementation initiatives and plans which the VA's Medical Care Cost Recovery (MCCR) Program is pursuing in an effort to create greater efficiencies of operation, to enhance revenues and to add value to the health care delivery operation of the VA. In order to effectively explain the complex nature of these initiatives, this business plan presents in the appendices a brief history of the program, its accomplishments, its challenges and the many opportunities that remain.

**Mission.** *"To maximize the recovery of funds due VA for the provision of healthcare services to veterans, dependents and others using the VA system."*

**Imperatives.** The MCCR Program developed a series of *Imperatives* which serve as our operating guidelines and philosophy. These *Imperatives* establish a framework for our activities and serve to keep MCCR staff and our partners focused. Quite simply,

- *All activities engaged in and products produced by the MCCR office will be of the highest possible quality.*
- *All program functions will maintain a focus on "continuous improvement" of all activities directly or indirectly related to MCCR, consequently continuous emphasis is necessary on the identification and capture of appropriate indices which allow progress to be measured and assessed.*
- *Key to our success is the development of front line staff and first level supervisors. Education, recognition and career enhancement of these individuals must be a continuous focus of all program staff.*
- *Experimentation and innovation are critical to our continued success. Innovative efforts which fail are to be recognized as bringing us closer to a solution.*

- *Open communications between every level of the organization are essential. Direct access by field staff to management and management's access to field staff is critical to success.*
- *Key to continued success is the direct involvement of front line staff and first level supervisors in all aspects of MCCR from system and process redesign to the development and implementation of training programs and communications.*

**Strategies.** There are numerous functions, activities and processes that fall under the umbrella of the Medical Care Cost Recovery program. The majority of these elements can be grouped within four categories: (1) Insurance Identification, Verification, and Certification; (2) Data Capture; (3) Billing; and (4) Collection. Each of these functions, activities and processes offer levels of complexity and challenge that directly affect individual medical center performance and national recovery efforts.

We recognize that there are three fundamental ways to improve recoveries:

1. Introduce new processes or modify existing processes that will significantly increase revenues by identifying new payers and/or by increasing the payments recovered for each billable episode.
2. Improve the efficiency of each activity through reengineering, streamlining, standardization and automation and by reinvesting the savings into resources supporting the new or modified processes.
3. Restructure reimbursement rates to more accurately reflect the costs related to the actual services provided and the needs of individual payers to facilitate payment processing.

The MCCR Program Office used these three fundamental ways to improve recoveries since its creation in October 1990. The implementation of this strategy in a consistent and conscientious manner resulted in annual recovery growth from \$148 million in FY 1990 to \$574 million in FY 1995. Past, present and planned initiatives were and are predicated upon this strategy. Appendix B discusses more fully MCCR accomplishments and prior initiatives. .

The graph which follows on the next page plots the relationship between allocated staffing and recoveries and identifies the major milestones and initiatives introduced by the program from its inception through the current fiscal year. Specific initiatives such as the introduction of the Accounts Receivable (AR) and Integrated Billing (IB) software, as well as Electronic Claims Processing (ECP) have contributed to the increase in recoveries per FTE witnessed by the MCCR program. New initiatives that are currently in their initial phases of implementation such as Optical Mark Recognition (OMR) technology

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and the Automated Information Collection System (AICS) offer significant potential for streamlining process and improving recoveries.

In attempting to fully understand the relationship between initiatives, recoveries, staffing and performance measures, MCCR established a staffing committee charged with formulating a staffing model to predict resource requirements and distribution patterns. The staffing committee developed a model used during the last two years to redistribute staff among VA medical centers. The staffing committee recently began working with the MCCR reengineering task group to document, measure and evaluate the impact of organization and the introduction of new initiatives and new processes on staffing levels and performance. The staffing model development process will have a significant impact on the future staffing levels and staffing distribution models used by the program.

The MCCR program has routinely proposed and supported a variety of gainsharing models designed to encourage facilities to improve their recovery performance. Until recently, the gainsharing proposals have not received serious attention.



## Section 2. External and Internal Environmental Assessment

Since its creation in October of 1990, the MCCR program consistently focused upon new opportunities to increase collections and improve operating efficiencies. Like all new programs, MCCR faces external and internal forces which challenge our innovation and creativity and which complicate the task of collection.

In the course of developing our S.W.O.T. (Strengths, Weakness, Opportunities, Threats) Analysis, it became clear that improving recoveries and introducing efficiencies into the MCCR process requires that we maintain both an internal focus on improving process and resource utilization and an awareness of external influences that complicate our task.

External factors which shape our priorities, influence our progress, and affect our performance, include:

1. the rapidly changing nature of third party health care plans (e.g., the transition from fee for service models to Preferred Provider Organizations (PPOs) & Health Maintenance Organizations (HMOs) and our inability at this time to negotiate preferred provider arrangements with these payers and health plans;
2. the changing workload base upon which recoveries are based (e.g., the transition of care from inpatient to outpatient settings, the transition from specialty services to primary care, the elimination of discretionary --a.k.a. "highly insured" --patients from the patient base supported by appropriations).
3. litigation efforts of Medicare supplemental payers to avoid paying VHA claims;
4. efforts to direct the program to contract out recovery activities without a clear understanding of the nature of the request or its potential costs;
5. legislation and eligibility criteria which are inconsistent and confusing for both patients and staff, and which require major new systems and processes to be implemented or initiated without adequate impact assessments being performed. (e.g., At the time the medication copayment legislation was implemented, there was no income "means testing" for service connected (SC) veterans rated less than 50% to determine their medication copayment liability for nonservice connected (NSC) prescriptions. The legislation for medication copayments created different definitions of "income" for purposes of determining a patient's means test liability and their medication copayment liability.);
6. confusion related to MCCR's collection potential and collection performance and the subsequent debates, increased demands for performance and limitations imposed on budget authority;

7. misunderstandings of the program's cost of collection, scope of funded activities and inaccurate comparisons to private contractor collection activities;
8. requests for operational changes that come from outside MCCR which do not always have adequate justification;
9. General Counsel opinions regarding legislative intent which may adversely impact recovery potential and add complexity and administrative workload to MCCR field operations (e.g., waiverability of copayment debt and application of third party recoveries against first party copayment liabilities);
10. local field reorganizations of MCCR functions within integrated medical center sites and within medical center networks; and
11. organization configurations of MCCR which vary between facilities and result in different definitions between these facilities of coordinator and team leader roles and functions.

Internal functions which require our attention and focus in order to improve recoveries include:

1. improving clinical and cost data which are necessary to more accurately document the care provided and to develop alternative rate models.
2. replacing our current reliance on manual coding and billing of outpatient claims with an automated clinical data capture process;
3. obtaining clinician support to determine and document NSC treatments and medications to support claim generation;
4. updating incomplete or unknown insurance and employment data;
5. consistently implementing and utilizing existing software to supporting billing and collection; and
6. standardizing identification, billing and collection processes and procedures between medical centers;

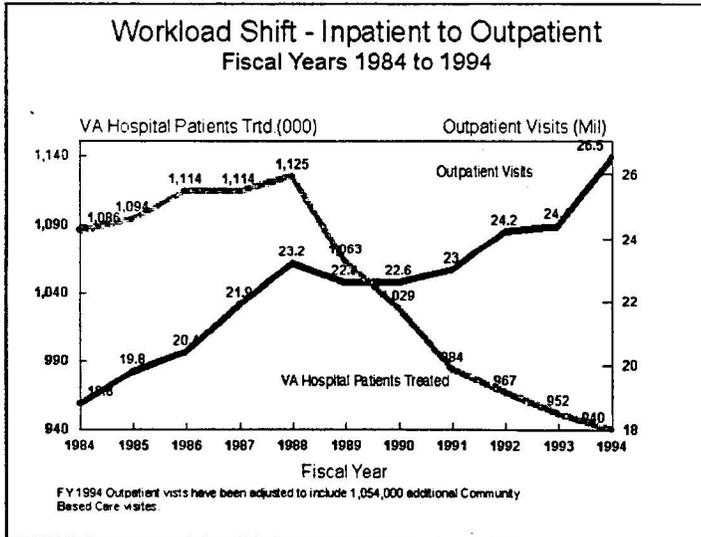
Of all the factors which influence our future course, there are three that present the greatest challenge to our ingenuity and creativity.

The first is the changing nature of the insurance industry. The last five years has witnessed a major redefinition in the basic nature of health insurance with the movement from traditional fee for service plans to broadly defined HMOs that create virtual health

care provider organizations through a complex orchestration of preferred provider agreements.

The second is the changing nature of VA's workload. The last decade has witnessed a continued decline in inpatient days of care provided and a corresponding increase in the number of outpatient clinic visits. The impact of this workload shift for MCCR translates into higher workloads with smaller recoveries, since nearly five times the labor and cost are incurred to establish and recover the revenue for outpatient treatments as are associated with a single inpatient bill.

Compounding the issue, is the concurrent decline in insured patients being treated by VA. Since 1980, VA's annual approved Medical Care appropriation has not kept pace with the Medical CPI. Cumulatively, since 1980, medical care appropriations have been funded on average 7.12% below the medical inflation adjustment. The cumulative effect of this failure to keep appropriations in line with medical inflation represents a \$10.5 billion shortfall between fiscal years 1980 and 1995. As a consequence of declining real dollar funding, VA was forced to apply much more stringent eligibility criteria and no longer provides treatment to many of its discretionary patients, who are those patients with the highest levels of insurance coverage.



And, third is the extremely important role that data capture now plays in our recovery process. MCCR is challenged by the need to improve its documentation of care provided in order to sustain present levels of recovery. Without the staff to manually capture and code this information or without the funding to automate the data capture process, the effort of sustaining recoveries will be compromised.

### Section 3. Strategy and Initiatives

#### A. Strategy

Improving recoveries and reducing operating expenses is a complex endeavor. It requires that a strategy be developed that addresses both the external and internal factors affecting MCCR operations. The strategy must overcome or mitigate the external challenges we face, while at the same time focusing upon the creation of an infrastructure that is sound, flexible and responsive to changing demands. Often there is overlap between the strategies designed to meet the external and internal challenges.

In order to lessen the impact of external challenges, a strategy that focuses on communication and education of our stakeholders is essential. The timely and accurate information they require is the same information needed by MCCR program officials and front line staff to measure performance and manage operations.

As we noted in Section 1., there are three fundamental ways to improve recoveries.

1. ***New Revenues.*** Introduce new processes or modify existing processes that will significantly increase revenues by identifying new payers and/or by increasing the payments recovered for each billable episode.
2. ***Improved Efficiency.*** Improve the efficiency of each activity through reengineering, streamlining, standardization and automation and by reinvesting the savings into resources supporting the new or modified processes.
3. ***Reimbursement Rates.*** Restructure reimbursement rates to more accurately reflect the costs related to the actual services provided and the needs of individual payers to facilitate payment processing.

In terms of the MCCR process itself, our ability to maximize recoveries is directly related to our ability to:

1. Identify and verify insurance coverage maintained by our patients or their spouses;
2. Determine patient "eligibility" status;
3. Determine the appropriateness of the service for billing veteran copayments;
4. Determine the nature of insurance and the scope of particular policy coverage;
5. Determine the nature of the treatment provided (service connected or nonservice connected);

6. Document the care provided (diagnosis, procedural codes, complexity of visits, ancillary services utilized, etc.);
7. Establish appropriate charges based upon the cost of the care in order to establish appropriate reimbursement rates;
8. Comply with insurer requirements for payment, such as obtaining pre-certifications, performing continued stay reviews, etc.;
9. Manage aging receivables;
10. Determine the appropriateness or adequacy of payment by performing reviews of Explanation(s) of Benefits;
11. Appeal insurer payments, partial payments or denials;
12. Obtain regional counsel support for disputed claims; and
13. Insure that appropriate and standardized processes and procedures are developed for those activities associated with items 1 through 12 and insure these are communicated to field staff in a consistent, reliable and useful manner.

As cost recoveries grow above the \$500 million mark, the work and skill required for the collection of additional dollars grows. Medical Centers have been instructed to invest in the areas of highest return, and it is well known that opportunities for collection improvement can be realized.

The collection process has been compared to apple picking. Experienced professionals can pick far more fruit per day than beginners, as well as picking a tree more fully. Beginning pickers pick only "low hanging" fruit. Studies show that entry level workers are given little training beyond "on the job experience and coaching from co-workers."

Training is central to improving MCCR operations and annual recoveries. The need for additional training comes at a time when training dollars are becoming more limited. Fortunately, training options are not limited to the traditional classroom settings commonly proposed by traditional trainers. A variety of training models have been evolving and are currently being tested and developed by MCCR to reach all levels of field staff. These include telephone conference training, hands on computer training between work sites and a centralized main frame, audio tape and others. Advances in technology allow a cost effective training tool to be added to the MCCR tool kit. Specifically, advances in digital information storage and PC based multimedia technologies, including digital video compression, allow reference and training materials to be presented on worker desk top PCs. MCCR has pioneered the design of desk top systems which offer more effective training at costs which are approximately one-sixth those of traditional training (\$212 vs. \$1314).

**B. Initiatives**

MCCR took the first steps approximately three years ago to inaugurate a business process reengineering effort designed to create living laboratories of process and organizational experimentation focused on examining the factors that affect MCCR program performance and improving the recovery effort. The reengineering effort was initiated with four objectives: (1) streamline the existing MCCR processes and procedures; (2) automate as much of the process as possible; (3) design and document standardized desk operating procedures for all processes; and (4) design and implement comprehensive training programs for all front line staff involved in the MCCR process.

Following initial training sessions for over 120 front line staff, work groups were created to document in work process flow diagrams the current variety of MCCR functions as they are performed at medical centers. As a part of this documentation, front line staff were asked to not only identify obstacles they encountered in performing their jobs, but to recommend solutions and ideas for overcoming challenges, streamlining tasks, and improving the way we do business. After nearly a year's effort, a streamlined, "ideal" MCCR process was designed. During this time, medical centers competed to become reengineering sites and ten medical centers were selected. Each site agreed to become a laboratory for the testing and enhancement of new procedures, software and hardware technology. Several of the initiatives that are currently in progress were alpha and beta tested at some of these sites. Other initiatives were created and tested wholly at one or more of these sites. Unlike the specific initiatives which follow, the reengineering effort was conceived as an on going, evolving process. As a laboratory and production unit combined, the reengineering sites play a vital role in the development of procedures, training, new automation and technology enhancements.

The specific initiatives described below are associated with the three strategies for improving recoveries, namely initiatives focused upon creating new revenue sources, improving program efficiency and restructuring reimbursement rates. Initiatives are prioritized within each group based upon the potential return of the initiative and the timeliness with which the initiative may potentially be implemented successfully. Within each of the three groups, initiatives appear in order of priority, with the highest priority initiative appearing first. The first initiative in each of the three categories represents the MCCR program's three highest priority initiatives.

**(1) *New Revenue (NR) Focus:*** The first cluster of initiatives introduce new processes or modify existing processes in a way that will significantly increase revenues by identifying new payers and/or by increasing the payments recovered for each billable episode.

**NR-1: Dramatically Increase Third Party Collections by Identifying New Insurance**

*Purpose:* To increase collections by properly identifying all veterans in all Veterans Administration Medical Centers (VAMC's) who have some type of billable third party health insurance coverage.

*Situation:* Data capture for MCCR purposes is the single most critical factor in our ability to maximize recoveries. Unfortunately the process of collecting patient data is not under the complete purview of medical center MCCR staff. Initial data gathering of employment and insurance information traditionally falls under the Medical Administration Service (MAS) umbrella. The Decentralized Hospital Computer Program (DHCP) data base contains patient demographic data and specific information, such as insurance, is often omitted. Other packages, including Integrated Billing (IB) and Accounts Receivable (AR), are dependent on the accuracy of this data. Employment and insurance information gathered at medical centers are often either incomplete or completely missing. Comparisons of national averages related to billable episodes for inpatient and outpatient care demonstrates the problem that exists with our data base information. Nationally, 18% of inpatient discharges result in a third party receivable being generated, while only 9% of all outpatient visits result in a third party receivable. This leaves MCCR in the position of having to contact each patient individually in an attempt to update these fields in order to maximize collections. Most facilities have attempted to do this by posting an employee in the outpatient areas of the medical center and interviewing patients while they are waiting to see a clinician. While this is somewhat effective, it is not the optimal situation.

The MCCR program office has looked at resolving the data base problem in three separate ways: 1) an MCCR - Health Care Financing Administration (HCFA) Data Match; 2) use of a General Services Administration (GSA) Health Care Cost Recovery Service contract; and (3) reengineering the clinic registration process.

- 1) **MCCR - HCFA Data Match.** There are two assumptions that make a match with HCFA desirable. First, the Congressional Budget Office estimates, from the March 1990 Current Population Survey, that 15% of Medicare recipients have other primary health insurance. The MCCR goals committee identified that a conservative estimate of 5.9% of the over 65 population treated by the VA could be expected to have primary health insurance other than Medicare. The revised estimate discounts the large female non-veteran Medicare population included in the CBO estimate and also discounts for health maintenance organization (HMO) plans which do not reimburse VA for care it provides to HMO enrollees. The Medicare eligible population included in the 5.9% estimate actually possess third party primary, full coverage reimbursable insurance as a result of their full time employment or the employment of a spouse. If the CBO estimate is correct, and the VA population mirrors the private sector, potential recoveries from this group may total \$97.4 million.<sup>1</sup>

<sup>1</sup> The estimate is calculated as follows: Of the 24.4 million outpatient visits, some 8.9 million visits are made by patients over 65 receiving care for NSC conditions. According to estimates provided by the

The second assumption is that since Medicare is considered a secondary payer, primary payer insurance information is available in the HCFA data bases.

Due to Privacy Act limitations, MCCR is seeking to initially perform a statistical match with HCFA to ascertain if the assumptions are valid. The statistical match will allow us to identify and verify veteran patients' insurance carriers by matching with the HCFA data bases which contain third party insurance information. These databases are the HCFA Beneficiary(BENE) file and HCFA Medicare Secondary Payer (MSP) auxiliary file.

Discussions regarding this match are in their third year. Accessing another federal agency data base is an extremely difficult, bureaucratic and political process requiring substantial documentation, review and approval. We have worked with our General Counsel, the VA Data Integrity Board and a variety of offices within HCFA to make the HCFA data match a reality. Recently we obtained approval from both General Counsel and the VA Data Integrity Board to move forward with this initiative. HCFA, however, has now determined that this match will require an interagency agreement. It is seeking several changes along with payment of \$1,600. MCCR prepared an Interagency Agreement which has just recently received the concurrence of VA General Counsel. A final copy of the agreement will be submitted to VA and HCFA officials for final signature.

Should the data match confirm the estimates of VA's patient Medicare patient population who are covered by a primary health insurance carrier other than Medicare, MCCR will initiate work to begin a complete computer name match of VA's Medicare eligible population with the HCFA Beneficiary file and the HCFA Medicare Secondary Payer auxiliary file.

2) **GSA Health Care Cost Recovery Service Contract.** MCCR has also sought to improve VA Medical Center employment and insurance data base integrity through the use of the GSA Health Care Cost Recovery Services contract for data matching and data validation. This contract requires VA to 1) identify patients for whom we have no insurance coverage information and 2) submit their names and other identifiers to the contractor. The contractor, in turn, attempts to match those patients and their associated information with third party insurance coverage contained in files to which the contractor has access.

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Survey of Medical System Users, 1.6 million of these visits are made by insured patients. Assuming that 5% of these visits are covered by full medical insurance, and each visit is billable at the rate of \$205, and outpatient recovery ratios are maintained at 68.25%, then outpatient recoveries from this population should reach \$11.2 million. Of the 901,666 inpatient discharges, some 346,829 discharges result from patients over 65 receiving care for NSC conditions. According to estimates provided by the Survey of Medical System Users, 62,132 of these visits are made by insured patients. Assuming that 5% of these visits are covered by full medical insurance, and each discharge is billed at an average \$4500 (MCCR National Data Base), and inpatient recovery ratios are maintained at 61.7%, then inpatient recoveries from this population should reach \$86.2 million. Together the recovery potential may be \$97.4 million.

In August 1995, MCCR provided the contractor, Health Management Systems, Inc. (HMS) with 38,748 patient names and identifiers. These patients all received care or are otherwise identified on the facility data base at one of three Chicago-area VAMC's participating in this pilot test (VAMC's Hines, North Chicago, and Chicago West Side). The contractor, in the succeeding six months, has delivered only 649 matches. No additional matches will be accomplished from the 38,748 names submitted. We consider these results, a basic match rate of only 1.67 percent, to be disappointing.

Based on a review of 223 of the basic matches, only 124 (56%) were considered valid. Valid, for the purpose of this document, refers to insurance information for which VA can establish a claim to an insurance carrier for the time-period covered by the contract. Based on our review, we estimate that we will have only 363 valid matches of the original 649 identified patients (56% x 649). We further determined that approximately 35% of the valid matches we received would not be billable due to the nature of the policy (HMO, Indemnity, etc.). Therefore, based upon these estimates (35% x 363) only 236 or 0.6% of the 38,748 names originally submitted would result in the generation of a claim to a third party health insurance carrier.

The contract cost of this pilot effort is projected to be under \$7,000. MCCR expects to establish over \$300,000 in receivables from these 236 matches. Ultimately, VA should recover approximately \$105,000 from these receivables if national averages hold constant for this billed population. Recoveries of this magnitude should pay for the cost of the contract and the associated staff time related to researching, billing and collecting. The return from this investment is lower than desired, however, and must be weighed against the return realized from the HCFA match and from the reengineering clinic registration initiative described next.

**(3) Reengineering Clinic Registration.** This involves testing a new data capture process through the use of the reengineering pilot sites which were discussed earlier. The MCCR Reengineering initiative also targeted insurance identification and verification as one of the areas requiring major attention. Rather than focus solely on the identification of insurance data, the reengineering group felt that additional patient data base information needed to be verified and updated.

In October 1994 each pilot site was provided with 2 non-recurring Full Time Employee (FTE) at an annual cost of \$81,000 per site or a total obligation of \$810,000. Various problems were encountered during FY 95 in getting the FTE on board. Not all medical centers began pre-registration on October 1, 1994. However, each medical center did begin pre-registration to some degree during FY 95.

The pre-registration process required that patients scheduled for outpatient clinic visits within the next 10 days would be contacted to remind them of their visit. In the course of this reminder call, the patients would be asked to update their information on file with the medical center.

The pre-registration process focused on five basic areas of the DHCP data base considered to be inaccurate or inconsistent: 1) patient demographic information; 2) next of kin information; 3) patient employment information; 4) next of kin employment information; and 5) patient and next of kin insurance information. Only two of the ten sites had pre-registration fully operational for the entire fiscal year. The other ten sites began the process between April and August of 1995. The following are data changes made and reported for the ten sites:

Demographic changes	6,291
Next of Kin changes	6,997
Employment changes	8,541
Insurance changes	12,675
Billable cases	7,699

The billable cases identified resulted in the following billing and collection figures:

Amount billed in pilots	\$18,363,942
Amount collected to date	\$3,891,559

Based upon national averages, an additional \$2.5 million (for a total of \$6.4 million) is anticipated to be recovered from the \$18.4 million billed. With total recoveries of \$6.4 million from an investment of less than the \$810,000, this initiative is financially sound. Assuming that other medical centers will meet the performance of these ten sites, the implementation of this initiative nationally will yield an additional \$100 million from newly identified insured patients.

While the above figures are impressive within themselves the overall benefits are much more far-reaching. The pre-registration process is helping to clean up a majority of the patient data base used by all other services and DHCP packages. Patients have been more willing to provide insurance information on the phone than was previously noted in personal interviews and this type of contact also addresses the Secretary's initiative on Customer Service Standards. The improved data base information also works to decrease other costs in the medical centers such as mail-out prescription costs and general mailing costs. All medications mailed to patients returned due to wrong address information must be destroyed. The amount of returned prescriptions should begin to decrease as accurate address information is obtained and entered in DHCP. This also holds true for overall mailing costs as patient statements, appointment reminders and other correspondence returned by the post office should decrease.

**Summary:**

NR-1 Initiative	Cost	Projected Recovery
HCFA Match	\$1,600 Statistical Match \$10,000 name match	Confirm assumptions \$97.4 million (if confirmed)
GSA Recovery Contract	\$7,000	\$105,000

Clinic Registration	\$12.96 million (or redirected savings from AICS)	\$100 million
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## Schedule:

NR - 1	Identifying New Insurance	Projected Completion	Status
		Date	
<b>Track 1</b>	<b>HCFA Data Match</b>		
1	Initiate project design and contact HCFA	Fall 1993	Completed
2	Prepare data match specifications	Early 1994	Completed
3	Obtain HCFA & VA Data Integrity Board Approval	Spring 95	Completed
4	Prepare Inter-Agency Agreement	Sep 95	Completed
5	Obtain General Counsel and Data Integrity Board approval	Apr 96; R:8/23	Partially Completed
6	Obtain HCFA Concurrence	Jul 96	Planned
7	Run Match	Aug 96	Planned
8	Assess Findings	Sep 96	Planned
9	If Assessment Positive, develop initiative strategy for patient name match	Oct 96	Planned
<b>Track 2</b>	<b>GSA Health Care Cost Recovery Service Contract</b>		
1	Identify, extract and provide vendor with selected sample of patient names for which VA has no insurance information	Aug 95	Completed
2	Contractor provides VA with insurance match information	Nov 95	Completed 3/96
3	VA performs review, verifies coverage and establishes insurance claims	Apr 96	Completed 4/96
4	Assesses contractor performance and pay vendor	May 96; R:8/96	partially completed
<b>Track 3</b>	<b>Reengineering Clinic Registration</b>		
1	Design improved process flow and prototype procedures for implementing clinic pre-registration contact	Aug 94	Completed
2	Provide resources and implement at reengineering sites	Oct 94	Partially completed
3	Track implementation results and assess opportunities	Ongoing	monthly statistics
4	Prepare procedures, software support, training materials, and marketing program for beta testing	Jun 96;R:7/96	anticipate completion
5	Assess beta test experience, revise process and materials	Dec 96	Planned
6	Revise materials, publish and distribute	Mar 97	Planned
7	Monitor implementation and track results	Ongoing after Mar 97	Planned

**NR-2: Processing Insurance Appeals**

*Purpose:* To maximize third-party reimbursement through a "winning" appeals process to insurance companies for partial payments and/or denied claims by insurance companies.

*Situation:* The Utilization Review (UR) coordinator is responsible for the review of patient treatment plans and supporting documentation in order to negotiate the payment of healthcare claims with an insurer. Negotiations are performed on a case-by-case basis and may involve prospective, concurrent or retrospective claim payment denials. There is not one single set of criteria delineating allowable admissions, lengths of stay and discharges used exclusively by all payers. Rather, payers will adapt review criteria to meet the needs of particular health benefit packages. The coordinator must be familiar with and apply a variety of criteria sets in order to negotiate the approval of denied admissions, continued hospital stays or rejected claim benefits. Nearly every health insurer has a process for the reconsideration of denied claims. However, not all VHA UR coordinators are familiar with or well versed in third party criteria, regulations and protocols to successfully conduct the reconsideration of a denied claim.

Successful negotiations require that the UR coordinator maintain a good working relationship with the insurance review staff, regional counsel, and respective VA medical staff. Reporting lines and conflicting internal priorities directly impact the time, motivation and overall success of third party payment negotiations.

Individual UR coordinators have successfully negotiated payments from payers that yield significant recoveries for the agency. Some of these UR coordinators report that as much as \$400,000 has been recovered solely as a result of a strong appeal program at the local medical center. Experienced UR coordinators maintain that of all the third party claims denied, approximately 10% could be overturned and recovery achieved. In FY 1995, approximately \$159.2 million non-Medigap inpatient claims and \$43.6 million non-Medigap outpatient claims (totaling \$202.8 million) were denied. Successfully negotiating 10% payment on these denials amounts to \$20.3 million, or \$118,600 on average per medical center. If we assume that only half of our medical centers (85) would achieve this level of reimbursement for denial appeals, an additional \$10 million in recoveries can be expected.

It should be noted that individual medical centers and respective networks will derive an additional benefit from this initiative as the skills used in tracking and negotiating with insurers may also be applied to cases for which VA pays non-VA providers of care (case management) resulting in cost savings to the agency.

**Action:** The MCCR Program Office is exploring opportunities for developing an education program to develop negotiation skills for successful appeals processes at the local level. Any educational endeavors would require the development and implementation of performance and success measures.

**Summary:**

NR-2 Initiative	Cost	Projected Recovery
Payment Appeals	\$250,000 Training Program	\$10 million

**Schedule:**

NR - 2	Processing Insurance Appeals	Projected Completion Date	Status
1	Develop education/performance measurement program for insurance appeal process.	Jul-96; R:1/97	In Process
2	Identify and select appropriate MCCR/UR staff to attend appeals process program	**Aug-96; track with step #3	Planned
3	Provide educational experience to UR nurses on the appeals process	Nov-96; R:1/97	Under development
4	Establish performance measures to monitor success of appeals process on local levels	Oct-96; R:1/97	Planned
5	Evaluate advantages of maintaining UR appeals experts vs. RN-based "appeals companies" to maximize reimbursement	Mar-97	Planned

**NR-3: Maximize Opportunities for Administrative and Benefit Offset by the Transfer of First Party Debt Over 90 Days Old to the Debt Management Center**

*Purpose:* Introduce a new process into first party delinquent debt which will result in increased revenue from first party charges.

*Situation:* Facility collection initiatives for first party charges are currently limited to issuing three notices to the veteran that a bill is due and payable. Interest and Administrative charges are added to the bill when it becomes 30 days old. Combined bills over \$25 in value and not paid within 90 days of issuance are referred once each year to the Debt Management Center (DMC) for the annual referral to the Internal Revenue Service (IRS) for offset against individual refunds. In FY 95, the IRS Offset program resulted in approximately \$3.2 million in recoveries. A recent audit by the Inspector General identified that a potential of \$6.5 million in collections could be achieved through the use of administrative offsets and other computer matches that are not available to the medical centers for delinquent debt greater than 90 days old. In the course of subsequent discussions with the IG auditors, MCCR determined that the \$6.5 million potential reported by the IG includes the \$3.2 million already recovered annually through the IRS offset. Consequently, computer matching and administrative offset could result in approximately \$3.3 million in additional revenue. Some of the DMC matching and offset activities could reduce collection credits to the IRS Offset program.

The Inspector General Report had identified pension and service connected veterans as inappropriately being billed by MCCR. The IG provided medical centers with information that resulted in the identification of 8,403 individual cases of apparent inappropriate billing amounting to \$952,005 since FY 1990. Following research into these cases, it was determined that 6,318 cases (\$685,112) had actually been billed appropriately, but for a variety of reasons, foremost of which was the legislative change in late FY 1992 exempting certain veterans with low income, medical centers had not taken action to correct the delinquent debt associated with these veterans. Of the 8,403 cases, 2,085 cases totaling \$266,892 had been billed inappropriately due to a variety of reasons, including incomplete HINQ data or failure to continually check HINQ at the facility level.

*Action:* Draft functional specifications to refer debts when they become 90 days old were delivered to the Veterans Benefits Administration (VBA) and the Office of the Assistant Secretary for Management in March 1995. Attempts were made during the spring and summer of 1995 to complete record layouts and develop test queues. However, Veterans Health Administration (VHA) developers were unable to obtain the necessary information to develop alpha software. The issue was revisited in the late summer of 1995 following the release of the Inspector General (IG) report when the Office of Management changed the scope of the project from referral of delinquent debt to referral of all copay obligations at time of establishment. Following discussions between VA's Office of Financial Management, VHA and VBA in March 1996, agreement was reached to initiate as soon as possible the computer matching and administrative offset of

copayment debts 90 days or older. As a part of the agreement reached in March, a pilot project targeting the immediate transfer of all copayment debt at the point of origin would also begin as soon as possible. This pilot initiative is discussed in detail in initiative IE-7.

**Timeline:** A firm target date for testing will be developed after project and performance specifications are finalized. The target date for finalizing project and performance specifications is June 30, 1996. (Also see initiative IE-7 which establishes a pilot program to evaluate the effectiveness of transferring all first party obligations at the moment the obligation is established.)

**Resources:** No new resources are currently programmed for this project. Existing resources will be needed to develop specifications, modify software and implement the project. This resource commitment is still being developed and will not be fully known until after completion of the specifications. Resources for storage should approximate current IRS Refund offset requirements.

**Summary:**

NR-3 Initiative	Cost	Projected Recovery
Administrative Offsets	Reprogramming Costs To Be Determined	\$3.3 million per IG Report

**Schedule:**

NR-3	Maximize Opportunities for Administrative and Benefits Offset by the Transfer of First Party Debt Over 90 Days Old to the Debt Management Center	Project Completion Date	Status
1	Establish Team	4/15/96	Complete
2	Develop Project Specifications	6/30/96	Complete
3	Develop Performance Measures	6/30/96	Complete
4	Program Extract, Receiver And DMC Processes	TBD	
5	Alpha Test Extractor	TBD	
6	Beta Test Extractor	TBD	
7	Match Against C&P File	TBD	
8	Evaluate Match Results	TBD	
9	Generate Offset Letter	TBD	
10	Offset And Process Payments	TBD	
11	Evaluate Results Of Offset	TBD	
12	Scale Up	TBD	

**NR-4: Contract Third Party Collections**

**Purpose:** To increase third party collections by utilizing "turn key" contract opportunities in areas that are currently without resource support.

**Situation:** Since the creation of the MCCR effort, there have been suggestions that contracting some or all of the third party recovery effort would maximize recoveries at far less expense than current operations require. To determine the value of this type of approach, MCCR recently contracted with Birch & Davis Associates to evaluate MCCR's Cost of Collections.

Birch & Davis Associates used complete FY 1994 data and compared VA and contractor costs. The report found that if the VA utilized contractors for its billing and collection activity, "the VA would continue to incur costs related to functions that a contractor would not perform under the turn key option of the GSA contract (e.g., determining service connected /nonservice connected status in preparation of a bill)." The Birch study estimates that in addition to the contractor costs of \$49.6 million for third party recovery, the VA would continue to incur costs of \$14.0 million to perform functions necessary for billing but which are not performed under contract.<sup>2</sup> The Birch study estimates that third party costs using a contractor would total \$63.7 million compared to VA's cost of \$58.3 million.<sup>3</sup> The Birch study notes that in addition to the economies offered by MCCR operations, "the MCCR program provides additional value and benefits to the entire VA system."<sup>4</sup>

All medical centers have MCCR allocated staff performing both third party and first party collection functions. Labor intensive activities like copayment recovery distort overall costs of operation figures.

**Cost to Recover \$1 By Category of Collection At Facility Level**

<b>Third Party Insurance</b>		
	Inpatient	\$0.056
	Outpatient	\$0.279
	<i>Average</i>	<i>\$0.118</i>
<b>Other</b>		
	Ineligibles	\$0.883
	Humanitarian	\$0.342
<b>Copayments</b>		
	Means Test	\$0.401
	Medication	\$0.384
	<i>Average</i>	<i>\$0.390</i>

<sup>2</sup> Birch, "Medical Care Cost Recovery, Cost of Collections Study, Final Report," Nov 21, 1995, p. 25. (Henceforth "Collections")

<sup>3</sup> Birch, "Collections," p. 26.

<sup>4</sup> Birch, "Collections," p. 27.

Similarly, within the third party function, high volume workload areas, such as ambulatory care, require manual documentation and coding. VA facilities are not like private sector hospitals with respect to outpatient billing. In the private hospital, outpatient billing is limited to establishing a single facility charge that is prorated by patient visit. The patient's physician and other supporting clinicians bill the patient (and insurance companies) directly for the specific procedures and services provided. Documentation of patient care is not required or accomplished by private facilities since this is a matter between clinician and patient. The VA on the other hand, not only bills a facility charge, but if it is to maximize recoveries, must document and submit claims for professional fee reimbursement to insurers.

Also, unlike private sector hospitals, VA copayment functions require extensive research, eligibility determinations and patient interaction, existing staff are utilized to manage the workload volume. As noted in the table above, the Birch study estimated the cost to collect one dollar to be \$0.279 for third party outpatient activities, \$0.401 for means test copayments and \$0.384 for medication copayments (compared with the \$0.056 estimated to bill and collect the highly automated and less manually labor intensive inpatient claim).<sup>5</sup>

Existing staffing levels have been relatively static for two years, as has the operating budget. Without additional resources to facilitate either automation of these high workload areas or to add staffing into areas of potentially high return within the medical centers, recoveries will remain flat.

Resource support for automation of ambulatory care documentation will allow MCCR to reallocate existing staff to perform functions that offer potentially higher yields for the investment of resources. Staff resources freed from ambulatory care documentation could be redirected into both processing insurance appeals and into the clinic registration initiative, both of which offer potentially high returns on the investment of resources. The Birch study noted that "VAMCs generally have limited resources to devote to account follow-up."<sup>6</sup> (see initiative NR-3 above.)

Rather than utilize contracts to replace existing MCCR operations (resulting in both an additional expense to the program and a loss to the VA system of the added value MCCR provides in a number of its partnership arrangements), contracts could be used to add value and enhance recoveries if they were directed toward satellite outpatient clinic operations that have no MCCR presence and unquestionably poor performing facilities. Focusing contractor turn key activities on these activities will tap new revenue sources, as yet untapped.

*Action:* MCCR created a team of program office and field representatives to research satellite outpatient workload, recovery activity and MCCR potential in states with large numbers of satellite clinics. Clustering turn key operations by state allows contractors to

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<sup>5</sup> Birch, "Collections," pp. 9 & 10.

<sup>6</sup> Birch, "Collections," p. 23.

achieve some economies of scale. The research is scheduled for completion by April 1996. In anticipation of positive findings, discussions with network directors and medical center management will follow. Depending upon negotiation outcomes with network directors, a task order could be executed in the last quarter of FY 96 with implementation targeted to begin first quarter FY 97. A pilot evaluation would ensue to determine the value of national roll out to all satellite clinics.

The importance of a pilot evaluation would be two fold. First, it would provide an opportunity to determine whether a private contractor can efficiently accomplish all activities associated with billing and collecting that MCCR currently performs. Second, it would give the private contractor an opportunity to become familiar with all the nuances that make billing and collecting at VA facilities different from private sector facilities without jeopardizing an existing MCCR program.

**Summary:**

NR-4 Initiative	Cost	Projected Recovery
Contract Third Party	To Be Determined	To Be Determined

**Schedule:**

NR-4	Contract Third Party Collections	Projected Completion Date	Status
1	Meet with Vendors	Apr-95	Completed
2	Develop Preliminary Cost to Operate Model	Jun-95	Completed
3	Schedule Vendors On-Site VAMC Tour	Aug-95	Completed
4	Review Results of Cost to Collect Contract	Nov-95	Completed
5	Get 1996 Goal Information by OPC	Feb-96	Completed
6	Get 1995 Collection Information by OPC	Apr-96	Completed
7	Project Estimate of Contracting Options	May-96	Completed
8	Present Contracting Out Recommendations to VHA CFO	May-96; R:6/7/96	Completed
9a New Milestone	Present Contracting Out Recommendations to OMB	June/July 1996; R:8/96	Partially Completed
9b	Present Contracting Out Recommendations to OMB	June-96; R:7/96; R:8/96	In Progress: pending action on 9a
10	Award Contracts	Aug-96	Planned
11	Initiate Contracts	Oct-96	Planned

**NR-5: Facilitate Medicare Supplemental Collections**

*Purpose:* Enhance cost recovery by improving the VA claims submission process to Medicare supplemental insurers.

*Situation:* Approximately 11.9% (\$62,375,750) of all third party recoveries are Medicare supplemental payments. MCCR has experienced mixed collections results in response to the submission of claims to Medicare supplemental insurers. A number of insurers are providing full payment in accordance with policy benefits, others have responded after legal action, a few are determining payment amounts in various ways and some are withholding payment pending the outcome of litigation challenging payment to VA without an appropriate Medicare Fiscal Intermediary or Carrier determination of Medicare benefits.

Since VA presently cannot receive reimbursement from Medicare for eligible veterans, MCCR has not been able to submit claims to Medicare Supplemental insurers similar to those of Medicare providers that have accompanying remittance advice (RA) and explanation of Medicare benefits (EOMB) payment vouchers. The RA from a Medicare Part A Fiscal Intermediary (FI) documents hospital payment according to the prospective payment system less the beneficiary deductible amount. The EOMB from a Medicare Part B Carrier documents the physician payment according to a fee schedule less the beneficiary copayment amount. Medicare Supplemental insurers commonly make payment based on the submitted claim and the attached RA and EOMB.

The development of an RA and EOMB for inpatient and outpatient care requires claims adjudication functions presently performed by Medicare fiscal intermediaries and carriers. These functions include (1) verifying that services provided are Medicare benefits; (2) providing admission certification; (3) conducting prepayment utilization screening; and (4) authorizing payment.

A task order is in process under the GSA Health Care Cost Recovery Services Contract to determine the feasibility, cost benefit analysis and work processes required for a Medicare FI and Carrier to provide claims adjudication services for VA claims submitted to Medicare Supplemental payers. While an estimated 65,000 inpatient and 1 million outpatient VA Medicare supplemental bills are generated annually, this a relatively low volume to Medicare FI's and Carriers. In order to estimate the potential cost of such a contract for the VA, MCCR researched present volumes and costs currently paid by the government to Medicare FIs and Carriers. Medicare, with its extremely high volume, pays contractors \$0.50 per claim to process EOMBs and \$0.50 per claim to process Remittance Advices. The Rail Road Retirement Board, with a volume of 11.6 million claims, pays the contractors \$1.60 per claim. VA's volume of 1.1 million claims per year may require \$2 or more per claim to process. Processing of paper claims may be necessary initially, but MCCR systems are expected to be able to transmit data electronically in about 9-12 months. HCFA's agreement will be necessary to allow a contract FI/Carrier to use HCFA systems and data bases for processing VA claims.

Estimating potential recoveries from this initiative is not possible at the present time. Although VA medical centers have the functionality to identify and track third party receivables, recoveries and denials by the type of policy (in this case Medicare Supplemental), this data is not currently rolled up to the National Data Base, nor is facility utilization of this claims tracking functionality certain. Projecting enhanced recoveries for this initiative is difficult because we do not know what we are not collecting and we do not know whether collection levels will decrease as a result of EOMB and RA determinations of non-Medicare covered services. Despite our current inability to project the enhancement potential, it is clear that failure to proceed with this initiative will result in an adverse opinion in the current litigation facing the VA. Our failure to implement this initiative will establish the basis for Medicare Supplemental carriers who are currently paying VA to stop their payment practices. Such action will result in a loss of \$150.6 million recovered by VA annually from these payers.

*Assessment:* If improved payment from Medicare Supplemental insurers is to be realized, change may be necessary from the present practice of forwarding a claim form without accompanying information on beneficiary out-of-pocket payment requirements. Current per diems and visit rates can be used initially in the provision of an RA and EOMB to a Medicare Supplemental insurer. Implementation of itemized outpatient procedure rates planned for FY 1998 and itemization of inpatient bills with Decision Support System (DSS) data at a later date will allow the production of more optimum EOMB's by a contract Medicare Carrier. Failure to modify our current billing practice may adversely affect the recovery of Medicare supplemental payments (amounting to over \$150.6 million in FY 95).

The success of this contract initiative is tied directly to the Ambulatory Data Capture initiative (AICS) IE-1, the Centralized Electronic Claims Processing Activity initiative IE-3 and the two Reimbursement Rate initiatives RR-1 and RR-2.

*Action:* Evaluate the contractor's report to be received in 2-3 months using a Medicare FI/Carrier to perform adjudication of VA claims for submission to Medicare Supplemental payers. Develop contract requirements for Medicare contractors that will be used in requesting the FI/Carrier bids to perform these services for VA. With VA General Counsel and Acquisitions support, determine most appropriate contracting vehicle including being added to existing HCFA or Railroad Retirement Fund contracts or contracting directly with Medicare contractors on a competitive basis. Contract award timing is dependent on the VA Acquisitions process. Annual costs to obtain Medicare-equivalent claims adjudication is estimated to be in the \$2.0-2.5 million range.

**Summary:**

NR-5 Initiative	Cost	Projected Recovery
Contract for FI/Carrier Claims Adjudication	\$2.0 to \$2.5 million	To Be Determined

## Schedule:

NR-5	Facilitate Medicare Supplemental Collections	Projected Completion Date	Status
1	Propose Medicare equivalent claims adjudication	November 1995	Completed
2	Complete VA's general requirements	March 1996	Completed
3	Obtain HCFA's support to access present contracts	May 1996; R:7/96	In Process
4	Conduct work flow design and cost/benefit analysis	June 1996; R:9/96	In Process
5	Finalize specifications with HCFA	August 1996; R:10/96	In Process
6	Reach agreement with HCFA contractor	November 1996	Planned
7	Begin VA claims processing by HCFA contractor	January 1997	Planned
8	Monitor implementation & resolve operational issues	June 1997	Planned
9	Initiate VA competitive bid process for long term contract to replace the short term HCFA agreement	July 1997	Planned
10	Award VA contract for claims processing to the selected Medicare contractor	July 1998	Planned
11	Facilitate conversion of claims submission to new contractor	October 1998	Planned
12	Monitor performance	Ongoing	Planned

**NR-6: Contract with health plans and insurers.**

**Purpose:** Obtain the authority and negotiate with HMOs to provide care to their enrolled population as a participating provider. Aggressively pursue negotiations with major plans.

**Situation:** The rapidly changing nature of third party health care plans is characterized by the transition from fee for service models to creatively modeled HMO and HMO/PPO operations. These new models are attracting an increasing share of the insured population. These new HMO hybrid plans are more closely modeled after popular PPO insurance plans than they are modeled after traditionally closed HMO models. A number of medical center report that these new HMO models are eroding our pool of insured patients with billable insurance. "The InterStudy Competitive Edge 5.1" report, Parts II and III (April 1995), supports VA facility observations of increased HMO enrollment in large metropolitan areas. We have had limited success in negotiating with these plans to serve as preferred providers for a variety of reasons, including statutory limitations in negotiating unique reimbursement rates, as determined by our General Counsel.

**Action:** Initiate a joint effort between the MCCR Program Office and the General Counsel to develop a feasibility study based on present regional counsel experience and legislative interpretations. The study outcome will include an implementation plan and guidelines to regional counsel staff and MCCR facility coordinators. Legislative initiatives should also be developed by General Counsel to change the existing law and eliminate the protective exclusions which preclude billing the newly crafted HMO plans. This legislation is essential with the increasing popularity of HMO coverage. Legislation is needed to require that HMO providers recognize VA has a preferred provider for medical care services for HMO enrollees. The MCCR Program Office with the assistance of the General Counsel's office will continue to seek provider agreements with other health insurance carriers. The MCCR Program Office and the General Counsel's Office will also actively pursue maximum reimbursement from all health insurance carriers.

**Summary:**

NR-6 Initiative	Cost	Projected Recovery
Legislation & Contracts for new HMO plans	To Be Determined	To Be Determined

**Schedule:**

NR-6	Contract with health plans and insurers	Projected Completion Date	Status
1	Meet with General Counsel staff on HMO authority	ongoing	ongoing
1a	Two HMO contracts were reviewed and returned to Regional Counsel for finalization (PA and Reno)	June 96	Completed

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2	Initiate survey on HMO penetration at VAMCs	Jul 96	In Progress
3	Review study results	Aug 96	planned
4	Develop guidelines for VAMCs and Regional Counsels	Nov 96	planned
5	Develop legislative initiatives	Nov 96	planned

**NR-7: Expand to other areas agreements similar to the DOD Sharing Arrangement Between Ft. Meade and Ellsworth AFB**

*Purpose:* Initiate VA Sharing or similar agreements with other Department of Defense (DOD) facilities to provide MCCR third party recovery services similar to the Ft. Meade VAMC/Ellsworth AFB project.

*Situation:* In FY 1993 Ft. Meade VAMC entered into an agreement with Ellsworth AFB to provide MCCR services for inpatient cost recovery. This MCCR recovery effort using PC-based IB software was expanded to outpatient services using encounter forms in all clinics in FY 1995. Collections have steadily increased and are projected to reach \$200,000 in FY 1996. VA retains 25% of collections to cover the cost of the 2 FTE that operate the program. Future collection increases are dependent on DOD staffing at the AFB and military retirees and dependents. Opportunities can be explored for similar MCCR agreements with other DOD facilities where there is a desire to contract out third party recovery services. However, the GSA Contracts for Health Care Cost Recovery Services require DOD facilities to use the vendor awarded the turnkey operation item of the contract. Future MCCR agreements with other DOD facilities are unlikely should participants be limited to the awardee of the GSA contract.

*Action:* Request a VA General Counsel opinion on the applicability of the GSA contract to MCCR efforts to initiate sharing or other agreements with DOD facilities for the provision of third party insurance recovery services. Should DOD facilities not be bound by the GSA contract, a plan will be developed by MCCR to expand cost recovery agreements to additional military treatment facilities. If DOD facilities are bound by the GSA contract, VA and DOD should pursue legislation to allow VA to compete for DOD collection business. Should a General Counsel legal opinion be available in 6 months, a plan to market MCCR services can be completed and implementation begun in first quarter of FY 1997. Similarly, if the opinion does not allow VA to support DOD, draft legislation could be initiated in the first quarter of FY 1997.

**Summary:**

NR-7 Initiative	Cost	Projected Recovery
Provide recovery services to DOD	Cost of Recovery Reimbursed by DOD Recoveries	Marginal Costs Credited to VA with Primary Collection to DOD

**Schedule:**

NR-7	Expand to other areas agreements similar to the DOD Sharing Agreement between Ft. Meade VAMC and Ellsworth AFB	Projected Completion Date	Status
1	Request General Counsel opinion	May 1996; R: 6/96; R: 7/96	In Process
2	Receive General Counsel opinion	Dec 1996	Planned
3	Develop marketing plan and begin implementation	Mar 1997	Planned
4	Monitor performance	Ongoing	Planned

**(2) Improved Efficiency (IE) Focus:** The second cluster of initiatives improve the efficiency of MCCR activities through reengineering, streamlining, standardization and automation. By reinvesting the savings obtained from improved efficiencies into resources needed to support the new or modified processes described above, efficiency gains are multiplied by using them to generate new revenues.

**IE-1: Implement Ambulatory Data Capture**

*Purpose:* To increase collections while reducing the cost to identify, bill and collect outpatient care.

*Situation:* MCCR currently captures the majority of its ambulatory care billing data through retrospective review of the outpatient record. In FY 1994, this process cost MCCR approximately \$9 million or 24.5% of its \$38 million outpatient billing budget.<sup>7</sup> This level of effort resulted in collections from ambulatory care of \$136,330,954. Prior to 1995, there was no VHA requirement to collect information associated with the diagnosis, procedure or provider in either the DHCP or Austin Automation Center (AAC) data bases. Some facilities did capture a portion of this data through a cumbersome key entry process. Recognizing the need to capture ambulatory patient data for both billing purposes and for clinical management, MCCR initiated in FY 1994 work with other components of VHA to develop strategies to capture and store ambulatory data in a systematic way which would allow timely access to ambulatory treatment information. Richer ambulatory data would allow VHA to produce more accurate billings and, consequently, increase collections and deposits to Treasury. MCCR funded the development of automated technology prototypes to capture the information, the software to facilitate the capture and the data linkages with DHCP, and the enhancements of the Patient Care Encounter file which would serve as a repository and interface with other DHCP modules for the captured information. In April 1995, the Under Secretary for Health changed VHA policy to require the capture of the diagnosis, procedure and provider data for all ambulatory care encounters or services. This policy change allowed the shifting of Medical Care priorities and the redeployment of existing Medical Care resources to this project.

*Action:* This initiative implements the Under Secretary's policy change. MCCR is a partner with other VHA elements in developing and funding the initiative. Total cost associated with implementing full collection of ambulatory data are about \$238 million over seven years.<sup>8</sup> These estimates, developed by the Birch study, were reviewed and accepted by MIRM and MCCR staffs. MCCR's anticipated costs for this same period are about \$51.7 million or about 22 percent of the total cost.<sup>9</sup> The approach to collecting data is based on industry practice of using encounter forms to capture clinical and billing data. However, MCCR has taken this opportunity to enhance a basic industry process to

<sup>7</sup>Birch, "Collections," Exhibit 4, p.14.

<sup>8</sup>Birch & Davis Associates, Inc. "Medical Care Cost Recovery Cost Benefit Analysis, Optical Scanning," Dec. 5, 1995, p. 14. (Henceforth referred to as "Benefit".)

<sup>9</sup>Birch, "Benefit" p. 15.

overcome two major impediments of existing paper technology. These enhancements include: the ability for users locally to customize encounter forms to meet the changing needs of clinical staff; the ability to merge patient specific clinical and administrative data on or with encounter forms; and the ability to scan the encounter form for data entry, in lieu of manual key entry, into clinical and administrative data bases. The storage of all ambulatory care data will allow MCCR units to begin utilizing the automatic billing features of the Integrated Billing package for ambulatory care. By eliminating the vast majority of manual medical record review and coding, the process will reduce by 572 FTE the resources currently expended on the capture of billing information through retrospective review of medical records.

*Timeline:* Development and testing of the software components related to scanable form generation are scheduled for FY 96. Roll out had been scheduled for summer 1996. However, the unresolved availability of funds in FY 96 for equipment purchase will slip implementation to the first quarter of FY 97. Testing of the software is scheduled to continue throughout the spring and summer of FY 96. As an interim implementation strategy, 25 sites were funded with an earlier prototype system which provides them the ability to enter their data into a beta test version of the Patient Care Encounter (PCE) package. The PCE package will be the clinical information repository for all ambulatory care encounter data. Experience from these prototype facilities is being applied to the planned roll-out of the Ambulatory Data Capture components.

*Resources:* MCCR resources, approximately \$51.7 million over the seven year life of the system, account for less than 22 percent of the total resources associated with this project.<sup>10</sup> MCCR resources are targeted more to support implementation and start-up costs of the project because MCCR has the most to gain from early start up of this project (see discussion below). Medical Care resources support both the implementation and ongoing operation of the system. Initial resources required in FY 96 represent a combination of recurring MCCR resources that have been redirected to this effort and new non recurring resources needed to acquire equipment on which to run the data collection portion of the initiative.

*Return on Investment:* Return on investment estimates supporting this initiative are based on the Cost of Collections study and the Cost Benefits Analysis conducted by Birch & Davis Associates in the fall of 1995. MCCR currently spends a little over \$9 million dollars a year to retrospectively review medical records and to generate claims. That expenditure resulted in approximately \$136 million in collections from outpatient claims in FY 94.

The Birch & Davis Cost Benefit Study determined that MCCR recoveries would directly benefit from this initiative in four areas: 1) increased revenue potential resulting from improved identification of billable visits; 2) increased reimbursement due to improved capture and reporting of procedures; 3) increased revenues resulting from more timely

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<sup>10</sup> Birch, "Benefit," p. 14.

billing that thereby decreases revenue lost due to insurance company statute of limitations; and 4) interest earned due to a reduction in accounts receivable days outstanding.<sup>11</sup>

The Cost Benefit Analysis estimates that we currently utilize approximately 55 FTE for outpatient record retrieval and 667 FTE for the 35 minutes per claim average required of outpatient pre-billing review and coding of the medical record. The AICS process would eliminate the need for the 55 FTE retrieving records and reduce from 667 FTE to 95FTE the number of staff needed to process claims. The anticipated savings in manpower from this initiative is about 627 FTE (572 from pre-billing and 55 from record retrieval).<sup>12</sup> While these FTE could generate a savings of personnel services dollars of a little over \$9 million per year, their reinvestment to improve billable insurance offers promising cumulative returns of \$492.46 million at a cost only \$54 million in seven years. Without the reinvestment of these 627 FTEE, the remaining benefits derived from improved capture and reporting of procedures, more timely billing and interest earned by reducing accounts receivable days outstanding would amount to \$9.66 million in seven years. This places cumulative benefits (without reinvestment of the 627 FTE) in seven years at \$9.6 million vs. costs of \$51 million. The return on investment from this initiative without a reinvestment of staffing resources would be negative.

By shifting these staffing resources to the insurance identification initiative NR-1 and to the insurance appeals initiative NR-2, the anticipated cost to operate MCCR in year 4 would be closer to \$0.16 and Treasury would begin to realize revenue enhancements of about \$100 million a year.<sup>13</sup> This benefit would be achieved by shifting the 627 FTE an average of 3.8 per site to pre-registration, insurance identification functions and insurance appeal processes.

The Birch "Benefits" study estimates that an increase in the insurance identification rate from 8 percent currently to 12 percent can be achieved by this shifting of staff utilization. The Birch study finds that

Currently, approximately 8 percent of all outpatient visits and 14 percent of inpatient admissions are identified as being billable (i.e., patients with reimbursable insurance). The 1987 Survey of Veterans (SOV III) and the 1988-89 Survey of Medical System Users (SMSU) indicated that approximately 18 to 20 percent of all episodes of VA health care are potentially billable. This would suggest that there exists a potential for increasing the numbers of billable episodes of outpatient and inpatient care by 10 percent and 4 percent, respectively. However, many insurance policies that cover inpatient care do not cover non-emergent outpatient care. Therefore, while the VA's inpatient insurance identification rate may have the potential to reach 18 percent, we do not feel that it is realistic to assume that the outpatient rate could be increased to the same level. However, we do feel that a 12 percent outpatient insurance identification rate is realistic and conservative and have used this number in estimating the increased revenue benefit in this study.<sup>14</sup>

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<sup>11</sup> Birch, "Benefit," p. 13.

<sup>12</sup> Birch, "Benefit," pp. 16-17.

<sup>13</sup> Birch, "Benefit," pp. 14-15.

<sup>14</sup> Birch, "Benefit," p. 17.

Exhibit 5 of the Birch "Benefit" study (page 18) provides a table which demonstrates the calculation used to estimate the \$492 million VA will realize from increased revenue from improved identification of outpatients with insurance.

The following two tables were extracted from the Birch & Davis, Associates "Cost Benefit Study" on Optical Scanning (Exhibit 4, pp. 14 & 15). The first Table estimates total system costs and benefits for implementing the AICS. The second Table isolates the estimated MCCR costs and benefits associated with the AICS implementation. Both tables assume the transfer of staffing resources saved by AICS implementation to insurance identification functions. Under the benefits enumerated, "increased revenues" refers to "increased revenue potential resulting from improved identification of billable visits;" "increased procedures" refers to "increased reimbursement due to improved capture and reporting of procedures;" "increased statutes" refers to "increased revenue resulting from more timely billing that thereby decreases revenue lost due to insurance company statute of limitations; and finally, "A/R interest" refers to "interest earned due to a reduction in accounts receivable days outstanding."<sup>15</sup>

Benefits	Total System Costs and Benefits for AICS						
	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7
Increased revenue	\$0	\$21,863,427	\$46,106,358	\$97,321,059	\$103,071,770	\$109,070,896	\$114,961,445
Increased procedures	\$0	\$192,000	\$192,000	\$192,000	\$192,000	\$192,000	\$192,000
Increased statutes	\$0	\$1,137,145	\$1,192,887	\$1,254,204	\$1,315,521	\$1,382,412	\$1,449,302
A/R interest	\$0	\$0	\$214,428	\$273,786	\$289,756	\$0	\$0
<b>Total benefit</b>	<b>\$0</b>	<b>\$23,192,572</b>	<b>\$47,705,673</b>	<b>\$99,111,048</b>	<b>\$104,869,047</b>	<b>\$110,645,308</b>	<b>\$116,602,747</b>
Cumulative benefit	\$0	\$23,192,572	\$70,898,245	\$170,009,294	\$274,878,341	\$385,523,649	\$502,126,396
<b>COSTS*</b>							
Equipment	\$900,000	\$21,150,000	\$0	\$0	\$0	\$7,033,000	\$7,033,000
Maintenance	\$0	\$90,000	\$2,115,000	\$2,178,450	\$2,243,804	\$1,500,000	\$1,500,000
MAS Personnel (Managerial)**	\$0	\$17,907,456	\$0	\$0	\$0	\$0	\$0
MAS Personnel (Clerical)**	\$0	\$12,618,550	\$12,896,315	\$13,167,138	\$13,443,648	\$13,725,964	\$14,014,209
IRM Personnel**	\$0	\$12,141,965	\$12,518,366	\$12,781,251	\$12,141,965	\$13,049,658	\$13,323,700
Software Programming	\$0	\$180,000	\$0	\$0	\$0	\$0	\$0
Fixed Cost-Disk Storage	\$0	\$1,176,000	\$1,213,632	\$1,252,468	\$1,292,547	\$1,332,615	\$1,373,927
Fixed Cost-Supplies	\$0	\$432,000	\$1,312,000	\$1,560,384	\$1,810,316	\$1,660,236	\$1,711,703
Implementation Costs	\$0	\$1,206,090	\$534,090	\$312,090	\$0	\$0	\$0
Enhanced Technical Support	\$0	\$200,000	\$51,600	\$53,251	\$54,955	\$56,659	\$58,415
<b>Total Cost</b>	<b>\$900,000</b>	<b>\$47,102,061</b>	<b>\$30,841,003</b>	<b>\$31,325,032</b>	<b>\$30,787,235</b>	<b>\$38,358,132</b>	<b>\$9,014,954</b>
Cumulative Cost	\$900,000	\$48,002,061	\$78,843,064	\$110,168,096	\$140,955,331	\$179,293,463	\$238,308,417
<b>NET BENEFIT</b>	<b>(\$900,000)</b>	<b>(\$43,909,489)</b>	<b>\$16,864,670</b>	<b>\$67,836,017</b>	<b>\$74,281,812</b>	<b>\$72,287,176</b>	<b>\$77,587,793</b>
<b>CUMULATIVE NET BENEFIT</b>	<b>(\$900,000)</b>	<b>(\$44,808,489)</b>	<b>(\$27,944,819)</b>	<b>\$39,861,198</b>	<b>\$113,943,010</b>	<b>\$186,230,185</b>	<b>\$263,817,979</b>
<b>PV of Net Benefits @ 10.0%</b>	<b>1</b>	<b>0.9091</b>	<b>0.8264</b>	<b>0.7513</b>	<b>0.683</b>	<b>0.6209</b>	<b>0.5645</b>
<b>PV of Net Benefits</b>	<b>(\$900,000)</b>	<b>(\$39,918,117)</b>	<b>\$13,836,964</b>	<b>\$50,942,660</b>	<b>\$50,597,878</b>	<b>\$44,863,107</b>	<b>\$43,798,309</b>
<b>Cumulative Net Benefits</b>	<b>(\$900,000)</b>	<b>(\$40,818,117)</b>	<b>(\$26,881,153)</b>	<b>\$24,061,507</b>	<b>\$74,659,385</b>	<b>\$119,542,492</b>	<b>\$163,340,801</b>

\* Includes total estimated project costs

\*\*MAS and IRM personnel will come from a redirection of existing resources

Note: Not included in the software programming estimates being funded by MCCR nor in the Cost/Benefit Analysis is the significant programming effort now underway involving impacted DHCP packages other than AICS, nor are any Austin costs for the centralized system. Software Services recently estimated approximately 8 programmers for 2 years will be needed for the changes to Scheduling and PCE alone. The Austin Automation Center resource issues and funding are not yet resolved.

<sup>15</sup> Birch, "Benefit," p. 13.

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MCCR Costs and Benefits for AICS

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7
<b>BENEFITS</b>							
Increased revenue	\$0	\$21,863,427	\$46,106,358	\$97,391,059	\$103,071,770	\$109,070,896	\$114,961,445
Increased procedures	\$0	\$192,000	\$192,000	\$192,000	\$192,000	\$192,000	\$192,000
Increased statuses	\$0	\$1,137,145	\$1,182,687	\$1,254,204	\$1,315,521	\$1,382,412	\$1,449,302
AR interest	\$0	\$0	\$214,428	\$273,786	\$289,756	\$0	\$0
Total benefit	\$0	\$23,192,572	\$47,705,673	\$99,111,049	\$104,869,047	\$110,645,308	\$116,602,747
Cumulative benefit	\$0	\$23,192,572	\$70,898,245	\$170,009,294	\$274,878,341	\$385,523,649	\$502,126,396
<b>COSTS***</b>							
Equipment	\$900,000	\$21,150,000	\$0	\$0	\$0	\$7,033,000	\$7,033,000
Maintenance	\$0	\$90,000	\$2,115,000	\$2,178,450	\$2,243,804	\$1,500,000	\$1,500,000
Software Programming	\$0	\$180,000	\$0	\$0	\$0	\$0	\$0
Fixed cost - Disk Storage	\$0	\$235,200	\$242,726	\$250,494	\$258,509	\$266,523	\$274,785
Fixed cost - Supplies	\$0	\$86,400	\$302,400	\$312,077	\$322,063	\$332,047	\$342,341
Implementation cost	\$0	\$1,208,090	\$534,090	\$312,090	\$0	\$0	\$0
Enhanced Technical Support	\$0	\$200,000	\$51,600	\$53,251	\$54,955	\$56,659	\$58,415
Total cost	\$900,000	\$23,147,890	\$3,245,816	\$3,106,361	\$2,879,332	\$9,188,229	\$9,208,541
Cumulative cost	\$900,000	\$24,047,890	\$27,293,506	\$30,399,868	\$33,279,199	\$42,467,429	\$51,675,970
NET BENEFIT	(\$900,000)	\$44,882	\$44,459,857	\$96,004,687	\$101,989,715	\$101,457,079	\$107,394,206
CUMULATIVE NET BENEFIT	(\$900,000)	(\$855,118)	\$43,604,739	\$139,609,426	\$241,599,141	\$343,056,220	\$450,450,426
PV of Net Benefits @ 10.0%	1	0.9091	0.8264	0.7513	0.683	0.6209	0.5645
PV of Net Benefits	(\$900,000)	\$40,802	\$36,741,626	\$72,128,322	\$69,658,976	\$62,994,700	\$60,624,029
Cumulative Net Benefits	(\$900,000)	(\$859,196)	\$35,882,428	\$108,010,749	\$177,667,725	\$240,664,425	\$301,288,454

\*\*\* Includes MCCR costs only--i.e., Equipment, maintenance, software, implementation costs, and 20 percent of fixed costs

Summary:

IE-1 Initiative	Cost	Projected Recovery
Implement Automated Data Capture	\$24 million thru year 2	\$23.2 million 1st year
	\$51.7 million seven year cumulative	\$502.1 million seven year cumulative (Refer to NR-1)

Schedule:

IE-1	Implement Ambulatory Data Capture	Projected Completion Date	Status
1	Establish Implementation Working Group	7/1/95	Complete
2	Develop Work Plan	8/30/95	Complete
3	Introductory Satellite Uplink	9/26/95	Complete
4	Prepare Cost benefits Analysis	12/1/95	Complete
5	Contract for Test Site Equipment	9/30/96	Complete
6	Identify Field implementation Teams	1/15/96	Complete
7	Test Version 2.1 of Automated Information Collection System (AICS)r	3/25/96	Complete
8	Provide Initial Team Training to Field Implementation Teams	3/22/96	Complete
9	Implement AICS version 2.1	4/96	Complete
10	Provide training on Rapid data entry and Patient Care Encounter Software (satellite uplink)	7/96	Complete
11	Implement Patient Care Encounter (PCE) version 1	7/96; R: 8/96	In Progress
IE-1	Implement Ambulatory Data Capture	Projected	Status

(con't)	(continued)	Completion Date	
12	Implement Rapid data Entry Patch to AICS version 2.1	7/96; R: 8/96	Delayed due to milestone 11
13	Test Version 3.0 AICS (Scanning)	9/96	
14	Provide Training on Scanning and scheduling changes	9/96; R: 11/96	pending release of software
15	Implement AICS version 3.0	10/96; R: 11/96	Planned
16	Implement Primary Care Management Module (Scheduling changes)	10/96	Planned
17	Post Implementation follow-up	10/97	Planned

**IE-2: Establish the Consolidated Copayment Processing Center**

*Purpose:* The Consolidated Copayment Processing Center represents an effort to improve the efficiency of specific processes related to the issuing patient statements and collecting first party obligations.

*Situation:* Efforts over the past five years have automated the process of identifying health care events that are subject to patient copayments and other charges. All charges are automatically identified in the Integrated Billing (IB) package and, except for selected cases, are automatically priced and passed to the Accounts Receivable (AR) package. The AR package consolidates charges incurred from the different programs and issues a monthly statement of charges and payments. Interest and administrative charges are automatically calculated and added when appropriate. Rights and obligations data is printed with the statement. Exception cases involve cases returned from the IVM center (cases must be first reviewed and then released) and discretionary cases involving insurance which are held until insurance benefits can be applied to the first party debt in accordance with General Counsel procedures. Up to the point of statement mailing all tasks are performed in the computer with minimal MCCR staff intervention. Payment processing represents the other functional activity that has been significantly automated once data has been entered into the computer. Payment data is entered by veteran SSN, payment amount, check number and date of payment. Since the data entry mechanism is tied to the account records, potential duplicates are evaluated at the time data is entered. The AR package then applies payments to existing charges using the age of debts. AR then manages the process of recording the deposits and appropriate FMS documents.

Performance data from FY 95 indicates that well over 75 percent of all charges are paid in the first 60 days following the establishment of a charge. While data collected during a cost benefits analysis indicates that approximately 30 percent of all medication copayment charges are collected at the time of service, the remainder of charges are not available at the time services are provided because they are either handled as batch processes or are completed through the mail. These charges are processed through the patient statement.

To improve the efficiency of processing first party charges and payments, the functions of statement processing and payment processing were reviewed by the MITRE corporation under contract to MCCR.

*Action:* MITRE recommended that patient statement printing be consolidated to a single site using electronic transfer of the variable data needed to produce the statement to that site.<sup>16</sup> MITRE also recommended that VHA pursue a Treasury Lock Box agreement to handle payment processing. Both of these processes would fit into existing automated routines.<sup>17</sup>

<sup>16</sup> MITRE, "Consolidated Copayment Processing Center," October 1994, p. 5-44.

<sup>17</sup> MITRE, "Consolidated Copayment Processing," p. 5-44.

*Timeline:* Functional specifications were developed during FY 95, and a Memorandum of Understanding was completed with the Austin Automation Center in December 1995. The project was put on hold during December and January because of the furlough. Further delays were experienced because of disagreements over the scope of the VBA's Debt Management Center (DMC) Referral. The project officially resumed February 28, 1996 with a project team conference call. Targets for alpha testing of the statement printing is currently scheduled for May 1996. Lock box processing was delayed by our inability to obtain price quotes from Treasury for the use of their bank contracts until March 1996. Estimates from Treasury's bank contracts were higher than anticipated and estimates from the DMC are being sought before a final decision on lock box services is made.

*Resources:* MITRE developed estimates for implementing the Consolidated Copayment Processing Center utilizing two options, contractor and VA-provided services. MITRE estimated that initial start up costs for the VA alternative would include a major hardware acquisition which we were able to eliminate through available capacity at the Austin Automation Center.

In addition, Austin's actual cost estimates were somewhat below MITRE's estimates making implementation of the copayment center with in-house resources cost effective. Initial review of the services we have requested from Treasury indicates that these services are equivalent to many standard check clearing processes and should be provided at no cost to VA. Further, use of the Treasury Lock Box requires no use of MCCR FTE for this portion of the process. While we have yet to receive formal cost estimates from the DMC, informal estimates indicate that lock box services provided by the DMC will require between 25 and 30 FTE.

*Return on Investment:* Initial estimates by MITRE indicated that base line costs for statement processing were approximately \$9.8 million per year.<sup>18</sup> Remittance processing costs were estimated at approximately \$13.7 million per year.<sup>19</sup> Total costs for these functions were estimated by MITRE to be \$23.5 million. This compared favorably to an estimated operating cost of \$3 to \$4 million for the CCPC model. Because the original investment analysis was done based on FY 1994 data and involved limited site verifications of the data, we have compared the MITRE results with more recent studies by Birch & Davis.<sup>20</sup> That analysis differs significantly from the MITRE study. Birch & Davis estimate that the cost of performing the same functions totaled only \$6.8 million out of a total program cost of \$16 Million. This reduction in costs is the result of program improvements in operations, automation and a better understanding of where costs functionally occur. The functions contributing to the \$16 million in copayment costs include interviewing, statement preparation and mailing, answering questions, receiving, depositing and posting payments, generating IRS offset letters, District

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<sup>18</sup> MITRE, "Copayment," Table 6-1.

<sup>19</sup> MITRE, "Copayment," Table 6-4.

<sup>20</sup> Birch, "Collections," p. 15.

Counsel referrals, management and administrative overhead, and miscellaneous costs associated with training, overtime, benefits, etc. The \$6.8 million in costs specifically associated with the functions which the CCPC replace are limited to the preparation and sending of means test statements and the receiving, depositing, and posting of payments.<sup>21</sup>

Overall the cost of implementing the program has also been further reduced from the Birch estimates. Operating costs projected by the Austin Automation Center (AAC) are estimated to be approximately \$2.6 million per year or a little over a third of the current cost of operations for those functions associated with the CCPC.

If the Austin estimates hold true, the estimated \$4.2 million in annual savings from this initiative which exist in both the all other (Supplies and maintenance) and in the personnel services categories will net a savings of approximately 120 FTE. The initial savings envisioned by MITRE assumed that all personnel doing tasks associated with remittance processing would be eliminated; however, the approximately 30% of remittance processed at the cashier window would continue as would other third party remittance processing functions reducing the number of cashier personnel. Therefore baseline analysis will be needed to identify the number and type of savings that will occur from implementation.

Staff resources saved through the introduction of CCPC will be offset by the additional staffing resources necessary to support the DMC lock box activity associated with this initiative, with the pilot initiative IE-7 which directs the transfer of all first party debt to the DMC and with resources needed to support the numerous MCCR third party software applications with IRM support personnel at local facilities.

**Summary:**

IE-2 Initiative	Cost	Projected Savings	Recoveries
Consolidated Copayment Processing Center	\$2.6 million	\$4.2 million to be reinvested	To Be Determined (Redirect Savings)

**Schedule:**

IE-2	Establish Consolidate Copayment Processing Center	Projected Completion Date	Status
1	Develop specifications	12/1/95	Complete
2	Establish MOU with Austin Automation center	12/4/95	Complete
3	Develop Performance Measures	6/30/96	
4	Program AAC and DHCP Software for Patient Statement Printing	6/15/96	Complete
5	Alpha Test Statement Printing	6/30/96; R:7/96	In Progress
6	Beta Test Statement Printing	7/30/96; R:8/96	Delayed 1 mo milestone #5
7	Implement Statement Processing	9/30/96; R:10/96	Delayed 1 mo milestone #5

<sup>21</sup> Birch, "Collections," p. 15.

8	Establish Lock box Site	4/30/96; R:8/96	In Progress
9	Program AAC and DHCP software for Remittance Processing	TBD	
10	Alpha Test Remittance Processing	TBD	
11	Beta Test Remittance Processing	TBD	

**IE-3: Establish Centralized Electronic Claims Processing Activity**

*Purpose:* To increase the efficiency of third party claims processing using electronic claims processing.

*Situation:* The traditional process for submitting claims against health insurance policies is to produce a paper Uniform Bill version 92 (UB-92) or a HCFA 1500. This process delays the submission of the claim based on mail float. The process also increases handling time by the insurance carrier, who must enter the data from the form into their computer. Claims submitted via the paper process may also include errors, omissions, or inaccurate information. During routine follow up, medical center staff routinely discover that insurance payers assert that they never received claims for payment mailed by the facilities. In addition, claims are routinely returned unpaid from insurers if any error or omission is found. These returned claims add one to two months of additional processing time required to receive payments. The use of electronic claims processing provides facilities with immediate feedback regarding errors, omissions or inaccurate information by means of payer specific automated edit routines. Within a single day, billers are notified of errors and can take immediate steps to make corrections. Claims submitted electronically provide for both immediate insurance verification and information regarding policy coverage to facility billers. In addition, payers provide automated receipt notification for all claims submitted electronically. Claims processed electronically by payers are paid much more rapidly, often within seven days of receipt.

For the past three years, MCCR has experimented with Electronic Claims Processing at individual medical centers. Approximately 100 medical centers have some form of EDI claim processing capability. The program office has also participated in the development of ANSI standard X.12N transactions for insurance billing and payments. Our experience has indicated that the industry is not ready for a pure X.12N EDI process and that clearing houses are needed to deal with existing proprietary formats in use by the industry. Our experience has also indicated that local processes range from duplicate key entry of claims into carrier terminals to full transfer of print images of UB-92 directly from the DHCP. Full DHCP solutions have been developed through local modifications of the software and involve greater involvement of local IRM staff. Given the current limits on IRM FTE, a national solution that increases their workload is not feasible.

The solution proposed establishes a standard process that will run in DHCP and produce a common transaction that will pass data to the Austin Automation Center (AAC). To deal with the plethora of formats present in the industry, one or more value added network vendors will be contracted to provide translation services to the various insurance carriers. To prepare for future direct connections to carriers promised by X.12N, claims will be sent to the value added network via standard transaction sets.

*Action:* Development is underway on the transactions to be sent to the Austin Automation center. The Austin Finance Center (AFC) will complete mapping of the DHCP transaction within the translator software. Data on insurance carriers with whom

MCCR files claims was consolidated in mid March. A request for comment on the proposed VAN contract has been filed and responses received. A working group met in Austin during March to finalize test plans and to begin to send test data. Plans call for release of the Request for Proposals (RFP) in May. Initial testing of production data will begin once a contract is awarded.

*Benefit:* Implementing electronic claim processing nationally will provide a one time recovery benefit of at least an average months recovery, i.e. approximately \$25 million. This one time benefit is attributable to reducing the outstanding accounts receivable days by 30 days.

**Summary:**

IE-3 Initiative	Cost	Projected Savings	Recoveries
Centralized Electronic Claims Processing	To Be Determined	To Be Determined	To Be Determined

**Schedule:**

IE-3	Establish Centralized Electronic Claims Processing Activity	Projected Completion Date	Status
1	Develop specifications	4/30/96	Complete
2	Develop Contract Specifications for national clearing house contract	5/30/96; R: 7/96	90% Complete
2a	<i>Obtain ITM approval (New Milestone)</i>	7/96; R: 8/96	In Progress
2b	<i>Release RFP (New Milestone)</i>	7/96	dependent on completion 2a
2c	<i>Award Contract (New Milestone)</i>	8/96	dependent on completion 2a
3	Develop Performance Measures	6/30/96	Complete
4	Program AAC and DHCP Software for EDI	6/15/96; R: 7/96	90% Complete
5	Alpha Test EDI	6/30/96; R: 9/96	dependent on task 2c
6	Beta Test EDI	7/30/96; R: 10/96	dependent on task 5
7	Implement EDI Facilities w/o capability	9/30/96; R: 11/96	dependent on task 6
8	Implement EDI Facilities with current capability	9/30/97	planned

**IE-4: Introduce Electronic Fund Transfer to All VAMCs**

*Purpose:* To increase the efficiency of third party claims processing using electronic funds transfer.

*Situation:* Some insurance carriers have begun to pursue payment of their claims using electronic funds transfer. Opportunities for using this approach were discussed with Treasury officials and the opportunity was presented to pilot test a Treasury process called remittance express. This approach results in payments being automatically deposited into facility level accounts within the current Agency Location Code (ALC) used by all VHA facilities. The process, when used with Cash Link software, improved the timeliness with which commercial payments were deposited into the Treasury. The process does not provide any automation for the posting of the payment into Accounts Receivable or for receiving and processing the remittance advise that accompanies the payment. Automation of these processes will be pursued as the volume of electronic payments makes such development by MCCR and the Treasury Contractor economically feasible.

*Action:* Two facilities tested remittance express during FY 1995. Based on the experience of these facilities and the development of implementation procedures, the process was rolled out to all facilities in February 1996. (Our goal for FY 1996 is to collect 10 percent of our health insurance reimbursements through this process.) Performance will be monitored through Cash Link. MCCR coordinators must contact individual carriers and determine if they are willing to participate in the program. We will also review the listing of carriers that we do business with on a nationwide basis and contact these carriers directly.

**Summary:**

IE-4 Initiative	Cost	Projected Savings	Recoveries
Electronic Fund Deposit	To Be Determined	Reduction of "float" Reduction of manual check processing	To Be Determined

**Schedule:**

IE-4	Introduce Electronic fund Transfer to All VAMCs	Projected Completion Date	Status
1	Develop specifications	1/30/95	Complete
2	Alpha test	7/30/95	Complete
3	Beta test	10/1/95	Complete
4	Package Materials and sent to facilities	2/15/96	Complete
5	Target for 10 Percent of collections	9/30/96	Downsized to 1%

**IE-5: Introduce Multimedia Training for Front Line Staff**

*Purpose:* Increase collections and/or reduce training costs by increasing individual worker effectiveness and improving supervisory control over resource management.

*Situation:* Different levels of cost recovery require different levels of worker knowledge and skills. Studies show that worker skill and knowledge are a direct function of training and experience. It is estimated that both the amount of collections per bill and the quantity of bills collected is directly related to worker knowledge and skill level. Thus, the amount of collections can be expected to increase and the cost of collection decrease if training is provided. Traditional methods of training (Conference training at off site training locations ) cost on the average of \$1,314 per employee whereas the cost of multimedia training is only \$212 per employee (approximately one-sixth the cost). Additionally, multimedia training is potentially more effective since it provides multiple training exposure opportunities, immediate and continual feedback on performance and rapid access to job related regulations, procedures, guidelines, forms, computer screens, etc.

As an example, figures taken from the Richmond VAMC Business Office show that entry level accounts receivable clerks take on the average 15 minutes to process an Explanation of Benefit (EOB), whereas a worker on the job 3-6 months requires only 10 minutes per EOB. Also, accuracy in EOB processing increases during a receivables clerk's first 3 months on the job by 5%. Multimedia training has the potential for accelerating this increase in accuracy and speed since it provides new staff from the outset with clear, standardized instructions, multiple examples, and training exercises with immediate feedback for performing required tasks. The consequences of this improvement to both speed and accuracy could have substantial benefits to enhanced recoveries.

Accounts receivables clerks are not currently given formal training due to the high cost of conference style training. The cost of providing multimedia training to an accounts receivables clerk depends on the availability of a Multimedia workstation. If available, (estimated to be the case in less than 20% of the current workers), the cost of providing such training is, as stated above, estimated to be \$212. For cases where multimedia equipment is not available, the cost to purchase necessary equipment (\$1,600) could most likely be justified through a cost benefit study.

*Action:* Design and implement a PC based desktop information system for 1) MCCR workers which defines jobs, presents procedures, provides training, allows performance measurement, tailors training to performance deficits, and provides information necessary to support job performance; and for 2) MCCR supervisors which provides a means for communication of work assignments, procedures and changes to policies to all workers. The supervisory system is to also be designed to assess the performance of workers individually and collectively on collection goals.

The process of design and implementation will include the following steps:

1. Completion of the first generation system (exhibited at the January '96 MCCR National Conference) ;
2. Establishment of an ongoing process for development of additional training modules (Veterans relations, contractual adjustment, and DHCP billing and AR packages represent the current modules);
3. Completion of new modules in the areas of pre registration and appeals and denials; and
4. Distribution of software to all MCCR stations.

Approximately \$300,000 was budgeted for multimedia training for FY 96. During FY 96 and FY 97, data studies will be undertaken to pinpoint more precisely the return on investment of these training dollars. Multimedia training designed to supplement new revenue initiatives (NR-1 to NR-7) can target skill development and standardized procedure implementation that will maximize recoveries. Investment in multimedia is tied closely to our ability to secure the recoveries projected in these earlier initiatives.

**Summary:**

IE-5 Initiative	Cost	Projected Savings	Recoveries
Multimedia Training	\$300,000	To Be Determined	To Be Determined (supports NR-1 to NR-7)

**Schedule:**

IE-4	Introduce Multimedia for Front Line Staff	Projected Completion Date	Status
1	Design Evaluation Model	Jun 96: R: 7/96	In Progress
2	Alpha test at selected reengineering sites	Sep 96	Planned
3	Beta test at selected additional sites	Dec 96	Planned
4	Complete Cost Benefit proposal	Mar 97	Planned
5	Obtain concurrence for national release of module	Apr 97	Planned
6	Prepare & Package Materials and send to facilities	May 97	Planned
7	Track implementation and impact on recoveries	Sep 97	Planned

**IE-6: General Counsel/ VAMC Electronic Interface**

*Purpose:* To automate the current process of referring denied insurance payments to the Regional Counsel offices from VA medical centers.

*Situation:* In order to maximize collections, it is necessary to pursue insurance carriers who fail to reimburse VA for the nonservice connected care it provides to veterans covered by a valid insurance policy. The actual referral process from medical centers to Regional Counsel has been traditionally problematic for a variety of reasons. The process had been inconsistent between counsel offices and medical centers. The accounting practices of counsel offices and medical centers differed, making reconciliation of referred cases cumbersome, time consuming and nearly impossible. Understanding what had been acted upon and what was the current status of referrals was difficult.

The reengineering project gave MCCR and participating Regional Counsel staff the opportunity to look at the current flow of information between medical centers and Regional Counsels and to map out a strategy to streamline the whole process. The streamlining process required that Regional Counsels begin utilizing computers more intensively in the referral process. Agreement was reached on the definition of a referral and the manner in which referrals would be made, tracked and reported. Consensus was also reached regarding the dollar limitation for referrals to Regional Counsel so that medical centers and Regional Counsels can begin pursuing all potential cases of carriers refusing to reimburse VA. The Reengineering group identified several areas where enhanced software could make referral and tracking simpler. Beginning in FY 96 we will begin to track referrals, action and collection activities at the 10 pilot sites. Future enhancements to current software will automate the entire referral and collection process between medical centers and Regional Counsels.

**Summary:**

IE-6 Initiative	Cost	Projected Savings	Recoveries
Regional Counsel Referrals	To Be Determined	To Be Determined	To Be Determined

**Schedule:**

IE-6	General Counsel/VAMC electronic Interface	Projected Completion Date	Status
1	Develop specifications	Jan 96	Complete
2	Program RC and DHCP systems	May 96	Complete
3	Alpha test	May 96; R:6/96; R:7/96	In Progress
4	Beta test	Jul 96	In Progress
5	Roll out to facilities	Sep 96	

**IE-7: Establish a Pilot Program to Evaluate the Effectiveness of Transferring All First Party Obligations at the Moment the Obligation is Established**

*Purpose:* Introduce an immediate referral process into first party delinquent debt to determine if this new process will (1) improve service; (2) improve revenues; and (3) reduce costs.

*Situation:* The Office of the Assistant Secretary for Management has maintained that referral of debts at the time of creation will reduce administrative costs, improve collections and improve service to veterans. The Deputy Secretary, Veterans Benefit Administration and the IG also support the concept of immediate referral. VHA had introduced a highly automated copayment billing system at the facility level. Costs associated with copayment recovery are disproportionately distributed to personnel services costs related to pre-billing activities, such as the verification of treatment and the service connected nature of the care or medication provided, and post billing activities related to answering patient inquires regarding appropriateness of the billing for care provided. (See consolidated copayment initiative for process improvements to issuing of statement and processing payments).

*Action:* This initiative will test the assumptions that service will be improved, revenues improved and costs reduced by transferring copayment obligations to the DMC immediately following establishment. Several facilities will be chosen to develop procedures that will be programmed and tested. Based on the outcome of these tests, recommendations will be made to either expand or terminate the pilot process.

*Timeline:* A firm target date for testing will be developed after specifications are finalized. Specifications will require the establishment of a working group and pilot sites (members of the working group will be from the pilot sites). The target date for selecting the pilots is May 30, 1996. Specifications should be delivered three months following the selection of the pilots. Pilot sites should be volunteers.

*Resources:* No new resources are currently programmed for this project; however, it is expected that resources will need to be shifted from Medical Centers to the DMC. In addition, new equipment may be needed to support this effort. Existing resources will be needed to develop specifications, modify software and implement the project. This resource commitment is still being developed and will not be fully known until after completion of the specifications. Resources that are identified as savings in the CCPC initiative IE-2 will be used in part to support the lock box activity and the additional FTE as yet undetermined by DMC.

**Summary:**

<b>IE-7 Initiative</b>	<b>Cost</b>	<b>Projected Savings</b>	<b>Recoveries</b>
Pilot Referral to DMCs	To Be Determined	To Be Determined	To Be Determined

## Schedule:

IE-7	Establish a Pilot Program to Evaluate the Effectiveness of Transferring All First Party Obligations at the moment the obligation is established	Projected Completion Date	Status
1	Call for Pilot Sites	Apr 96	Complete
2	Identify participating pilot sites	May 96	Complete
3	Develop Performance Measures	Jun 96; R: 7/96	In Progress
4	Develop Primary Design Architecture	Jun 96	Complete
5	Approval of Design by VHA, VBA and Assistant Secretary for Management	Jul 96; R: 8/96	Approval delayed
6	Develop Design specification	TBD	
7	Develop Operating Procedures for Medical Centers	TBD	
8	Alpha Test Referral	TBD	
9	Beta Test Referral	TBD	
10	Evaluate Pilot Performance	TBD	
11	Scale Up	TBD	

**IE-8: Process Consultation Teams (PCT)**

*Purpose:* To enhance VAMCs MCCR processes and performance in a positive professional, and non-punitive manner through peer review and analysis.

*Situation:* Process Consultation Teams (PCTs) were created as a means to enhance customer service and to support individual VAMC MCCR programs. In addition to strengthening these programs PCTs will provide VISN Directors, VAMC Directors, and MCCR Coordinators and staff a means of acquiring expert advice relating to all aspects of identification, claim generation and recovery. Additionally, the PCT process will provide the MCCR Program Office with an opportunity to operationalize the concept of horizontal integration by bringing together individuals from various MCCR disciplines and support areas (e.g., Utilization Review nurses, MCCR Coordinators, front line billers and collectors, reengineering experts, software application experts) to address specific problems and challenges and develop the most appropriate solutions. Finally, PCTs will provide the MCCR Program Office with a means to establish a knowledge base that will be integral to identifying ongoing educational and training needs for MCCR staff and developing appropriate programs and services to meet these needs.

Standard program review criteria will be used by all PCTs thereby establishing a degree of uniformity in the consultation process; however, these criteria will also be designed to allow more in-depth, focused review in areas that may require such attention. From insurance identification and verification through account collection and reconciliation, PCT members will be trained to effectively integrate automated DHCP applications with MCCR processes to maximize results.

*Action:* Guidance and instruction that will be provided to medical center personnel at the time of the PCT visit will be used by National Field Coordinators and the MCCR Program Office to determine educational needs and develop appropriate and timely educational programs. Analysis and trending of information are to be done to determine the current "health" of the program on a local, regional and national basis. The information gathered will permit the program office to monitor trends and plan for future development and changes within the MCCR program.

**Summary:**

<b>IE-8 Initiative</b>	<b>Cost</b>	<b>Projected Savings</b>	<b>Recoveries</b>
Process Consultation Teams	\$67,000 in FY 1995 \$35,000 training in FY 1996	To Be Determined	To Be Determined

## Schedule:

IE - 8	Process Consultation Teams	Projected Completion Date	Status
1	Establish standard program review criteria	Aug-95	Completed
2	Identify and select MCCR staff members to participate in PCT process.	Aug-95	Completed
3	Provide educational experience to PCT members.	Sep-95	Completed
4	Establish national guidelines for PCT reviews, consultant and reporting requirements.	May-96; R: 12/96	In Process
5	Develop and market strategy to offer PCT services to medical center, network, and VISN managers.	Jul-96; R: 12/96	In Process
6	Provide global feedback re: trending analysis, best practices and potential educational opportunities.	Sep-96; R: 3/97	In Process

**IE-9: Evaluate Alternative Organizational and Delivery Strategies for MCCR functions**

*Purpose:* To evaluate alternative organizational structures and service delivery strategies in order to improve the integration of MCCR resources within and between networks and to improve the flexibility and efficiency of service delivery.

*Situation:* In its attempt to respond to changing health care needs, delivery, access, government mandates and the needs of the veteran population, VHA is changing the way that it delivers health care to its beneficiaries. VHA has reorganized itself from a traditional centralized, hierarchical organization to a more decentralized, flexible and integrated organizational structure based on 22 Veterans Integrated Service Networks (VISNs). The new structure emphasizes an interdisciplinary approach to providing patient care and support to the field through increased integration of resources, innovation and accountability at the VISN level.

Utilizing the National Health Care Cost Recovery Contract, the MCCR Program is working with a consultant to identify and analyze viable alternatives for more effective and efficient MCCR program organization that will enhance MCCR operations and service delivery at the VISN and VAMC level.

*Action:* The MCCR Program Office and a health care consultant are currently exploring alternative organizational strategies for improving MCCR performance. These strategies include:

- Maximizing cost effectiveness, models for consolidating or redistributing resources, increasing productivity, incorporating current technology and software into MCCR operations;
- Identifying opportunities for improved integration of MCCR resources, service delivery and program efficiencies; and
- Identifying and analyzing alternative MCCR organizational structures that support the new VISN structure.

It is too early in the review and assessment of organization options to determine the alternatives which will be pursued and the associated costs of these alternatives and their estimated benefits.

**Summary:**

<b>IE-9 Initiative</b>	<b>Cost</b>	<b>Projected Savings</b>	<b>Recoveries</b>
Alternative Organizations	\$64,000 contractor study	To Be Determined	To Be Determined

## Schedule:

IE - 9	Evaluate Alternative Organizational and Delivery Strategies for MCCR Functions	Projected Completion Date	Status
1	Identify current VHA structures and restraints and contrast them to our vision of successful organizations.	Oct-95	Completed
2	Prepare a task order based on the Health Care Cost Recovery (HCCR) national contract.	Oct-95	Completed
3	Award contract to examine organizational strategies.	Oct-95	Completed
4	Examine alternative organizational structures and service delivery strategies to improve integration of MCCR resources.	May-96; R:9/96	pending Birch/Davis study (final)
5	Develop and market strategy to offer alternative organizational structures to medical center, network, and VISN managers.	Sep-96; R:12/96	In Process
6	Monitor implementation of alternative structures.	Oct-96; R:3/97	Planned
7	Establish performance measures to quantify levels of success.	Oct-96; R:3/97	In Process

**IE-10: Standardize Income Criteria Definitions between Means Test and Medication Copayment Programs**

*Purpose:* To standardize veteran's income criteria definitions between means test and medication copayment programs.

*Situation:* The means test copayment program was implemented with the passage of PL 99-272. The means test copayment program was established to allow veterans whose annual family income was above certain threshold levels to make copayments for the care provided. The income determination includes veteran and spousal income and assets. Automated software facilitates the calculation process. Veterans whose income falls above certain threshold levels are assessed a copayment for the care received within the VA system and are considered to be 'discretionary' patients.

PL 101-508 implemented the medication copayment program. A \$2.00 medication copayment is assessed for each 30-day or less supply of medication to all nonservice-connected veterans and to service-connected veterans rated less than 50% when the medication is for a nonservice-connected condition.

PL 102-568 provided the authority for the low income exemption from the medication copayment requirement. This allows a veteran whose annual income does not exceed the maximum annual rate of pension with aid and attendance, which would be payable to such veteran if such veteran were eligible for pension, to be exempt from the medication copayment.

The MCCR Office proposed using the same income criteria used in the means test determinations for implementing the low income exemption. Automated software was already in place and functioning. General Counsel provided an opinion stating that VA can only consider the veteran's *income* (and *not assets* as in the means test determination) in applying the criteria for the exemption. This created the need to maintain a dual set of income criteria for copayments as well as the development of additional software to automate the medication copayment exemption. Confusion among field staff as well as the veteran population was created by the implementation of these procedures. As a result of the conflicting definitions of income, a veteran may be exempt from the \$2.00 medication copayment due to low income but still be responsible to pay \$41 for an outpatient copayment or \$736 for an inpatient copayment (if incurred during FY 1996) as well as a \$10 inpatient per diem copayment.

*Action:* The MCCR Office will re-open the issue of dual income criteria for copayments. MCCR will attempt to gain the support of MAS in documenting and pursuing resolution of this issue. Legislation is not required for a resolution of this issue as it involves internal VA interpretation of eligibility.

## Summary:

IE-10 Initiative	Cost	Projected Savings	Recoveries
Standardize Income Definitions	To Be Determined	To Be Determined	To Be Determined

## Schedule:

IE-10	Standardize Income Criteria Definitions between Means Test and Medication Copayment Programs	Projected Completion Date	Status
1	A series of meetings will be arranged with General Counsel staff and MAS staff to review existing definitions and legislation	Jun-96, R 7/96, R.8/96	In Process
2	Changes to definitions and legislation will be prepared according to the decisions from the meetings.	Sep-96	planned
3	Prepare legislation package and obtain concurrence.	Nov-96	planned
4	Submit legislation with A-11 package	Jan-97	planned

**(3) Reimbursement Rates and Support (RR) Focus:** The third cluster of initiatives attend to the restructure of reimbursement rates to more accurately reflect the costs related to the actual services provided, the needs of individual payers to facilitate payment processing and the support systems to assist in making these rates possible.

**RR-1: Implement Flexible, Multiple Facility Level Rate Models to Maximize Recoveries and Support Alternative Revenue Sources**

*Purpose:* Utilize new rate schedules that optimize third party recoveries; and provide rates functionality to facilitate new revenue streams from public and private health insurance programs such as Medicare, Medicaid, CHAMPUS and Sharing agreements.

*Situation:* Itemized rates are more compatible with payer requirements, however VHA has been limited to per diems because of a lack of detailed cost and workload data from the cost distribution report and patient data bases. The result is that payments are sometimes delayed, reduced and not paid because VHA bills are not compatible with the billing rate conventions of payer automated claims systems.

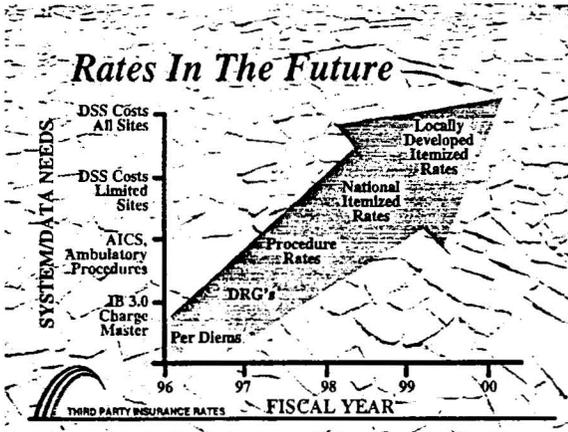
Implementation of new rates can now be planned because of scheduled systems capability and data availability including the following: 1) incorporation of a table-driven charge master in IB/AR to accept large numbers of billing rates, 2) implementation of AICS for image scanning of outpatient encounter forms to support the VHA requirement to capture outpatient procedure and diagnosis data, 3) availability of drug costs linked to patients in the Pharmacy software, and 4) full implementation of DSS with detailed cost and workload data. Rate schedule development will emphasize cost recovery with billing formats that meet payer requirements while reflecting VHA cost and clinical practice consistent with OMB Directive A-25 on User Charges. MCCR Research with HSR&D will compare estimated collections with present and proposed billing rates to project financial impact. When sufficient data is available, statistically significant sampling studies will be conducted at representative facilities in the development and testing of new rate schedules and to fast-track new rates into use. Recent studies and data reviews<sup>22</sup> project between a 15% and 25% increase in collections should a diagnosis related group (DRG) rate schedule be used for inpatient billing. Excluding Medicare Supplemental recoveries, inpatient recoveries in FY 1995 exceeded \$256.4 million. A 15% to 25% improvement would net between a \$38.5 and \$64.1 million gain in annual recoveries. Accordingly, DRG rate schedule development is underway. Rate schedule performance will be measured based on collections of the current year compared to the previous year adjusted for inpatient and outpatient case mix and budget changes.

*Action:* The phased installation of new billing rates is planned subject to concurrence from MCCR, VA Budget, VA General Counsel, Department of Justice and the Office of Management and Budget, and on the availability of necessary systems improvements and data. The schedule is as follows: FY 1997 - Inpatient DRG's with a charge master in

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<sup>22</sup> VA's MDRC study of MCCR rates and DOD experience with the introduction of DRGs.

IB 3.0, FY 1998 - Ambulatory procedure rates with AICS and procedure/diagnosis data, FY 1999 - national itemized rates using DSS data from selected sites, and FY 2000 - Locally developed itemized rates using DSS data from all facilities. Implementation will be complete when a VHA policy directive is issued to develop rates locally based on the unique cost structure of each facility. This capability will also allow facilities to review patient costs as part of clinical streamlining opportunities, provide informed data on resource allocation, and allow accurate evaluation of business opportunities on a timely basis.



**Summary:**

RR-1 Initiative	Cost	Projected Savings	Recoveries
Rate Revisions	To Be Determined	To Be Determined	\$38.5 to \$64.1 million (15 % - 25% of Non Medigap Inpatient recoveries)

## Schedule:

RR-1	Implement Flexible, Multiple Facility Level Rate Models to Maximize Recoveries and support Alternative Revenue Sources	Projected Completion Date	Status
1	Contract through MDRC with an HSR&D researcher to conduct rates research	Oct 93	Ongoing Contract
2	Develop an advisory committee of VA field and headquarters personnel and a scientific panel of VA and university researchers to develop study methodology and identify VA needs	Jan 94	Meets semi-annually
3	Begin annual studies to identify new rate schedules that optimize recoveries and meets billing requirements of new revenue sources	Jan 94	Annual Studies
4	Studies using PTF, OPC data and extracted MCCR claims and payments from each medical center identified DRG's as significantly increasing inpatient care collections	Oct 94 and Dec 95	Results Replicated 2 years
5	Calculate a DRG rate schedule for inpatient care	Jun 96, R. 7/96	In Process
6	Submit a DRG rate schedule for concurrence by VA Budget, General Counsel, OMB and Dept. of Justice	Jul 96, R. 11/96	Birch/Davis deliverable delayed 9/96
7	Publish the DRG rate schedule in the Federal Register for public comment prior to implementing a final regulation	Oct 96, R. 2/97	Planned
8	Implement the DRG rate schedule subject to availability of a multiple rate schedule pricer in IB/AR	Mar 97, R. 10/97	Planned
9	Conduct a sampling study of outpatient procedure and facility costs subject to the availability of outpatient procedure data from medical centers to determine collections impact and billing functionality needs	Jun 97	Planned
10	If appropriate, calculate outpatient procedure and facility rate schedules	Sep 97	Planned
11	Submit the outpatient procedure and facility rate schedules for concurrence including publishing in the Federal Register prior to implementation	Oct 97	Planned
12	Implement the outpatient procedure and facility rate schedules subject to the availability of AJCS at the medical centers to collect billing data	Mar 98	Planned
13	Conduct a study of DSS cost and work load at a limited number of sites subject to availability of accurate and complete data to develop itemized rate schedules to determine collections impact	Mar 98	Planned
14	If appropriate, calculate itemized rate schedules using DSS cost and work load data	Jun 98	Planned
15	Submit the itemized rate schedules using DSS data for concurrence	Jun 98	Planned
16	Implement itemized rate schedules using DSS data	Oct 98	Planned
17	Conduct a study to determine collections impact of itemized rate schedules using local facility unique cost and work load data subject to the full implementation of DSS at all VA facilities	Mar 99	Planned
18	If appropriate, develop rate schedule policy and procedures for facility use to calculate local rate schedules	Jun 99	Planned
19	Submit rate schedule policy and procedures for concurrence including publishing in the Federal Register for public comment prior to publishing a final regulation	Jun 99	Planned
20	Implement decentralized rate schedule policy and procedures	Oct 99	Planned

**RR-2: Develop Flexible Pricer For Integrated Billing.**

*Purpose:* To improve the effectiveness of the IB software to accommodate new rate structures for MCCR and to accommodate sharing initiatives under VA/DOD sharing.

*Situation:* Current pricing of claims is tied directly to the VHA interagency rate structure. This rate structure is based on per diem charges. Over the past year new programs associated with CHAMPUS sharing as well as potential new revenue sources from Medicare are forcing us to look at different approaches to pricing health care products delivered by our medical centers. New cost accounting efforts such as Decision Support System (DSS) are also providing new opportunities to price VHA products on a basis of other than daily charges.

The task is to build a series of tools for managing the billing of services using multiple rate structures.

- The first tool is for pricing services on a billing document. That document may be a UB-92, a HCFA 1500, or an electronic transaction, but the basic data remains the same.
- The second tool is a process for updating the pricing tables from an external source. That source can be expected to be a file containing listing of values in the appropriate sequence.
- The third tool is a process for updating the pricing tables from a keyboard.
- The fourth tool is a process for moving the priced data to the billing engine to be incorporated into the bill document, and to be forwarded to the accounts receivable software.

*Action:* Specifications are being developed to modify the IB software. The current schedule is to have the software in test beginning summer of 1996 using the sharing sites as test sites. Software will then be moved to other sites in FY 1997 to accommodate approved rate changes.

*Resources:* Costs represent approximately 2 FTE at the Albany IRMFO, approximately 1 FTE in program office and field support over the next six months. Field testing of the software should be considered as resource neutral because the functions associated with billing for sharing services

*Return on Investment:* Benefits from this project will come in the form of increased revenue to MCCR through rate adjustment initiatives which rely on modified pricing capability to implement.

**Summary:**

RR-2 Initiative	Cost	Projected Savings	Recoveries
Flexible Pricer for Billing	To Be Determined	To Be Determined	To Be Determined

**Schedule:**

RR-2	Develop a Flexible Pricer for Integrated Billing	Projected Completion Date	Status
1	Develop specifications	May 96, R: 7/96	In progress
2	Program software	TBD, R: 8/96	Software under development
3	Alpha Test	TBD, R: 9/96	Test sites will be Tricare sites
4	Beta Test	TBD	
5	Implement Software	TBD	

**RR-3: Develop a Reliable Forecasting Model for MCCR Recoveries**

*Purpose:* To develop a quantitative and qualitative forecasting model for medical care cost recoveries that will provide a basis on which forecasts of future performance can be made using a variety of indicators.

*Situation:* Quantitative forecasting relies on the premise that the future can be predicted by identifying certain regularities in the past. This may be true in specific instances and for relatively short-term forecasting and is the model that MCCR currently uses to project MCCR recoveries. However, for long-term forecasting, qualitative forecasting must also be used that explicitly incorporates the subjective assessment of the internal and external environment and recognizes that decision makers have some influence on future developments. Recovery projections made by MCCR must be accepted by oversight bodies as the best and most credible figures available. MCCR wishes to reduce the amount of political influence affecting agreement on recovery amounts in the Department budget requests.

MCCR's national recovery projections rely on collection performance from previous years based on human resources, analyses of MCCR's overall collection potential and inflationary effects on billing rates. The MCCR Goals distribution process to medical centers distributes the recovery level contained in the President's Budget for a particular year to individual facilities based on the facility's relative share of the national collection potential and the programs projected collections identified in the President's Budget. The methodology used to distribute the third party and means test goal identifies individual facility's raw workload sources from the Patient Treatment Files (PTF) and Outpatient Treatment (OPT) files and adjusts for known indicators that affect the rate of recovery from insurance and first parties. The indicators include types of services (e.g., medical, surgical, outpatient); age of the veteran (e.g., over 65 years of age are affected by Medicare); eligibility category; and geographic factors applied to Metropolitan Statistical Areas (MSA) such as Health Maintenance Organization (HMO) penetration, and population not insured. The following chart projects the third party total workload potential compared to FY 1995 actual collections. The workload collection potential is based on a roll up of the FY 1994 national workload for third party, adjusted for the percentage of veterans who have insurance categorized by age and eligibility criteria using information from the Survey of Medical Systems Users (SMSU).

Collection Estimates	FY 1995 Actual Collections	Percent of Estimate
\$596,013,888	\$522,822,352	87.71%

Projections have been increasingly accurate, but have not incorporated other measurements such as effects of financial incentives, improvements to efficiency resulting from technology advancement, effects of changes to the local health care community on the VA Medical Center recoveries; improvements in efficiency due to

**RR-3: Develop a Reliable Forecasting Model for MCCR Recoveries**

*Purpose:* To develop a quantitative and qualitative forecasting model for medical care cost recoveries that will provide a basis on which forecasts of future performance can be made using a variety of indicators.

*Situation:* Quantitative forecasting relies on the premise that the future can be predicted by identifying certain regularities in the past. This may be true in specific instances and for relatively short-term forecasting and is the model that MCCR currently uses to project MCCR recoveries. However, for long-term forecasting, qualitative forecasting must also be used that explicitly incorporates the subjective assessment of the internal and external environment and recognizes that decision makers have some influence on future developments. Recovery projections made by MCCR must be accepted by oversight bodies as the best and most credible figures available. MCCR wishes to reduce the amount of political influence affecting agreement on recovery amounts in the Department budget requests.

MCCR's national recovery projections rely on collection performance from previous years based on human resources, analyses of MCCR's overall collection potential and inflationary effects on billing rates. The MCCR Goals distribution process to medical centers distributes the recovery level contained in the President's Budget for a particular year to individual facilities based on the facility's relative share of the national collection potential and the programs projected collections identified in the President's Budget. The methodology used to distribute the third party and means test goal identifies individual facility's raw workload sources from the Patient Treatment Files (PTF) and Outpatient Treatment (OPT) files and adjusts for known indicators that affect the rate of recovery from insurance and first parties. The indicators include types of services (e.g., medical, surgical, outpatient); age of the veteran (e.g., over 65 years of age are affected by Medicare); eligibility category; and geographic factors applied to Metropolitan Statistical Areas (MSA) such as Health Maintenance Organization (HMO) penetration, and population not insured. The following chart projects the third party total workload potential compared to FY 1995 actual collections. The workload collection potential is based on a roll up of the FY 1994 national workload for third party, adjusted for the percentage of veterans who have insurance categorized by age and eligibility criteria using information from the Survey of Medical Systems Users (SMSU).

Collection Estimates	FY 1995 Actual Collections	Percent of Estimate
\$596,013,888	\$522,822,352	87.71%

Projections have been increasingly accurate, but have not incorporated other measurements such as effects of financial incentives, improvements to efficiency resulting from technology advancement, effects of changes to the local health care community on the VA Medical Center recoveries; improvements in efficiency due to

changes in process, and due to employee training.. Also, effects of new billing markets (such as Medicare) should be considered. Finally, recovery levels are inextricably linked to the concepts of gain sharing now under discussion. Inaccurate recovery projections may negate any beneficial effects of gain sharing when put into practice.

*Action:* As part of VA/Private Sector Information Management Training Program being done by the VA Management Sciences Group and the Association of University Programs in Health Administration (AUPHA), several MCCR Staff will collaborate on MCCR-related activities with mentors/advisors. A group project is underway to develop a better model for projecting MCCR recoveries. A series of analyses will be developed to consider both internal and external factors and to determine which factors have measurable effects on MCCR recoveries, and which will provide for more accurate projections. The goal is to develop a recovery projection methodology which considers the most influential of those factors and yields accurate, defensible projections. The timetable for completion of the academic work is scheduled for August 1996, however, the need for improved projections is more urgent. The FY 98 Budget Submission must be completed for internal review in May or June 1996. With staffing changes in the MCCR Program Office, and for purposes of establishing a credible model, there may be a need for more dedicated consulting services than those provided in the academic project.

**Summary:**

RR-3 Initiative	Cost	Projected Savings	Recoveries
Recovery Forecast Model	To Be Determined	To Be Determined	To Be Determined

**Schedule:**

RR-3	Develop a Reliable Forecasting Model for MCCR Recoveries	Projected Completion Date	Status
1	Draft Statement of Work/Task Order	Mar 96	SOW developed
2	Circulate for Comments in MCCR, Office of Budget and OMB	Apr 96	Complete
3	Finalize Work/Task Order	May 96; R:6/96	MDRC response
4	Decide whether to contract out or do in House through Committee Process	May 96	Complete
5	Select Contractor or Committee Members	May 96	Complete
6	Initial meeting to establish forecasting approach and needed resources	May 96; R:8/96	Complete
7	<b>Stage 1: Third Party Recoveries</b>		
7.1	Gather workload and statistical information from existing VA data bases	Jun 96; R:8/96	In Process
7.2	Gather insurance industry information	Jun 96; R:8/96	Planned
7.4	Mid Review of Process, including update to Office of Budget and OMB	Jul 96;	Planned
7.5	Review Draft Third Party Forecasting Model	Jul 96; R:10/96	Planned
7.6	Submit Draft Third Party Model for comments	Jul 96; R:12/96	Planned
7.7	Final Third Party Forecasting Model	Aug 96; R:1/97	Planned
RR-3	<b>Develop a Reliable Forecasting Model for</b>	Projected	Status

(con't)	MCCR Recoveries	Completion Date	
8	<b>Stage 2: Means Test IVM Recoveries</b>		
8.1	Meet with IVM to discuss workload and historical information	Jun 96	Complete
8.2	Re-survey field as to unpaid or unbilled referrals	Jun 96, R.7/96	98% complete
8.3	Review eligibility reform and policy issues	Aug 96	Planned
8.4	Mid Review of Process, including update to Office of Budget and OMB	Aug 96	Planned
8.5	Review Draft IVM Forecasting Model	Sep 96	Planned
8.6	Submit Draft IVM Model for comments	Sep 96	Planned
8.7	Final IVM Forecasting Model	Oct 96	Planned
9	Review eligibility reform and policy issues	Oct/Nov 96	Planned
10	Evaluate collection projections based on Gainsharing	Dec 96	Planned
11	Evaluate effects of Policy Decision on Recovery Potential	Jan 97	Planned
12	Test Model based on FY 1996 Workload and statistical information	Jan 97	Planned
13	<b>Stage 3. Medication Copayment Model</b>		
13.1	Gather workload and statistical information from existing VA data bases	Mar 97	Planned (see 7.1)
13.2	Gather insurance industry information	Mar 97	Planned
13.4	Mid Review of Process, including update to Office of Budget and OMB	Jun 97	Planned
13.5	Review Draft Medication Forecasting Model	Jul 97	Planned
13.6	Submit Draft Medication Model for comments	Jul 97	Planned
13.7	Final Medication Forecasting Model	Aug 97	Planned
14	Review Forecasting Model for Accuracy	Jan 98	Planned

**Section 4. Financial Plan**

The driving forces behind the MCCR Program are its visionary leadership, attention to innovation and trained workforce. These forces can be clearly seen in MCCR's past financial usage and its results driven bottom line that has consistently strive for increased productivity and quality in the way MCCR does business. Recoveries per total FTE have risen from \$218,000 in FY 1991 to \$257,633 in FY 1995 and are projected to reach approximately \$350,000 by FY 2001. At the same, MCCR has been able to sustain operating costs at less than 20 percent of revenues. The financial data sheets demonstrate that MCCR focuses its resources in areas that have the potential to provide the greatest benefits – innovation and a trained workforce. Equipment resources have been expended in the initial years to support the DHCP core systems at medical centers, enabling them to process the enormous volume of financial data that was generated in accounts receivable. Equipment resources have also been expended on technology that has enabled VHA to currently pursue the capture of all ambulatory data. Travel for work group development of strong internal capabilities in systems development and design of new software and process has enabled MCCR to most efficiently automate its processes. The results of a trained work force are evident in the increases of collections per FTE as well as in the desire of medical center employees to work for the MCCR program.

MCCR's financial requirements to support its strategic initiatives are ever evolving, requiring a great deal of flexibility. MCCR's pioneering efforts include contracting out certain processes, consolidating other processes, and retaining those functions that can most efficiently be accomplished in-house. All this requires a certain degree of trial and error. The ability to reprogram resources between the major object classes (Personal Services, Equipment, Other Services and All Other) for the MCCR Appropriation would provide MCCR with needed flexibility. According to Vice President Gore, head of the Administration's National Performance Review, the current efforts to reinvent government focus on allowing managers more flexibility, including the ability to shift funds from one account to another to meet program or worker needs. An internal reprogramming of funds, with the approval of the Assistant Secretary for Finance and Information Resource Management, not to exceed \$1 million per object class or a total of \$4 million, would allow the MCCR program office the flexibility to meet the evolving needs of the program.

A predicator of continued success is the measurement of current performance and requires a climate of trust that enables resource to be managed according to priorities. MCCR is still an evolving organization that has not reached its full potential. The following Financial Data provides a picture of past performance and future potential.

Summary of Recovery Data:

(Dollars in 000)

ACCOUNT 36_5014: Medical Care Cost Recoveries	FY1991 Actual	FY 1992 Actual	FY 1993 Actual	FY 1994 Actual	FY 1995 Actual	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001
Third Party Recoveries	247,815	378,823	441,297	506,156	522,823	643,678	667,572	672,132	665,501	693,897
Medication Copayment	11,300	60,747	53,136	26,168	30,623	33,787	35,545	37,186	36,710	40,116
I/M third party					3,377	4,431	5,083	5,449	5,841	6,233
<b>SUBTOTAL</b>	<b>259,115</b>	<b>439,570</b>	<b>494,433</b>	<b>532,324</b>	<b>553,446</b>	<b>681,896</b>	<b>708,200</b>	<b>714,767</b>	<b>707,052</b>	<b>740,246</b>
ALCOUNT 2431: Medical Fees and Other Receipts	7,800	8,830	12,053	11,714	12,122	12,371	12,726	13,067	13,381	13,903
Means Test	N/A	N/A	N/A	2,525	2,236	2,198	2,162	2,117	2,073	1,974
Per Diems				0	6,118	30,514	32,038	33,641	35,323	37,089
Income Verification				12,053	20,478	45,083	46,927	48,823	50,777	52,769
<b>SUBTOTAL</b>	<b>7,800</b>	<b>8,830</b>	<b>12,053</b>	<b>14,239</b>	<b>20,478</b>	<b>48,062</b>	<b>49,823</b>	<b>50,777</b>	<b>52,769</b>	<b>54,821</b>
<b>TOTAL RECOVERIES</b>	<b>266,915</b>	<b>448,400</b>	<b>506,486</b>	<b>546,563</b>	<b>573,922</b>	<b>728,958</b>	<b>758,023</b>	<b>765,544</b>	<b>759,821</b>	<b>795,067</b>

ACCOUNT 0160: Chapter 17 Recoveries (not applied toward goal)

OMB Estimated Recoveries	286,915	448,400	506,486	551,579	580,704	648,798	735,907	772,943	790,383	802,798
% Recovered to Projected	69%	83%	77%	95%	99%	100%	100%	100%	100%	100%
% Recovery Increase Over Previous Year				8%	5%	12%	4%	1%	2%	2%
FTE Budget	1,300	1,603	2,128	2,172	2,275	2,295	2,295	2,295	2,295	2,295
FTE Actual	1,233	1,636	2,066	2,149	2,954	N/A	N/A	N/A	N/A	N/A
Operating Budget	51,000	77,000	103,360	99,399	107,951	132,205	119,082	122,686	126,108	135,266
% Operating Cost Increase Over Previous Year				34%	18%	4%	-11%	3%	3%	7%
MCCR Transfer to Treasury	0	182,115	345,053	398,669	420,000	421,241	477,702	559,200	582,092	578,978
Recoveries Per FTE	218,246	274,083	245,153	256,668	257,633	282,701	320,657	333,013	336,794	344,393
ROI	19%	17%	18%	17%	18%	20%	16%	16%	17%	17%

Estimates Based on FY 1997 President's Budget



## Summary of Initiatives

## New Revenue Initiatives:

NR-1 Initiative	Cost	Projected Recovery
HCFA Match	\$1,600 Statistical Match \$10,000 name match	Confirm assumptions \$97.4 million (if confirmed)
GSA Recovery Contract	\$7,000	\$105,000
Clinic Registration	\$12.96 million (or redirected savings from AICS)	\$100 million

NR-2 Initiative	Cost	Projected Recovery
Payment Appeals	\$250,000 Training Program	\$10 million

NR-3 Initiative	Cost	Projected Recovery
Administrative Offsets	Reprogramming To Be Determined	\$3.3 million per IG Report

NR-4 Initiative	Cost	Projected Recovery
Contract Third Party	To Be Determined	To Be Determined

NR-5 Initiative	Cost	Projected Recovery
Contract for FI/Carrier Claims Adjudication	\$2.0 to \$2.5 million	To Be Determined

NR-6 Initiative	Cost	Projected Recovery
Legislation & Contracts for new HMO plans	To Be Determined	To Be Determined

NR-7 Initiative	Cost	Projected Recovery
Provide recovery services to DOD	Cost of Recovery Reimbursed by DOD Recoveries	Marginal Costs Credited to VA with Primary Collection to DOD

## Improved Efficiency Initiatives:

IE-1 Initiative	Cost	Projected Recovery
Implement Automated Data Capture	\$24 million year 2 \$51.7 million seven year cumulative	\$23.2 million thru year 2 \$502.1 million seven year cumulative (See NR-1)

IE-2 Initiative	Cost	Projected Savings	Recoveries
Consolidated Copayment Processing Center	\$2.6 million	\$4.2 million to be reinvested	To Be Determined (Redirect Savings)

IE-3 Initiative	Cost	Projected Savings	Recoveries
Centralized Electronic Claims Processing	To Be Determined	To Be Determined	To Be Determined

IE-4 Initiative	Cost	Projected Savings	Recoveries
Electronic Fund Deposit	To Be Determined	Reduction of "float" Reduction of manual check processing	To Be Determined

IE-5 Initiative	Cost	Projected Savings	Recoveries
Multimedia Training	\$300,000	To Be Determined	To Be Determined (supports NR-1 to NR-7)

IE-6 Initiative	Cost	Projected Savings	Recoveries
Regional Counsel Referrals	To Be Determined	To Be Determined	To Be Determined

IE-7 Initiative	Cost	Projected Savings	Recoveries
Pilot Referral to DMCs	To Be Determined	To Be Determined	To Be Determined

IE-8 Initiative	Cost	Projected Savings	Recoveries
Process Consultation Teams	\$67,000 in FY 1995 \$35,000 training in FY 1996	To Be Determined	To Be Determined

IE-9 Initiative	Cost	Projected Savings	Recoveries
Alternative Organizations	\$64,000 contractor study	To Be Determined	To Be Determined

IE-10 Initiative	Cost	Projected Savings	Recoveries
Standardize Income Definitions	To Be Determined	To Be Determined	To Be Determined

**Reimbursement Rates and Support Initiatives:**

RR-1 Initiative	Cost	Projected Savings	Recoveries
Rate Revisions	To Be Determined	To Be Determined	\$38.5 - \$64.1 million (15%-25% of Non Medigap Inpatient recoveries)

RR-2 Initiative	Cost	Projected Savings	Recoveries
Flexible Pricer for Billing	To Be Determined	To Be Determined	To Be Determined

RR-3 Initiative	Cost	Projected Savings	Recoveries
Recovery Forecast Model	To Be Determined	To Be Determined	To Be Determined

## Section 5. Contracts and Reports

### A. Contracts

The following contracts were let in Fiscal Year 1995 by the MCCR Program Office:

#### TECHNICAL CONTRACTS

Lockheed Integrated Solutions Site Prep Proposal	\$352,270
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The following Medical Centers were included in this proposal for Site Preparation for the Pandas Mark Sense Scanning. Danville, Fresno, Northport, Oklahoma City, San Antonio, Milwaukee, Asheville, Manhattan, Denver, Seattle, Buffalo, North Chicago, Boise, Brockton/West Roxbury, White River Junction, Reno, Baltimore, Huntington, Murfreesboro, Prescott.

Lockheed Integrated Solutions Co.	\$ 45,333
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The purchase of Pandas Software Support for Mark Sense Scanning.

Lockheed Integrated Solutions Co.	\$ 250
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Patch Cabling for the Pandas Software Support.

KW Tunnell Company, Inc.	\$ 31,223
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The creation of the Multimedia teleconference CD-ROMS for the National Conference

MITRE CORPORATION	\$ 99,925
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Task orders to do an analysis of the AICS architecture on print management and a review of the options on Electronic Interchange of Data.

#### MANAGERIAL CONTRACTS

HMS	\$ 41,000
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Contractual agreement for data match of selected Medical Center Records in the Chicago area against third party insurance companies

Birch & Davis Associates, Inc.	\$ 91 ,342
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This is the Cost to Collect Contract of First Party Debts, Third Party Debts, Ineligible Hospitalization, and Humanitarian. This contract also compared MCCR to the private sector hospitals and analysis of contracting different aspects of the MCCR program.

Birch & Davis Associates, Inc. \$ 63,794

Contract that examines the organizational options that will enhance the efficiency and effectiveness of the MCCR process, capitalize on the use of current technology and provide quantifiable data regarding alternative organizational and functional configurations.

Birch & Davis Associates, Inc. \$ 50,000

Contract for Birch & Davis Associates, Inc. to conduct a Cost Benefit Analysis of the Pandas Mark Sense Scanning Project.

#### **EDUCATIONAL CONTRACTS**

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American Management Association \$ 23,805

This was a training course in Project Management for the MCCR Program Office.

Question 4a: Please provide the methodology by which you projected a more than doubling of annual "sharing" revenues by 2001.

Answer: The basis for the significant increase in annual "sharing" revenues is found in Public Law 104-262, the Veterans Healthcare Eligibility Reform act of 1996, which became law on October 9, 1996. This law greatly expands VA's ability to obtain, or share, healthcare resources with, or from, the private sector and other Government entities. This increase in non-appropriated revenues, along with proposed MCCR and Medicare receipts, will assist the VA in meeting its future requirements and goals at a straight lined appropriation level. Even in 1996 under the prior sharing legislation, some Networks had obtained between 4 percent and 5 percent of their total revenue from non-appropriated sources (sharing, other reimbursements, and MCCR collections). The leading Network had achieved almost 1.8 percent from sharing and other reimbursements. While we have set "stretch" goals, if other Networks make efforts to emulate the most successful ones, and with the greatly expanded authority contained in Public Law 104-262, our goals for sharing revenue can be reached by 2002.

Question 4b: In that connection, please provide brief "case analyses" prepared by the directors of any five major VA medical facilities which have contributed significantly to the existing VA-community sharing record (or prepared by VISN directors); such case studies should specifically illustrate by example how such sharing-revenue growth (which is based on excess capacity) can be achieved at the same time as the Department proposes to achieve greater efficiencies through a 20 percent increase in veteran workload and through anticipated restructuring/streamlining activities. If the increased sharing goal and the expansion of workload goals are not inherently inconsistent, directors providing such case studies should illustrate or explain, with as much specificity as possible, the manner in which expanded sharing, increased workload, and streamlining would be achieved at their respective medical centers or in concert with other VA medical centers in their networks.

Answer: Network examples included below are preliminary and do not reflect final decisions of the Department. The proposed plans are subject to final legal review and determination regarding new contracting authorities recently provided by PL 104-262. They illustrate that the Networks are ready, willing, and able to expand sharing and other reimbursable activities.

### VISN 3

Answer: In VISN 3, the goal of doubling annual sharing revenue can be achieved with the establishment and implementation of network-wide sharing initiatives with other facilities and entities in the health care community. The Network's strategy for revenue generation through medical sharing is to enhance and to develop both VA/DoD and private sector sharing opportunities.

VA/DoD Sharing: The VAMC's within the VISN currently have 14 VA/DoD sharing agreements with regional DoD facilities. The estimated revenue generated from these contracts should exceed \$400,000. Six of the 7 VAMC's within the Network have DoD sharing agreements with the 2 Military Treatment Facilities in the VISN (West Point and Fort Monmouth), as well as with Reserve Units, the Air National Guard, the Army National Guard, and the Coast Guard.

The short-term goal is the consolidation of those individual VAMC/DoD sharing agreements into Network-wide initiatives. There are approximately 16,000 active duty armed forces personnel stationed in the geographic area and approximately 5,000 reservists. Only a fraction of these active duty personnel and reservists receive care under the terms of VA/DoD sharing agreements. The following VISN initiatives are being developed to consolidate, enhance, and broaden the range of VA/DoD sharing arrangements:

- 1) The development of a VISN-wide sharing agreement with Fort Monmouth, NJ, to consolidate 2 active and 1 proposed VA/DoD sharing agreements.
- 2) The development of a VISN-wide sharing agreement with West Point (i.e. Keller Army Hospital) to consolidate 2 active and 1 inactive VA/DoD sharing agreement.
- 3) The development of a State-wide intra-Network VA/DoD sharing agreement between VISNs 2 and 3 and the Army National Guard.

The development of Network-wide VA/DoD sharing contracts will enable the VISN to achieve uniformity in prices charged, clinical services provided, contract administration, billing, and will allow us to expand the services that we are now providing to dispersed DoD commands and units in a systematized fashion.

The long-term goal for the VISN for VA/DoD sharing is the effective provision of services as a TRICARE/CHAMPUS provider. TRICARE will be implemented in VISN 3 by December 1, 1997. There are approximately 41,000 CHAMPUS beneficiaries living in the geographic area of VISN 3. By fostering "partnering" relationships between the Network and the Managed Care Support Contractor and its sub-contractors, and by achieving the short term goals of consolidating and systematizing active-duty sharing arrangements, it is the aim of VISN 3 to be a major provider of care for DoD beneficiaries

**Private Sector Sharing:** While all VAMCs within VISN 3 have initiated sharing programs, the Brooklyn VAMC has progressed the furthest in the development of private sector sharing agreements. Revenue generated by Brooklyn VAMC's private sector sharing agreements should exceed \$500,000 in FY 1997. (In addition, Brooklyn's 4 VA/DoD sharing agreements should generate over \$100,000 in revenue).

Brooklyn has executed sharing agreements with its affiliated Medical School, practice groups, and other health care facilities providing laboratory, radiology, and audiology services.

The expansion of the sharing authority in October 1996 has enabled the VAMC to explore sharing opportunities with other area hospitals and health care organizations. The VAMC has excess capacity in many clinical services including MRI, diagnostic radiology, mammography, dialysis, lab and pathology services. And like all VAMCs in VISN 3, Brooklyn has excess specialized medical space to share, and is aggressively pursuing sharing opportunities. For instance, negotiations are currently underway with a local hospital in which the VA will provide space and relevant ancillary services for surgical outpatient procedures.

The active and proposed sharing initiatives with the private sector that have been developed at the Brooklyn VAMC serve as models for the other VAMCs in the VISN. In addition, the integration of health care delivery systems across the Network and the implementation of service lines will enable the VISN to develop strategic sharing initiatives with other similar private sector networks and alliances.

#### VISN 8

Answer: Sharing revenues can be enhanced greatly by the new contracting authority recently provided through P.L. 104-262. This law is designed to simplify the process of entering into sharing agreements and was enacted to allow the sharing of health care resources to include health related administrative and support services. Also VA facilities can enter contracts as either buyers or sellers of services with any health care provider, including health insurers, health care plans, groups of physicians and

individuals. Procedures for entering into agreements has also been liberalized; competitive bidding in the traditional sense is not required in many instances, e.g. with affiliates.

Even with the 20 percent projected increase in veteran workload, places like the Tampa VAMC will be able to continue sharing with community and DoD partners. Tampa was able to generate \$1.5 million worth of sharing services in FY 1996. Most of the opportunity for sharing came from DoD where Tampa was able to care for active duty service personnel needing specialized care found there. The Tampa VA has a Traumatic Brain Injury center that is able to accept these active duty personnel and subsequently bill DoD at the interagency billing rate.

Other opportunities exist in our VISN for revenue production as follows:

- Increasing CHAMPUS beneficiaries seen using TRICARE contracts where locations of care are the VA Facility (Hospital or outpatient clinic). Humana Military HealthCare Services signed a contract with our Network earlier this year. It is unknown, today, how much revenue we will be able to generate through this process but there are approximately 200,000 CHAMPUS beneficiaries in Florida. (Possible \$5.0 million in revenue at 15 percent of market penetration)
- Caring for many more eligible veterans in less costly, available community based settings for care with dollars generated from sharing revenue production. (More veterans seen with same dollars)
- Reduction in inpatient utilization will allow for a shift of staff, freeing valuable space that can be "rented" to other HealthCare organizations and also give additional support for more ambulatory care settings. (Vacant wards can be sold to private HealthCare organizations under expanded use leasing arrangements)
- Advanced technology equipment (MRI's, Cat Scans, Lithotripsy's, etc.) can be utilized much more than they presently are. Sharing with physician groups, as well as other providers can take place during times when the VA patient would not be scheduled for testing.
- Medical Education capability is readily available, private sector HealthCare professionals are seeking the ability to buy our expertise.
- Laundry and incineration services are becoming a more likely candidate for selling this excess capacity to others.
- Medical specialists in a variety of setting (Nuclear Medicine; Mental Health, Surgical Services, etc.) will be able to expand their specialization to private sector needs through sharing arrangements.
- There has been interest expressed by both state and federal prisons to enter into agreements for care of veterans that are incarcerated.

#### VISN 9

Answer: Efforts made towards increasing revenue streams while at the same time achieving a 20 percent increase in veteran workload will center around three areas: first the movement towards managed care and accompanying efficiencies, second implementation of a broad network of community-based primary care and mental health care access points. The final area has to do with utilization of areas, particularly inpatient capacity, where there may be economies developed by providing care to a mixed larger group, i.e., CHAMPVA, Tricare and veteran patients.

A basic assumption is that VISN 9 will be allowed to contract for community-based primary care service and that we will be successful in negotiating rates which reduce our current annual outpatient cost per veteran by up to 30 percent. We have been able to negotiate, in lightly competitive areas, three community based contract rates that will result in 20 to 30 percent decrease.

Specific actions being pursued:

**CHAMPVA** - Currently there are active CHAMPVA programs in five of the seven VISN 9 medical centers. One of the active programs is less than a year old. Historically, efforts have been made to capture CHAMPVA eligible only in those areas where there was close proximity to a VA Medical Center. Additionally, the services offered have centered in the areas of outpatient and pharmacy. With the growth of women's programs in VA Medical Centers as well as anticipated Tricare work, there will be better economies for delivery of inpatient services to women who make up the preponderance of CHAMPVA eligibles. Additionally, with the development of access points we anticipate being able to market to and access larger numbers by a factor of two over the next three to five years. Currently, we have identified five additional sites in Tennessee where we will market CHAMPVA services. In FY 1996 the average CHAMPVA revenue per hospital with an active CHAMPVA program was \$92,900; we are assuming that the average will increase to \$185,700 by FY 2001.

	FY 96 TOTAL CHAMPVA INCOME	FY 97 PROJ CHAMPVA INCOME	FY 98 PROJ CHAMPVA INCOME	FY 99 PROJ CHAMPVA INCOME	FY2000 PROJ CHAMPVA INCOME	FY2001 PROJ CHAMPVA INCOME
HUNTINGTON	0	0	0	0	0	0
LEXINGTON	0	0	0	0	0	0
LOUISVILLE	\$288,403	\$346,084	\$374,924	\$461,445	\$519,125	\$576,806
MEMPHIS	89,848	107,818	116,802	143,757	161,726	179,696
MTN. HOME	4,261	5,113	5,539	6,818	7,670	8,522
MURFREESBORO	28,042	33,650	36,455	44,867	50,476	56,084
NASHVILLE	53,741	64,489	69,863	85,986	96,734	107,482
VISN #9	\$464,295	\$557,154	\$603,583	\$742,873	\$835,731	\$928,590

**Non-Federal Income** - Recent changes which provide greater freedom in sharing resources with private sector healthcare enterprises as well as more aggressive pursuit of maximizing our utilization of diagnostic capabilities are the primary mechanism by which we believe that we can either generate increase revenue and/or savings. VISN 9 has had success in providing high tech services, such as photopheresis, magnetic resonance imaging, etc., to affiliate and community health care providers. The potential has been limited by past restrictions on contracting with private sector healthcare providers and groups. VISN 9 collected over \$800,000 in non-federal revenue in FY 1996 from three of its seven medical centers. There is substantial opportunity for two more medical centers, Memphis and Louisville, to generate income from the sale of capacity in areas of lithotripsy, MRI, clinical laboratory and diagnostic cardiology. Additionally, there are opportunities for Murfreesboro to achieve significant savings by leasing excess building space for long term psychiatry (\$350,000) and exchanges of services (\$300,000) with the city of Murfreesboro. The Quillen Medical Center in Johnson City, Tennessee, has developed an enhanced sharing proposal for a new energy plant (\$3,000,000) as well for leasing excess buildings and space. Similar cost avoidance programs, while not directly bringing in revenue, will support the 20 percent increase in veteran care.

New initiatives such as the environmental disease program at Louisville, diabetes research grant at Nashville and the VISN 9 educational partnership with the Kentucky and Tennessee Departments of Health are all non-federal revenue generators. Additional services being considered as revenue generators include the sale of excess clinical dietetics, industrial hygiene and safety services to local communities, school districts and small community hospitals.

	FY 96	FY 97	FY 98	FY 99	FY2000	FY2001
	TOTAL	PROJ	PROJ	PROJ	PROJ	PROJ
	NON-FED	NON-FED	NON-FED	NON-FED	NON-FED	NON-FED
	INCOME	INCOME	INCOME	INCOME	INCOME	INCOME
HUNTINGTON	\$32,606	\$39,127	\$42,388	\$52,170	\$58,691	\$65,212
LEXINGTON	101,670	122,004	132,171	162,672	183,006	203,340
LOUISVILLE	0	0	0	0	0	0
MEMPHIS	0	0	0	0	0	0
MTN. HOME	0	0	0	0	0	0
MURFREESBORO	0	0	0	0	0	0
NASHVILLE	679,054	814,865	882,770	1,086,486	1,222,297	1,358,108
VISN #9	\$813,330	\$975,996	\$1,057,329	\$1,301,328	\$1,463,994	\$1,626,660

**VA-DoD** - The one area which may be most speculative in terms of ability to generate additional revenue is VA-DoD. The inception of Tricare has resulted in a great deal of fluctuation in revenue streams in VISN 9. Additionally, there are some Medical Centers in VISN 9 which, because of their rural nature, do not have potential for attracting DoD workload. The little that they may have will disappear if DoD includes those active duty staff who live outside the 40-mile catchment area in Tricare arrangements. Estimates of Tricare eligible for VISN 9 range between 170,000 and 200,000. Specific actions planned include VISN 9 medical centers having direct on base presence in three areas - Millington Naval facility through Memphis VAMC, Fort Campbell base through Nashville VAMC, and Fort Knox through Louisville VAMC. The intent is to provide onsite primary acute medical and mental health care and referral inpatient services in medicine, surgery and psychiatry. Access to special emphasis programs would not be a provided service. A subset strategy which has been pursued is meeting with retired military organizations in Tennessee and Kentucky to identify their support for utilization of community-based primary care services.

	TOTAL	PROJ	PROJ	PROJ	PROJ	PROJ
	VA/DOD	VA/DOD	VA/DOD	VA/DOD	VA/DOD	VA/DOD
	INCOME	INCOME	INCOME	INCOME	INCOME	INCOME
HUNTINGTON	\$2,020	\$2,424	\$2,626	\$3,232	\$3,636	\$4,040
LEXINGTON	53,163	63,796	69,112	85,061	95,693	106,326
LOUISVILLE	215,072	258,086	279,594	344,115	387,130	430,144
MEMPHIS	1,265,767	1,518,920	1,645,497	2,025,227	2,278,381	2,531,534
MTN. HOME	16,000	19,200	20,800	25,600	28,800	32,000
MURFREESBORO	0	0	0	0	0	0
NASHVILLE	32,264	38,717	41,943	51,622	58,075	64,528
VISN #9	\$1,584,286	\$1,901,143	\$2,059,572	\$2,534,857	\$2,851,715	\$3,168,572

Estimates of increasing VA/DoD income are based on the assumption that the Tricare program remains as established, that Tricare contractors not only stay solvent, and that they are encouraged to consider using VA as a provider. Initial discussions with Tricare contractors indicate that VISN 9 may pick up 10 to 14 percent of Tricare in geographically dense areas in Tennessee and Kentucky. Initial projections are based on two factors: first assuming a 14 percent market share with an estimated revenue, as noted below, of approximately \$1.4 million and secondly picking up an additional 5 percent of the market. The additional market share and income estimated at \$480,000 is not expected to be achieved until at the earliest FY 2001.

A review of the literature on integrated system, and in particular HMO environments reports hospital admissions per 1000 were 69 for non-Medicare recipients, and 238 for Medicare recipients. Average lengths of stay were four days for non-Medicare and six and one-half days for Medicare. Additionally, there were four physician encounters for non-Medicare and eight for Medicare.

Following are some of the assumptions on which projections of future DoD income are based:

- Assumption that the estimated 170,000 VISN 9 Tricare eligible figure is correct and stable.
- Assumption of a 14 percent utilization rate for VA-VISN 9 = 23,800 participants.
- Assumption 70 percent (16,660) will be non-Medicare and 30 percent (7,140) will be Medicare eligible.
- Assumption of inpatient utilization at 69 admissions per thousand and a 16 thousand share equates to 1,104 non-Medicare admissions and with 238 admissions per thousand and a 7 thousand share equates to 1,666 Medicare admissions, for a total of 2,770 inpatient admissions in VISN 9.
- Assumption of an average length of stay four days for non-Medicare equals 4,416 bed days of care and 6.5 days for Medicare inpatients equates to 10,829 bed days of care for Medicare eligible group.

Total of 15,245 bed days of care would be used annually with an average negotiated charge of \$825.00. An 8 percent (\$66) margin over cost equates to \$1,006,170. The margin cost is based on negotiated inpatient per diem charges plus 85 percent of associated professional inpatient charge. Additional income will be generated on an estimated 142,800 visits based on national HMO average of six outpatient encounters for 23,800 enrolled patients. At 78 percent of CMAC rate, we estimate generating three dollars per visit above cost which will generate an additional \$428,400 per year.

#### VISN 18

Answer: The Tucson VA Medical Center foresees opportunities to enhance revenue through expansion of sharing programs in a broad variety of methods. Actions have been implemented such as streamlining of administrative activities and redeployments of staff to concentrate on the negotiation and administration of sharing agreements without additional FTE. The streamlined process allows for focused efforts in matching excess capacity with needs of local government and private sector entities. There is almost always excess capacity in any form of specialized tertiary care. As a specific example, an MRI unit, even if utilized non-stop during normal business hours, can always operate a few additional hours if the staff and supply resources are made available. Sharing revenue ideally funds necessary resources to support the additional operational requirements and, in turn, increases the choices of appointment times for our veterans.

A Sharing Team is being developed within VISN 18 with participation from each member facility. The team is facilitated by an administrative manager who has assumed this role as part of the Network's matrix contracting organization. This team will capitalize on the strong historical success of the sharing activities of the member facilities. VISN 18 has two joint venture facilities with the Department of Defense (Albuquerque, NM, and El Paso, TX). Additionally, two of its facilities have sharing agreements with the State of Arizona. Another facility has a very comprehensive sharing agreement with the Indian Health Service. These sharing agreements provide the necessary capital to leverage untapped excess clinical capacity. The Sharing Team will concentrate on expanding these successes to each of the seven VISN 18 facilities. The use of these methodologies to upgrade revenue opportunities, while at the same time improving services for our customers, will appropriately position the Department of Veterans Affairs to upgrade services through reallocation of enhanced revenue levels. Reiteration of this methodology on a nation-wide basis will serve both the Department and its customers effectively and well for the future.

Development and implementation of expanded sharing opportunities, effective delivery of services to meet the needs generated by increased workload levels, and streamlining of services are not mutually exclusive. To the contrary, they go hand-in-hand. Competent management, reduction of duplicative activities, energetic and compassionate delivery of services, and generation of improved methodologies for addressing the needs of our customers will create an environment which can achieve the goals of our three-part vision for the future. By way of example, the Tucson VA Medical Center is currently in the process of opening community based outpatient clinics in both Sierra Vista and Yuma, Arizona. Veterans in these areas presently travel between 150 and 500 miles round-trip to receive basic care. Through establishment of a mutually beneficial sharing agreement with the Department of the Army, the Tucson VA Medical Center will provide basic primary care at the Army facilities at Ft. Huachuca Army Hospital and the Yuma Proving Grounds Clinic. These agreements will provide U.S. Army personnel with specialized services previously obtained more expensively from the private sector. This income to the VA Medical Center will not only fund the costs associated with providing care at these clinics, but will also enhance sharing income overall. Furthermore, with the reduced workload volume at the Tucson campus, further capacity will exist to help offset the anticipated 20 percent overall workload increase. Thus, the increased sharing workload not only pays for itself but enhances and expands services available to our veterans.

The Tucson VA Medical Center has a unique agreement with the State of Arizona to provide outpatient blind rehabilitation services to state beneficiaries. Income from this agreement will help provide necessary resources to the Blind Rehabilitation program that, in turn, will assist in increasing the responsiveness of the inpatient program which serves our blinded veterans from the entire Southwest

The Tucson VA Medical Center, as representative of many VA facilities, has a variety of subspecialty services in the areas of surgery and internal medicine. Many of these specialties involve technical equipment and specialized staff. Specialty areas which illustrate this sharing potential are esophageal motility studies and pulmonary spirometry studies. Both of these studies can reasonably be anticipated to significantly increase with the expanded sharing authority provided by Public Law 104-262. This potential clearly illustrates that expanding utilization of both the equipment and the specialty staff more than fully amortizes the fixed costs required to keep such services available. The expanded sharing authority will generate the mechanism to offer these services to a broad assortment of providers in the Tucson area, many of whom have approached the VA in search of an agreement

The Tucson VA Medical Center also illustrates that successful sharing revenue and increasing service to veteran patients are, in fact mutually beneficial. Tucson has averaged an annual sharing income exceeding \$1 million over the past couple of years. For FY 1997 we are projecting \$1.2 million in sharing revenue. During the period of FY 1995 through FY 1997, unique patient workload has increased approximately 10 percent per fiscal year while the facility has reduced staffing/FTE.

#### **VISN 20**

Answer: Over the last several years the Spokane VA Medical Center has been moving toward the industry standard of increased outpatient care whenever it is medically indicated. As a result, the number of inpatient beds required has decreased. This is due to fewer admissions and shorter admissions allowing more patients to be admitted/discharged with fewer beds. The best examples to demonstrate this change are in the mental health programs. The specific, illustrative data follow:

<b>Acute Mental Health Beds</b>	FY 1994	FY 1995	FY 1996	FY 1997 thru 1/97
Beds	46	45	45	45
Avg. Daily Census	37	33	27	23
Avg. Length of Stay	15.3	13.0	9.9	8.9
Discharges	861	896	1,012	294 (4 mo. only)

<b>Chemical Addiction and Rehabilitation Beds</b>	FY 1994	FY 1995	FY 1996	FY 1997 thru 1/97
Beds	28	30	30	30
Avg. Daily Census	25	25	25	18
Avg. Length of Stay	25.6	26.9	23.9	15.2
Discharges	374	362	397	171 (4 mo. only)

At the Spokane VA Medical Center there is potential for selling Chemical Addiction services to Fairchild AFB. If this Chemical Addiction program is approved, veterans will, at all times, receive priority for treatment. No delay or denial of care may be attributable to the establishment of this new program. It will be beneficial to veterans as it will provide funding for new services at the Spokane VAMC. We plan to treat approximately three DoD patients per month at an average cost of \$3000 per patient.

Question 5a: Please provide the methodology by which you projected Medicare revenues of \$203, \$328, and \$557 million in FY 2000, 2001 and 2002, respectively?

Answer: We estimate that approximately one-fifth of the workload increase by 2002 will be Medicare-eligible veterans. The chart below provides the number of higher income Medicare-eligible veterans projected and the estimated reimbursements (gross Medicare receipts). These estimates assume our currently projected overall cost of care per unique veteran. Since there are about 3.1 million Category C Medicare-eligible veterans 65 years old or older, our goal of adding approximately 106,000 by 2002 is not unreasonable.

	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>
Medicare eligible veterans (in thousands)	1	37	61	106
Estimated reimbursements (\$ in millions)	\$5.6	\$202.8	\$328.5	\$556.8

Question 5b: Do such revenues represent gross Medicare receipts or net revenues above costs?

Answer: The Medicare reimbursements are estimates of gross Medicare receipts.

Question 5c: What are the total projected costs to VA for each such fiscal year of providing care to those Medicare-eligible veterans for which the Department projects revenues in fiscal years 2000 through 2002?

Answer: The budget request includes the following estimates of gross receipts from providing healthcare to Medicare-eligible veterans in FY 1999-2002. We assumed, for this purpose, that our receipts would equal our cost of providing care to these veterans.

	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>
Projected Cost (in Millions)	\$5.6	\$202.8	\$328.5	\$556.8

Question 5d: For how many unique patients do you estimate you will provide care for which you will receive Medicare reimbursement in those three fiscal years? Are these all category C veterans?

Answer: The number of unique patients for which we expect to receive Medicare reimbursement is estimated to be 36,980, 61,263, and 105,523 for FY 2000, FY 2001, and FY 2002 respectively. These patients will be category C veterans.

Question 5e: How many episodes of Medicare-reimbursed care do you project providing; what would be the projected mix, as between hospital care, ambulatory care, etc.?

Answer: Undetermined at this time.

Question 6: With respect to that facet of the General Operating Expense account of the FY 1998 budget which provides the Veterans Benefits Administration \$68 million with which to obtain compensation & pension examinations from any source, please explain the basis for the assumption that for the period FY 1998 through FY 2002 VHA would be the sole provider of these services? What concrete experience in terms of successful VHA performance of C&P exams and failure on the part of community providers make this assumption credible?

Answer: VHA would be the sole provider in FY 1998. After FY 1998, VBA may or may not choose VHA as the service provider. The baseline assumes the reimbursement to VHA only until such time as pilot information on the use of contract physicians for disability examinations is available.

Regional offices selected as pilot sites will present a variety of geographic and demographic areas, as well as a range of regional office sizes, in order to determine if contract examinations are universally beneficial, never beneficial or of limited benefit (identifying those circumstances that make it beneficial).

If the information shows that contracting with other than VHA is judicious, it will be proposed.

Question 7a: Was it your position in testifying before our Committee that in the event that the Department were to have to rely on medical care appropriations alone for the period FY 1998 through 2002, with such appropriations frozen at FY 1997 funding levels, that VA would have no option but to close some number of hospitals?

Answer: In 1998, workload would be reduced to stay within the frozen resource level. If Congress does not provide increased budget authority through 2002, we would face the possibility of closing medical centers. With the rapid changes occurring in our system, we cannot reasonably predict at this time what those efficiencies would be in dollar terms. Although we do not know the specific Network actions that would be taken to live with an approximate 3 percent - 4 percent shortfall per year (for inflation) and approximately 16 percent - 22 percent over the 5 year period, we do know that treatment would be provided in accordance with the treatment priorities specified in P.L. 104-262, the Veterans Healthcare Eligibility Reform Act of 1996.

Question 7b: With respect to your references at the hearing to the subject of closure of hospitals, what specific criteria would planners employ or be asked to employ in identifying particular VA medical centers which should be closed? In answering, please address specific workload indicators, utilization criteria and cost indicators. For each

relevant indicator and criterion please indicate the numerical or other objective level which would suggest or tend to support the case for closure.

Answer: No numerical criteria have been developed as thresholds for closing facilities. Furthermore, were closures necessary, decisions would more likely be based upon comparisons among medical centers than upon a pass-fail analysis of one medical center. Planners would be asked to consider a number of measures related to effectiveness, efficiency, costs and alternatives for care, such as:

- total cost avoidance over a relevant time horizon related to closure, including not only current operating expenditures but also planned capital improvements and expenditures, etc.
- relative cost efficiency of the closure candidate compared to nearby facilities
- relative treatment efficiency and quality level of the closure candidate, and
- availability (nearness and capacity) of other VA or contract facilities to absorb displaced workload.

Question 7c: In contrast to circumstances leading to identification of a medical center as a site for outright closure, please identify the specific indicators and criteria (addressing specific workload indicators, utilization criteria and cost indicators) which would warrant identification of a VA medical center as a site for a major mission change, one aspect of which would include terminating delivery of hospital care at the facility. For each relevant indicator and criterion employed in such an analysis please indicate the numerical or other objective levels which would suggest or tend to support the case for terminating provision of hospital care.

Answer: In general the same measures and criteria would be used for mission change analysis as for closure, except that some measures of substitutability of one type of workload (and costs) for another would be added. In the case of several facilities in the same metropolitan area, comparative advantages including clinical staff skills and capital assets, would also be assessed.

No national thresholds have been or could be set. Delivery of health care is local and analyses would have to take local/regional cost and supply information into account. For this reason, the VISNs will be in the best position to identify candidates for closure or mission change.

## Questions from the Honorable Bob Stump

National Cemetery System (NCS)

**Question 1:** The NCS budget contains \$10 million for construction of state veterans cemeteries and to increase the federal share of construction and initial equipment to 100 percent. How many more states do you expect to elect to construct a state cemetery under this formula as opposed to the old 50 percent formula? Specifically what states, if any, have expressed an interest in developing a state cemetery if NCS awards a 100 percent grant?

**Answer:** At least eight states have indicated that the change to the 100 percent funding formula would likely have a positive effect on their decision to participate in the VA State Cemetery Grants Program. Four of those states have not participated in the past. In addition, four other states that have received grants in the past have indicated that they would most likely construct additional cemeteries if the change were to become law. We will continue to work with the States to further explain this new legislation. Discussions with these States are still ongoing. Some of the States that have expressed interest include Massachusetts, North Carolina and Wisconsin.

**Question 2:** The budget proposes 52 new FTE for NCS. How will those new employees be distributed?

**Answer:** All 52 FTE will be distributed to the cemeteries. Forty-one will be Wage Grade and eleven will be GS.

**Question 3:** The budget provides \$825,000 for equipment replacement. What effect will this funding have on the equipment backlog?

**Answer:** The budget request includes additional funding of \$825,000 over the 1997 level of \$961,000 for replacement equipment. This level of funding will enable us to reduce our backlog from \$6.5 million in 1997 to \$6.3 million at the end of FY 1998.

**Question 4:** Please describe how this budget will advance the new cemetery construction program

**Answer:** This budget provides \$13 million for the construction of a new cemetery in the Cleveland area, the last of the five new cemeteries planned before the year 2000.

**Question 5:** Upon opening, what percentage of the available spaces in the new cemeteries will be devoted to columbaria?

**Answer:** In the initial opening phases of the five new cemeteries (Tahoma, Chicago, Dallas/Ft. Worth, Saratoga, and Cleveland) we plan to have approximately 84,300 burial spaces. Of these spaces 12 percent or 10,300 spaces are planned to be available in columbaria. Of the rest, approximately 81 percent or 68,000 will be double-depth gravesites for casketed remains, and approximately 7 percent or 6,000 will be spaces for in-ground remain burial.

**Question 6:** What will NCS spend this year constructing columbaria in existing cemeteries?

**Answer:** In prior years we have had multiple projects to construct columbaria in our existing cemeteries. The Fiscal Year 1998 NCS budget supports a \$893,000 project to construct a 1,660-unit columbaria at the Calverton National Cemetery.

Question 7: The budget lists the 114 national cemeteries. Could you please provide the committee with a list, by cemetery, of management and wage grade FTE assigned to each. Please note those maintained or operated by contractor.

Answer: The list of the 114 national cemeteries with the management and wage grade FTE assigned to each is attached. There are 70 of the 114 cemeteries that have FTE assigned. Three of these 70 cemeteries with FTE assigned are operated and maintained by contract and have a total of 4.5 FTE assigned to the sites. The remaining 44 cemeteries without FTE assigned are operated and maintained in one of four ways: by contract; by the supervision of another national cemetery; by the VAMC on whose grounds the cemetery is located; or for one small, inactive cemetery, by the neighboring private cemetery.

CEMETERY	GS	WG	TOTAL	METHOD OPERATED
Alexandria, LA	...	2.0	2.0	
Alexandria, VA			...	Operated and maintained by contract
Alton			...	Operated and maintained by contract
Annapolis			...	Operated and maintained by contract
Balls Bluff			...	Operated and maintained by Culpeper N/C
Baltimore	2.0	12.0	14.0	
Barrancas	3.0	10.0	13.0	
Bath	2.0	7.0	9.0	
Baton Rouge			...	Operated and maintained by contract
Bay Pines	3.0	2.0	5.0	
Beaufort	2.0	5.0	7.0	
Beverly	2.0	12.5	14.5	
Biloxi	3.0	6.5	9.5	
Black Hills	2.0	7.0	9.0	
Calverton	20.6	72.9	93.5	
Camp Butler	2.0	7.5	9.5	
Camp Nelson	2.0	4.5	6.5	
Cave Hill			...	Operated and maintained by contract
Chattanooga	5.0	11.5	16.5	
City Point			...	Operated and maintained by contract
Cold Harbor			...	Operated and maintained by contract
Corinth	...	2.0	2.0	
Crown Hill			...	Operated and maintained by neighboring private cemetery
Culpepper	2.0	6.2	8.2	
Cypress Hills			...	Operated and maintained by contract
Danville, IL	1.0	4.0	5.0	
Danville, KY			...	Operated and maintained by Camp Nelson N/C
Danville, VA			...	Operated and maintained by contract
Dayton	3.0	13.0	16.0	
Eagle Point	2.0	4.5	6.5	
Fayetteville	1.0	4.5	5.5	
Finn's Point			...	Operated and maintained by Beverly N/C
Florence	2.0	2.5	4.5	
Florida	10.0	30.5	40.5	

CEMETERY	GS	WG	TOTAL	METHOD OPERATED
Ft. Bayard			...	Operated and Maintained by Ft. Bliss N/C
Ft. Bliss	4.0	12.5	16.5	
Ft. Custer	4.0	11.0	15.0	
Ft. Gibson	2.0	5.5	7.5	
Ft. Harrison			...	Operated and maintained by contract
Ft. Leavenworth			...	Operated and maintained by Leavenworth N/C
Ft. Logan	6.0	18.0	24.0	
Ft. Lyon			...	Operated and maintained by Ft. Lyon VAMC
Ft. McPherson	1.0	3.5	4.5	
Ft. Meade			...	Operated and maintained by Black Hills N/C
Ft. Mitchell	2.0	5.0	7.0	
Ft. Richardson	2.0		2.0	Maintained by contract
Ft. Rosecrans	4.0	13.0	17.0	
Ft. Sam Houston	11.0	31.0	42.0	
Ft. Scott	1.0	3.0	4.0	
Ft. Smith	2.0	4.5	6.5	
Ft. Snelling	14.0	37.0	51.0	
Glendale			...	Operated and maintained by contract
Golden Gate	6.0	32.0	38.0	
Grafton			...	Operated and maintained by West Virginia N/C
Hampton	3.0	7.0	10.0	
Hampton (VAMC)			...	Operated and maintained by Hampton N/C
Hot Springs			...	Operated and maintained by Hot Springs VAMC
Houston	11.0	20.0	31.0	
Indiantown Gap	4.0	16.0	20.0	
Jefferson Barracks	14.0	44.4	58.4	
Jefferson City			...	Operated and maintained by contract
Keokuk	1.0	4.0	5.0	
Kerrville			...	Operated and maintained by contract
Knoxville	...	0.5	0.5	Operated and maintained by contract
Leavenworth	3.0	13.0	16.0	
Lebanon	1.0	2.0	3.0	
Lexington			...	Operated and maintained by contract
Little Rock	3.0	6.5	9.5	
Long Island	13.4	62.1	75.5	
Los Angeles	3.0	13.0	16.0	
Loudon Park			...	Operated and maintained by contract
Marietta	2.0	3.3	5.3	
Marion	1.0	4.0	5.0	

CEMETERY	GS	WG	TOTAL	METHOD OPERATED
Massachusetts	5.0	18.0	23.0	
Memphis	3.0	7.5	10.5	
Mill Springs			...	Operated and maintained by contract
Mobile			...	Operated and maintained by contract
Mound City			...	Operated and maintained by contract
Mountain Home	2.0	5.0	7.0	
Nashville	2.0	7.5	9.5	
Natchez	2.0	3.0	5.0	
New Albany	...	1.0	1.0	
New Bern	2.0	2.0	4.0	
NMCA	3.0	12.0	15.0	
NMCP	6.0	16.0	22.0	
Philadelphia			...	Operated and maintained by contract
Port Hudson	2.0	3.5	5.5	
Prescott			...	Operated and maintained by Prescott VAMC
Puerto Rico	7.0	19.0	26.0	
Quantico	5.0	13.0	18.0	
Quincy			...	Operated and maintained by Rock Island N/C
Raleigh			...	Operated and maintained by contract
Richmond	1.0	1.0	2.0	Operated and maintained by contract
Riverside	19.0	49.5	68.5	
Rock Island	2.0	9.0	11.0	
Roseburg			...	Operated and maintained by Roseburg VAMC
Salisbury	2.0	4.3	6.3	
San Antonio			...	Operated and maintained by contract
San Francisco			...	Operated and maintained by Golden Gate N/C
San Joaquin Valley	4.0	11.0	15.0	
Santa Fe	4.0	11.0	15.0	
Seven Pines			...	Operated and maintained by contract
Sitka			...	Operated and maintained by contract
Springfield	2.0	3.5	5.5	
St. Augustine			...	Operated and maintained by contract
Staunton			...	Operated and maintained by contract
Togus			...	Operated and maintained by Togus VAM&ROC
West Virginia	2.0	2.8	4.8	
Willamette	10.0	32.0	42.0	

CEMETERY	GS	WG	TOTAL	METHOD OPERATED
Wilmington			...	Operated and maintained by contract
Winchester			...	Operated and maintained by Culpeper N/C
Wood	3.0	9.0	12.0	
Woodlawn			...	Operated and maintained by Bath N/C
Zachary Taylor	3.0	3.0	6.0	
Total	279.0	843.0	1,122.0	
Tahoma	1.0	5.0	6.0	Maintained by contract
Grand-Total	280.0	848.0	1,128.0	

Question 8: Do you have figures yet for how many survivors have opted for an outer burial receptacle versus a graveliner since enactment of PL 104-275?

Answer: Since PL 104-275 was signed on October 9, 1996, 1,771 survivors have opted for the outer burial receptacle through March 9, 1997. This reflects no discernible increase in the number of privately purchased outer burial receptacles when compared to prior years.

Question 9: What are VA's plans to acquire additional land for gravesite expansion at existing cemeteries?

Answer: VA is actively engaged in acquiring additional land to keep existing national cemeteries open. Current efforts include, but are not limited to:

Camp Butler National Cemetery - VA is in the process of accepting a generous donation of approximately 16 acres of adjacent land from a private citizen.

Lebanon National Cemetery - Local veterans organizations of Marion County, Kentucky, have offered to purchase and donate approximately 9 acres of adjacent land.

West Virginia National Cemetery - The state of West Virginia intends to donate approximately 32 acres of adjacent land. This land will provide gravesites, improved road circulation, and a buffer to planned expansion of a neighboring correctional institution, as well as a housing development.

Question 10: How far into the future does NCS project its budgetary needs? Are there any plans to construct additional cemeteries after the 5 projects are completed?

Answer: NCS normally projects its funding needs five years into the future. This is consistent with the planning period included in the annual budget submission of the President.

In VA's 1998 budget request, however, we are proposing legislation to increase the Federal share of funds to States through the State Cemetery Grants Program from 50 percent to 100 percent of the costs of construction, plus 100 percent of the initial equipment costs. This would make it possible for states to obtain Federal funding for establishing complete and fully equipped cemeteries for veterans. Thus, new burial space will be provided to our nation's veterans through this enhanced Federal/State

partnership program. In light of this proposal, we are not planning to request funds for construction of any new national cemeteries.

Question 11: Do you feel the term "closed" is an appropriate term to use to describe the 57 cemeteries that do have some interment options available to veterans or their families? Of the 19 listed as having only in ground secondary burial space available, how many could accommodate columbaria? Are there any plans to construct columbaria in those cemeteries?

Answer: "Closed" is an appropriate term to describe the 19 cemeteries that have only secondary burial space available. A more appropriate term for the remaining 38 cemeteries with space for both the first interment of cremated remains and secondary casketed burials is "Cremation Only".

Virtually all of the 19 closed cemeteries have no space available that could accommodate columbaria. Also, if space were available at these cemeteries to construct columbaria, it would not be desirable to do so, nor an efficient use of resources. The service areas of these closed cemeteries are either entirely or significantly encompassed by the service areas of other national or state veterans cemeteries with space available for remains, and in most cases, casketed remains. Therefore, there are currently no plans to construct columbaria in the 19 cemeteries with only secondary burial space available.

#### **Veterans Benefits Administration (VBA)**

Question 1: Is it correct that the VBA budget request includes \$68 million to pay for the contract exam program? If that is so, if one deletes that transfer from VHA, the VBA budget is really a reduction of about \$1.3 million in GOE over 1997. Is that not correct?

Answer: Yes.

Question 2: The President has proposed an education package costing over \$50 billion to initiate new education programs and improve existing ones. Of that \$50 billion, not one penny is allocated to improve the Montgomery GI Bill. Mr. Secretary, can you explain why your department has not brought us a GI Bill funding increase?

Answer: We acknowledge that the buying power of the Montgomery GI Bill has been eroding because the cost of education has been increasing faster than the increase in the Consumer Price Index. However, we are pleased that other education benefit enhancements in the Administration's FY 1998 proposal will help veterans fund their education by augmenting Montgomery GI Bill (MGIB) benefits. For example, the education tax credit has the potential to help veterans as much as, and arguably even more than, any citizen. In fact, even though the proposal reduces the amount of the credit by any other non-taxable Federal education grant, MGIB is specifically excluded. Thus, veterans receiving MGIB benefits would also be entitled to the full tax credit in the Administration's plan.

By statute the MGIB monthly rates are increased annually based on the annual increase in the Consumer Price Index. Our budget proposal included a 2.9 percent increase based on the estimated annual increase in the Consumer Price Index. However, we have been unable to identify a source of savings in other veterans programs to fund a further increase in MGIB as required by Congressional budget scorekeeping rules.

Question 3: Mr. Secretary, the budget proposes a reduction of 543 FTE in VBA and a significant increase in the claims processing system's performance. With business process reengineering and computer modernization far from complete, how do you propose to do that?

**Answer:** The 543 FTE reduction in the budget includes the employment for all VBA business lines and support staff. Of that total, 100 FTE are direct Compensation and Pension employment.

Although business process reengineering and modernization are not complete, through performance improvements in regional offices, the implementation of team environments and a decline in aggregate incoming workload, we will be able to achieve our claims processing performance goals.

**Question 4:** Mr. Secretary, the VBA budget for the first time breaks out the overhead cost to each business line. Within the 5 VBA business lines, the overhead cost in FTE averages about 40 percent of the total FTE cost. Do you consider that appropriate and what is the trend in overhead costs?

**Answer:** In 1998, VBA, for the first time, has allocated the costs of its support staffs to its five main lines of business: Compensation and Pension, Education, Loan Guaranty, Vocational Rehabilitation and Counseling, and Insurance. Our definition of "overhead" includes Information Technology and Support Services (Administrative Services, Finance, Human Resources, Management Direction, and the Debt Management Center).

Veterans Services, while not existing as a "direct" business line, is VBA's main point of contact with veterans and their beneficiaries. The division supports the business lines, but would not normally be considered "overhead." When Veterans Services is excluded, the remaining percentage of overhead to total FTE is 24.2 percent, not 40 percent.

VBA has been, and will continue to, work towards reducing its overhead FTE which supports the five business lines. For example, VBA reduced its Support Services staff ratio to total employment by almost 40 percent (from 27.6 percent of total employment to 16.6 percent) from 1987 to 1998.

**Question 5:** The housing program proposes to contract out its management of its portfolio of direct loans. What are the current costs to VA, what are the potential outcomes, when do you anticipate this to happen, and will it be a full and open competition for the contract?

**Answer:** VBA proposed this initiative in the 1997 budget. Annual savings of 164 FTEE will be partially offset by the cost of the contract, for net savings of approximately \$524,000 in FY 1997. Projections for FY 1998-FY 2001 estimate total savings of approximately \$11 million.

VBA expects to lower the cost of loan servicing and to comply with RESPA (Real Estate Settlement Procedures Act) regarding escrows for taxes and insurance. There will be no impact on veterans, as most of the portfolio consists of loans which do not involve veterans' benefits, and no loan will be terminated without the prior approval of VA.

VBA issued a Request for Proposals on June 4, 1996, and awarded a contract on January 30, 1997. Transition planning has been ongoing since that date and the transfer of servicing should occur during May 1997.

The competition was full and open and a dozen technically acceptable proposals were received.

**Question 6:** Why is the department proposing to make several OBRA extenders permanent? By doing so, does the Department realize this committee would have to look elsewhere for reconciliation savings and the effect that might have on VA's core benefit programs?

**Answer:** The Administration has proposed the permanent extension of the OBRA provisions. The Administration believes that periodic extensions of these provisions do not result in true deficit reduction in the long run.

## Questions from the Honorable Terry Everett

Department of Veterans Affairs

Question 1: When will we see VA's draft strategic plan that ties performance to the budget as required by the Government Performance and Results Act?

Answer: The VA strategic plan is in the development stage and we anticipate consulting with the Congress on our strategic goals and performance objectives in June 1997. Under GPRA the annual performance plan rather than the strategic plan, ties performance to the budget. VA now includes performance information as an integral part of the budget and this is the vehicle that ties performance to the budget.

Veterans Health Administration (VHA)

Question 1: How does the VA's MCCR program cost to collect ratio, which was 21.3 percent in 1996 and 22.4 percent in 1997, compare to other federal and private sector programs?

Answer: We want to clarify that the 21.3 percent and 22.4 percent figures do not reflect MCCR's "cost-to-collect ratio" but, rather, MCCR's "total cost to operate" for the indicated years. Within the "total cost to operate" are costs to collect expenses for the wide range of receivables that MCCR is responsible for collecting. A survey of private sector costs of billing and collection resulted in a wide range (5 percent to 30 percent) of "costs" to collect. The range occurs because there is no consistent group of services and activities that are uniformly defined as part of the cost of doing business. For example, the cost of staff performing inpatient admissions, clinic registration, records retrieval, record coding, patient and clinical data collection, pre-certifications, continued stay reviews, cashier duties, medication dispensing, software development, internal audit, and attorney expenses are not normally included in private facility estimates of their cost to collect. Similarly, investments in hardware and assignments of overhead expenses for in-house leasing costs, utilities and facility management are also outside the costs normally reported by private facilities in their estimates of the cost to collect. All of these functions are currently charged to the MCCR program and are not routinely included in private sector estimates of collection costs.

Other factors affect the cost of recovery as well. The MCCR program has documented through a private contractor, that the cost of collection varies by the type of collection. For example, the cost of recovering third party insurance on an inpatient is approximately \$.06 per dollar recovered. Prior to the implementation of ambulatory data capture, the cost of collecting a dollar was \$.27 for outpatient visits due to the intensively manual activity associated with clinical data coding which MCCR funded entirely.

The MCCR program also collects statutory copayments and per diems for VA healthcare from certain veterans. The unique circumstances surrounding these collections, which include means testing and income verification, increases the cost to collect. We are in the process of reducing this cost by further automating this copayment collection process.

Compounding these costs is the fact that the same level of effort is required to generate an inpatient claim or outpatient claim whether the claim is for a patient under 65 or over 65. For patients under 65 with insurance, the opportunity to recover the full insurance payment is much greater (and thereby the cost to collect ratio is much lower) than the results of recovery efforts for patients over 65 who are Medicare eligible and likely to have insurance limited to covering the Medicare deductible. In cases of patients over 65, recoveries are a fraction of what the private sector recovers because VA cannot recover from Medicare. The cost of preparing a claim, while constant for all

patients, results in a much reduced collection effort for patients over 65. Over 70 percent of all claims generated by VA are for patients over 65 and collection potential is limited to less than 20 percent of established receivable due to the limitations of Medicare supplemental coverage.

Insurance identification is more difficult, as veteran patients have less incentive to report other health insurance coverage than do private sector patients. In most private hospitals, insurance coverage is a prerequisite to treatment. Patients can be requested to prepay if they have no insurance.

MCCR bears the cost of utilization review and other services that are not calculated as part of private sector cost to collect. Also, many contractors utilize the existing data systems in a medical center, which must continue to be maintained, but are not appropriately identified as a cost to collect by the contractor.

MCCR's estimate of 20.9 cents per dollar recovered in FY 1998 includes all costs from registration of patients, pre-admission certification, continued stay reviews, data collection on treatment and services received, bill preparation, collection activities, disputed billings and appeals, collections and reconciliation. Costs include design, maintenance and operation of computer systems, all personnel costs associated with the MCCR process, including General Counsel/Regional Counsel legal services, and training to maintain employee skills and knowledge of insurance payment practices. Higher MCCR cost to collect ratios in FY 1996 and 1997 are due to capital investment to allow medical centers to automatically capture data for billing and patient accounting purposes.

MCCR has studied options related to private sector collection contracts. In 1994, GSA awarded a contract making health care cost recovery services available to Federal agencies. VA participated in the development of the contract specifications. MCCR used the GSA contract to obtain a baseline cost-to-collect study from Birch and Davis. MCCR investigated the feasibility of using the GSA vendor for collection services. The cost for services of the GSA vendor, PAYCO American Corporation of Brookfield, WI, were based per region of the country, with costs per claim based on the amount collected per claim. For example, for Region 2 of the country, the cost per third party claim in the first year would be between 29.2 cents per dollar for collections under \$250.00 and 5.1 cents for claims collected over \$1500. The fourth year costs of the contract for the same region and claim sizes would be 31.9 cents and 5.6 cents. Based on preliminary contract provisions, MCCR determined that some functions must be maintained in the medical center for the contractor to perform. They included: Insurance Identification, Precertification; SC/NSC determinations, aftercare, in preparation of an in-patient bill; coding outpatient medical records, SC/NSC determinations, aftercare, in preparation of an outpatient bill; identifying all payers responsible for a veteran's care; billing responsible payers (autobiller); answering questions concerning bills; receiving and posting payments, and follow-up on bills less than 45 days old. MCCR would continue to process first party copayments. The analysis concluded that except for lower performing facilities, MCCR maintained a lower cost to collection ratio than that proposed by the vendor.

MCCR is moving on several fronts to ensure continued increases in our revenue from veterans' insurance companies. We have a variety of initiatives underway that will: increase the number of veterans that we identify as having insurance; decrease program operating costs; and develop billing rates that reflect our true cost of doing business. At the same time, we will use a health care consulting firm to assist us in determining whether we can collect more funds by continuing our in-house efforts, or whether we could more effectively increase collections through the use of private sector billing and collection services.

**Question 2:** Secretary Brown specifically stated in his budget testimony before the Committee that Persian Gulf Illness research was “fenced.” How is this reflected in the VA’s Budget Proposal?

**Answer:** Persian Gulf illness research is included in the 1998 VA Congressional Submission among the “Special Research Initiatives.” The table entitled “Obligations by Sub-Activity”, page 3-14, shows no change in FY 1998 for Special Research Initiatives. This is in contrast to other Research Programs (Individual), Career Development, Research Programs (Multi-Site), Agent Orange/Environmental Medicine and Rehab. Centers/Units, which show decreases in the FY 1998 budget request.

**Question 3:** The proposed construction budget is \$454 million. How does the VA intend to reduce the construction cost overruns that the VA construction management program has experienced in the past?

**Answer:** The proposed construction budget for FY 1998 is \$328.9 million. This includes new budget authority of \$79.5 million for major construction, \$166.3 million for minor construction, \$51 million for the construction grant programs, and \$32.1 million that is available for major construction from an advance appropriation in VA’s FY 1997 appropriation.

The VA has not experienced significant cost overrun problems for some time. The problems of the more distant past referenced in the question prompted VA to take vigorous action on several fronts to prevent cost overruns to the extent possible. These actions have included:

Prevention of scope and cost growth: The planning and design process has been modified to ensure early definition of the content of the project. A commitment contract is then established with all parties involved to adhere to the scope, square footage and cost. The Department has focused on improved project phasing and constructibility, value engineering, better equipment coordination and the use of alternative construction techniques to protect against cost growth. Shorter design and construction periods have been established to reduce the uncertainty in economic forecasting. Steps have been taken to increase competition and thus improve bid prices and bid alternates are used to position the Department to react if high bids are received. Also, increased monitoring of cost through the design and construction phases has taken place.

**Question 4:** Secretary Brown testified in his budget testimony before the Committee that the VA’s healthcare costs per beneficiary is \$4,300. He further stated that this figure included capital costs, capital improvements and personnel and benefits. Please explain in detail how the VA specifically calculates the adjusted average per beneficiary

**Answer:** The Secretary referred to a cost per patient number (corrected to be \$4,730) reported from VHA’s Veterans Equitable Resource Allocation (VERA) system. This estimate is a national average cost per patient across all 22 Networks for FY 1995 for only costs in the VERA model. VERA modeled funds account for 88 percent of the total Medical Care budget and includes capital costs (equipment), capital improvements (non-recurring maintenance), and personnel and benefits (payroll costs). When the non-modeled funds (12 percent of budget) are included to reflect total Medical Care obligations the comparable FY 1995 average cost is \$5,329. This obligation per unique patient includes all direct and indirect (fixed and variable) obligations paid from the Medical Care appropriation.

## CONGRESSMAN EVANS TO DEPARTMENT OF VETERANS AFFAIRS

## Questions from the Honorable Lane Evans

Question 1: How will veterans, and particularly veterans who now use VA health care, participate meaningfully in decisions made about restructuring VA health care?

Answer: VHA has established a National Customer Feedback Center (NCFC) whose primary mission is to learn what our customers think about the health care they receive and to provide that information to administrators and practitioners for the purpose of making improvements. Regular customer feedback surveys are conducted by the NCFC for both inpatients and outpatients to determine what our patients think about their care. Customer service standards are also included in the Network Director's performance agreements whereby all Network Directors are accountable for improving patient satisfaction with various components of their care. In addition, every Network has established a Service Evaluation and Action Team (SEAT) whose function is to track trends in customer concerns and complaints and refer these concerns to their medical facilities for resolution. Veteran Service Organizations are represented on SEAT. The goal of the SEAT is to improve communication with veterans, their families and other stakeholders, and, to improve the responsiveness of VA health care delivery.

Each VISN also has a Management Assistance Council that includes representatives of all local stakeholders, including the Veterans Service Organizations. Because of concerns that have been raised about how certain Management Assistance Councils function, we are currently reviewing Management Assistance Council operations to assure that they function as an effective mechanism for open communication and participation in planning efforts by veterans and other stakeholders. We will provide a report on this review to you when it is completed.

At the national level, VA management meets frequently to seek the advice of the major National Veterans Service Organizations concerning the full range of issues that are of concern to veterans.

Question 2: What are the VA's goals for improving the quality and timeliness of disability claims adjudication.

Answer: Our immediate goals for 1998 are to reduce the average days to process an original compensation claim to 106 days and improve the accuracy of all claims. Over the 5-year BPR implementation process, we intend to reduce the average days to process all claims and achieve an accuracy rate of no less than 97 percent for all claims. For a detailed list of scheduled timeliness improvements, please see page 2-42 of our General Operating Expenses Budget. For scheduled accuracy rate improvements please refer to page 2-44 of the General Operating Expenses Budget.

Question: Does the proposed budget provide all the resources needed to achieve these goals?

Answer: The resources requested in our proposed budget will be sufficient to achieve our goals in FY 1998.

Question 3: According to the proposed budget, at the end of five years, VA will be treating more patients with fewer staff and essentially the same budgetary resources. Do you know of any other health care system, public or private, that has accomplished what VA proposes?

Answer: VA's goal of reducing the cost per veteran treated by 30 percent by 2002 is based on the aggregate savings of the numerous efforts underway to utilize our resources more effectively, to redefine and restructure how we provide care, and on the co-dependent goal of increasing the number of veterans that we serve by 20 percent. The passage of Eligibility Reform legislation last year provided new tools and

momentum to our efforts to restructure how VA provides care. In the past, because of statutory and other restrictions, VA did not keep pace with innovations that were taking place in the private health sector. We are now actively pursuing best value approaches to providing health care, and the effect of changes that are taking place will increase year by year. Similar innovations are frequently reported in the private sector with resulting efficiencies of 30 percent and higher.

**Question 4:** The proposed budget projects a significant increase in resources for VA health care from sharing in future years. Give your scenario for achieving this increase in resources from sharing.

**Answer:** The basis for the significant increase in annual "sharing" revenues is found in Public Law 104-262, the Veterans Healthcare Eligibility Reform act of 1996, which became law on October 9, 1996. This law greatly expands VA's ability to obtain, or share, healthcare resources with, or from, the private sector and other Government entities. This increase in non-appropriated revenues, along with proposed MCCR and Medicare receipts, will assist the VA in meeting its future requirements and goals at a straight lined appropriation level. Even in 1996 under the prior sharing legislation, some Networks had collected the equivalent of between 4 percent and 5 percent of their total revenue from non-appropriated sources (sharing, other reimbursements, and MCCR collections). The leading Network had achieved almost 1.8 percent from sharing and other reimbursements. While we have set "stretch" goals, if other Networks make efforts to emulate the most successful ones, and with the greatly expanded authority contained in Public Law 104-262, our goals for sharing revenue can be reached by 2002.

**Question 5:** How many AIDS/HIV patients is VA currently treating and what is the average annual treatment cost per patient?

**Answer:** During fiscal year 1996, VA treated a total of approximately 17,000 individual patients with HIV/AIDS. The average annual treatment cost is estimated to be approximately \$10,000 for HIV-positive patients without symptoms and \$20,000 for patients with AIDS.

**Question:** Are these patients in the highest priority for VA treatment?

**Answer:** Veterans' priority for care is based on legal requirements as defined by P.L. 104-262, the Veterans' Health Care Eligibility Reform Act of 1996. Under that law, specific diseases or conditions are generally not a basis for establishing priority; however, veterans who are "catastrophically disabled" are given priority after veterans with compensable service-connected disabilities and former POWs. AIDS patients who are seriously ill may meet the requirements for being "catastrophically disabled." If so, they would receive the priority access to VA care given to all other enrolled "catastrophically disabled" veterans.

**Question 6:** What are VA's goals for improving the effectiveness and timeliness of vocational rehabilitation for veterans? Does the proposed budget provide all the resources needed to achieve these goals?

**Answer:** VR&C will be more effective and timely when (1) we can get more disabled veterans into jobs that will improve the quality of their lives, and (2) we can reduce the time it takes to achieve the above employment for our veterans.

We are finishing a major reinvention of the VR&C program that will ensure these two goals occur. It will include a multi-year plan with initiatives and resource requirements. We expect to include the results of this reinvention project in the FY 1999 Business Plan. In the meantime, we expect the resources requested in FY 1998 will enable us to continue to maintain existing service for disabled veterans.

**Question 7:** Assess compliance by the Veterans Benefits Administration and the Board of Veterans' Appeals with the decisions of the Court of Veterans Appeals.

**Answer:** With respect to instructions provided to field stations on implementation of Court decisions, VBA is in full compliance. Changes required in the adjudication process are distributed and enacted in a timely manner. In particular cases there will always be room to question individual judgments, but such questions do not rise to the level of "non-compliance."

The Board of Veterans' Appeals has a number of systems in place to ensure, to the greatest extent possible, that Board members and attorneys will be aware of controlling precedents of the Court.

Decisions are transmitted to the Board by the Office of General Counsel as soon as they are available. Usually within one working day, those cases are summarized in a one- to two-page memorandum by the Office of the Chief Counsel at the Board and transmitted through the Board's electronic mail system to all Board members and attorneys. Copies of these "headnotes" are also provided to VBA's Compensation and Pension Service and to the Office of the General Counsel. Within that same period of time, the full text of the decisions are copied and made available to each of the Board's four decision teams.

The Board also maintains an "Index to Veterans Benefits Law," a computer research tool which is available to the Board and to VBA.

In addition, the Board periodically conducts what it terms "Grand Rounds," a meeting with Board members featuring discussion of current important cases from the Court.

**Question:** What are the obstacles to fuller compliance by VBA and the Board with COVA decisions?

**Answer:** We do not presently see any obstacles to VBA's continued full compliance with COVA decisions. The Board believes that it is, to the fullest extent possible, complying with COVA decisions. Court decisions are quickly incorporated into the claims and appeals processes through the use of electronic technology. Considerable resources are expended in analyzing precedent decisions, and required action on decisions takes place upon receipt of instructions from the analysis. The Board has also taken steps to develop an effective, internal training curriculum for attorneys and Board members that includes instructional programs developed to ensure that BVA decisions are in full compliance with the law, including the decisions of the Court. There are no known obstacles to full compliance with Court decisions.

**Question:** Does the proposed budget provide all the resources needed to achieve timely and full compliance by VBA and the Board with COVA decisions?

**Answer:** VBA has requested sufficient resources to continue full compliance with COVA decisions.

The proposed FY 1998 budget for the Board of Veterans' Appeals provides all resources required for timely and full compliance by the Board with COVA decisions. The infrastructure in place that assures COVA decision analysis, distribution and compliance will remain.

**Question 8:** When does the Administration intend to nominate an Inspector General?

**Answer:** The Department is working with the White House to nominate an Inspector General. We submitted a recommendation, however, our candidate declined the offer. Therefore, we had to begin the selection process again.

Question 9: What is the Administration's philosophy on new national cemeteries:

Answer: The President's fiscal year 1998 budget includes funding for the construction of a new national cemetery in the Cleveland, Ohio, area. If funds are provided for this project, we anticipate opening the cemetery in the fall of 1999. This will be the sixth national cemetery to be constructed in those areas identified in a 1987 Report to Congress as most in need of burial sites for veterans. San Joaquin Valley National Cemetery in California was opened in 1992. Tahoma National Cemetery near Seattle is projected to open in September 1997. We expect to open Dallas-Fort Worth National Cemetery, Saratoga National Cemetery near Albany, New York, and a national cemetery near Chicago in the summer of 1999.

In VA's 1998 budget request, however, we are proposing legislation to increase the Federal share of funds to States through the State Cemetery Grants Program from 50 percent to 100 percent of the costs of construction, plus 100 percent of the initial equipment costs. This would make it possible for states to obtain Federal funding for establishing complete and fully equipped cemeteries for veterans. Thus, new burial space will be provided to our nation's veterans through this enhanced Federal/State partnership program. In light of this proposal, we are not planning to request funds for construction of any new national cemeteries.

Question 10. What percent of veterans are completely satisfied or very satisfied with the service they receive from VA? How does VA compare with other government and non-government service providers in terms of user or consumer satisfaction?

Answer: VA has worked closely with the National Performance Review and as a key member of the President's Management Council's Customer Service Workgroup in an interagency effort to share methodologies and systematic approaches to establishing customer service standards and performance measures; integrating customer service into the planning, budgeting, and other management systems; and benchmarking with both other agencies and the private sector. There is no general index that measures customer satisfaction across government. However, from this extensive interaction with other agencies, it is clear that VA is among the leaders in the Federal government in establishing a systematic process of improving customer service and measuring results. It is also clear that VA and all agencies have a long way to go.

A key business philosophy of the Walt Disney was that "you will never have good customer relations until you have good employee relations." That is why we are in the process of surveying VA employees and part of that survey will ask about impediments to customer service. The results of that survey will be available within a few months.

VA is using the Government Performance and Results Act to integrate our efforts. VA's Strategic Plan will include providing "One-VA" world class customer service as one of four corporate goals and six departmental strategic customer service goals. The strategic customer service goals will in turn lead to specific performance goals and measures for each of VA's nine business lines.

VA's Strategic Plan will provide a road map for the development of the FY 1999 budget proposal and the FY 1998 annual performance plan. It is anticipated that specific resource requirements for customer satisfaction surveys will be identified in the FY 1999 budget proposal.

VA has made significant progress in listening to its customers through enhanced use of focus groups, comment cards, and surveys. However, surveys have not yet been conducted on all veterans benefits programs. The results of surveys conducted are quite positive in many areas yet identify many areas where veterans are not satisfied and efforts to make significant improvement are underway. Extensive data from surveys

conducted is available and a brief summary of the results is provided for your information.

**Veterans Health Administration:** Annual surveys of users determine what they think about the health care received. These surveys are based upon sound principles that generate statistically valid and reliable results that can be generalized to the individual facility level and compared with similar telephone surveys conducted by the Picker Institute for private sector health care providers. Some of the differences between VHA and the private sector results may be attributed to survey technique. Survey methodologists are in general agreement that respondents to telephone surveys tend to be more positive than respondents to written surveys such as those conducted by VHA. Nonetheless, customer satisfaction in both VA and the private sector indicate that improvement needs to be made in both areas. VHA sees a huge opportunity for improvement in the fact that 35 percent of inpatients and 34 percent of outpatients did not rate their care as at least very good.

Inpatient Care: 65 percent described their overall care as excellent or very good, five percentage points higher than the 60 percent level in the previous survey. This compares to a 70 percent rating for the private sector.

Outpatient Care: 64 percent described their care as excellent or very good, a four percent improvement over the previous survey. This compares to a 69 percent rating for the private sector.

**Veterans Benefits Administration:** Data on three benefit programs are available from statistically valid surveys:

Compensation & Pension: In a pilot study, veterans served by 13 VA Regional Offices were surveyed to assess their experience with claims processing.

55 percent of respondents said they were either "very satisfied" or "somewhat satisfied" with the way their claims were handled, regardless of the outcome.

Housing Credit Assistance: 91 percent were "satisfied" or "very satisfied" with the information received from VA; 86 percent were "satisfied" or "very satisfied" with their contact with VA; and 89 percent were "satisfied" or "very satisfied" with the time it took to receive their certificate of eligibility.

Insurance Programs: 96 percent rated their service received as "you are the best" or "you are good."

**National Cemetery System:** In 1996, NCS provided Visitor Comment Cards to all staffed cemeteries for distribution to family members and other cemetery visitors. The survey asked respondents to prioritize those aspects of NCS service most important to them: 73 percent of survey respondents rated the cemetery appearance as excellent and 81 percent of survey respondents rated the quality of service provided by the national cemeteries as excellent.

**Board of Veterans' Appeals:** Respondents to the 1996 survey of appellants, 38 percent rated BVA's overall performance "Good" or "Excellent." It should be noted that 59 percent of respondents who had at least one appellate issue allowed, rated BVA "Good" or "excellent" while for those whose appeals were denied, the comparable rating was 17 percent. From respondents whose appeals had not yet been decided, 38 percent rated BVA "good" or "excellent."

**Question:** Does the proposed budget provide VA the resources needed for the Department to be a leader among other government and non-government service providers in terms of user or consumer satisfaction?

**Answer:** The proposed FY 1998 budget will allow VA to continue providing quality care and services to our veterans and their families. The budget is innovative and historic. It builds on our progress in making changes needed to operate within budget

realities. To keep our system vibrant and in step with world class standards, we will reach out with a high quality products and expand our customer base. The budget includes some new tools to accomplish these goals. VA has been very pro-active in changing the way we do business.

**Question 11:** Like society in general, sexual harassment continues to exist in VA. What is VA's policy on sexual harassment and describe the various disciplinary measures VA takes with respect to employees who engage in sexual harassment, particularly repeat offenders.

**Answer:** VA's policy on sexual harassment is simple and straightforward. Sexual harassment will not be tolerated in VA. Secretary Brown announced this zero tolerance policy shortly after coming to VA in early 1993. He has written to all VA employees on several occasions to ensure they understand the seriousness of this issue and his commitment to eliminate sexual harassment from VA. As integral parts of this zero tolerance policy, VA has

- conducted a mandatory 4-hour training program for all employees, with follow-up training every other year thereafter;
- established a "hotline" to provide an extra level of accessibility and privacy for individuals who wish to come forward; and
- established an ad hoc working group on sexual harassment, including field and headquarters representatives and prominent VA women.

Every allegation of sexual harassment is of concern. When the evidence supports the charge, VA will take strong, effective action to discipline the offender, protect the victim, and correct the situation. The discipline for a proven first offense can range from a letter of reprimand to a removal from Federal service based on the severity of the harassment. An egregious act of sexual harassment will result in the removal of the employee from the Federal service for the first offense. Where the offense is relatively minor, such as an inappropriate remark, a letter of reprimand may prevent the behavior from ever happening again. Penalties for further offenses range from suspension without pay to removal from Federal service.

**Question 12:** What percent of the value of VA's total acquisition and procurement is expected to be made from veteran owned or veteran controlled enterprises during fiscal year 1997? 1998?

**Answer:** From FY 1993 through 1996, VA has averaged 5.5 percent of total awards to veteran owned business. A goal of eight percent in FY 1997 has been established for each VA acquisition facility. FY 1997 accomplishments will be reviewed prior to establishing a goal for FY 1998.

**Question 13:** The budget proposes a ten-fold increase in the state veterans cemeteries construction grant program. Is this increase in response to current state requests or interest? Provide the total value of all currently pending requests.

**Answer:** Under the existing State Veterans Cemetery Grants Program the Fiscal Year 1998 requirement is \$6 million. An additional amount of \$4 million is requested for the new initiative to increase the Federal share of construction cost under the State Veterans Cemetery Grants Program from 50 percent to up to 100 percent, and fund 100 percent of the initial equipment.

At any time there are usually a large number of projects which have been proposed by the States at various stages of the application and review process; however, the actual date of a grant award is hard to predict. This depends on many factors under State control such as when State appropriations are enacted, fiscal constraints on State

budgets, and their own capital planning and development priorities and schedules. As a result, the actual level of Federal obligations for grants in any given fiscal year may vary considerably from the original estimates, resulting in a wide variation in the end of the year unobligated balances.

These factors resulted in a carryover of \$10.2 million from 1995 to 1996. With the appropriation of \$1.0 million in new budget authority in both 1996 and 1997, there was a total of \$12.2 million available for grants during this two year period. This was felt to be sufficient funding for anticipated requirements. A total of \$7.5 million was obligated in 1996, with \$4.7 million left available for 1997 requirements.

The total value of all current pending requests is \$12,705,909.

Question 14: The budget proposes a significant reduction in the state veteran extended care facilities construction grant program. Is this decrease in response to fewer state requests or less interest? If not, please explain this reduction.

Answer: This reduction in the Grants for State Extended Care Facilities request is not due to the lack of state requests or interest. The August 15, 1996, Priority 1 list contained 57 approved Priority 1 projects requiring \$192,847,000, of which 14 projects totaling \$77,367,000 (\$29,970,000 obligated prior to October 1<sup>st</sup> and \$47,397,000 appropriation) will be obligated in FY 1997. We expect the August 15, 1997, Priority 1 list to be approximately the same.

The request level was determined based on a balancing of program needs and the necessity for deficit reduction. Some programs were constrained more than others because difficult decisions had to be made within overall VA funding levels.

## CONGRESSMAN FILNER TO DEPARTMENT OF VETERANS AFFAIRS

## Questions from The Honorable Bob Filner

Mr. Secretary, last year in an exchange of correspondence with our former Chairman, Sonny Montgomery, you clarified that the VA is the lead policy-making agency for the Montgomery GI Bill - Active Duty. With that in mind, I would like to ask a series of questions that are my attempt to understand why the Administration budget did not include increases for education programs administered by your Department.

**Question 1:** By what percentage has the average total cost of a four-year education increased since the Montgomery GI Bill was implemented in 1985?

**Answer:** Between the 1985-86 academic year and the 1995-96 academic year the tuition, fees, room, and board at the average four-year college increased by 94.5 percent. These figures were calculated from data in the *1995 Digest of Education Statistics* and data from the College Board that appeared in the *Chronicle of Higher Education* on September 2, 1996.

**Question:** Same for a commuting student.

**Answer:** We do not have data concerning the transportation costs incurred by a commuting student in 1985-86, and so are not able to estimate the amount of the increase in education costs incurred by a commuting student between 1985-86 and 1995-96. However, we can state that the commuting student incurred education costs in 1995-96 that were approximately 83 percent of those incurred by a resident student. This figure was derived by comparing the basic benefit payable with data from the College Board that appeared in the *Chronicle of Higher Education* on September 2, 1996.

**Question 2:** When the Montgomery GI Bill was implemented in 1985, the total basic benefit under the program was \$10,800. What was the maximum benefit available at that time for a single veteran under the Vietnam Era GI Bill?

**Answer:** The maximum benefit available at that time for a single veteran under the Vietnam Era GI Bill was 45 months of full-time training at the monthly rate of \$376, or \$16,920. When the Montgomery GI Bill was implemented in 1985 education benefits were available to veterans training under the Post-Vietnam Era Veterans' Educational Assistance Program (VEAP). At that time the maximum benefit available was 27 months at \$300 per month or \$8,100.

**Question 3:** What payments were available for dependents under the Vietnam Era GI Bill?

**Answer:** Under the Vietnam Era GI Bill, veterans received a higher monthly payment for each dependent. At the time the Vietnam Era GI Bill ended on December 31, 1989, veterans in full-time training received an additional \$72 per month for the first dependent, \$62 per month for the second dependent, and \$32 per month for each additional dependent. There are no payments available for dependents to veterans training under the Post-Vietnam Era Veterans' Educational Assistance Program.

**Question 4:** What percentage of average total four-year education costs were covered by the Vietnam Era GI Bill in 1985?

**Answer:** A single veteran who received \$376 per month for each of the nine months of the 1985-86 academic year while attending an average four-year educational institution would have had 62 percent of his or her tuition, fees, room, and board covered by Vietnam Era GI Bill payments. A veteran who received \$300 per month for each of the nine months of the 1985-86 academic year while attending an average four year educational institution would have had 49 percent of his or her tuition, fees, room, and

board covered by Post-Vietnam Era Veterans' Educational Assistance Program payments. These percentages were calculated by comparing the total amount payable for nine months with the cost data for the 1985-86 academic year in the *1995 Digest of Educational Statistics*.

Question 5. What percentage of those same costs were covered by the Montgomery GI Bill basic benefit in 1985?

Answer: Assuming that a veteran qualified for the higher basic benefit of \$300 per month and received that benefit for each of the nine months of the 1985-86 academic year while attending an average four-year educational institution, he or she would have had 49 percent of his or her tuition, fees, room, and board covered by the Montgomery GI Bill. This percentage was calculated by comparing the total amount payable for nine months with the cost data for the 1985-86 academic year in the *1995 Digest of Educational Statistics*.

Question 6. What percentage of the same costs were covered by the MGIB basic benefit in 1995?

Answer: Assuming that a veteran qualified for the higher basic benefit of \$416.62 per month and received that benefit for each of the nine months of the 1995-96 academic year while attending an average four-year educational institution, he or she would have had 31 percent of his or her tuition, fees, room, and board covered by the Montgomery GI Bill. This percentage was calculated by comparing the total amount received with the costs calculated by the College Board that appeared in the *Chronicle of Higher Education* on September 2, 1996.

Question 7. In your FY 1998 budget proposal to OMB, did you include a request to increase the basic benefit paid under the Montgomery GI Bill? If yes, what percentage increase did you request?

Answer: By statute the Montgomery GI Bill monthly rates are increased annually based on the annual increase in the Consumer Price Index. Our proposal to OMB included a 2.9 percent increase based on the estimated annual increase in the Consumer Price Index.

Question 8. When was the last time an Administration requested an increase in the VA education program for surviving spouses and children?

Answer: The last rate increase in this program went into effect on January 1, 1990. The Administration had requested such an increase in 1989.

Question: In this budget filled with expanded education assistance, why can't I find a long overdue increase in education benefits for the widows and orphans of those who die in service to their country? I sincerely do not understand why these people are not one of our very highest national priorities.

Answer: We acknowledge that the buying power of Survivors' and Dependents' Educational Assistance has been continuously eroding since the last rate increase due to the rising cost of education. However, we have been unable to identify a source of savings in other veterans programs to fund an increase in Survivors' and Dependents' Educational Assistance as required by Congressional Budget Act scorekeeping rules.

Question 9: For at least 4 or 5 years, the Education Service has tested and proposed a system which would greatly simplify the system now used by veteran students to comply with the requirement that they certify their school enrollment monthly. The current system of cards mailed by the student to the VA has been fraught with

annoyances for all concerned. The plan the VA explored would enable vets to certify simply by using a touch tone telephone.

The cost of this modernization is minimal and the return is huge. Why isn't the funding included in the budget?

Answer: The project to allow veteran students to certify their enrollment by touch tone telephones was tested in the early 1990s. Although initial testing indicated that this automated method could be accomplished, further funding was not then available to complete the project.

We have continued to explore an alternative means to handle veterans' self certification utilizing telephone technology as well as installing toll free telephone service into our education regional processing offices. In January 1997, we began a pilot of toll free telephone service in St. Louis for VA education inquiries for the States of Missouri and Illinois. As a part of the pilot, we plan on using an interactive voice response system to answer frequently asked questions automatically or route the call to a veterans benefit counselor. Phase two of this pilot will include touch tone telephone certification by students. At the successful conclusion of phase two we anticipate nationwide installation.

Specific funds were not identified in the budget for this initiative as this service will be a part of our recurring telecommunications cost.

Question 10: In the vocational rehabilitation and counseling section, the budget states that you will streamline and simplify eligibility processing, purchasing and subsistence allowance award procedures. How and when will you accomplish these goals? I need more details.

Answer: We will streamline and simplify chapter 31's eligibility process by transferring the process from Adjudication to Vocational Rehabilitation and Counseling. This will eliminate 3-4 cross-referrals and improve timeliness. Many stations have already made this change, with resulting improvement in timeliness. A part of the VR&C reinvention effort, we expect to achieve nationwide implementation by July 1998.

The International Merchant Purchase Authorization Card (IMPAC) is assisting us to streamline and simplify purchasing. We will implement this tool fully, including expanded use across VR&C sites and expanded types of use by January 1998. Our objective is to remove every restriction on IMPAC's use which appropriate internal control and fiscal responsibility will permit.

Presently, seven (7) types of subsistence allowance awards require more than one signature; our objective is to change this requirement by April 1998 to only one signature. We will ensure against fraud by adequate audit samples, and we expect this change to result in more timely awards and elimination of unnecessary cross-referral and duplicative efforts.

Question 11: The budget also notes that revised qualification standards for counseling psychologists, vocational rehabilitation counselors, and vocational rehabilitation specialists will be fully implemented.

I would appreciate it if you would brief me on your proposed changes before they are implemented. These individuals generally require specialized training and skills -- and I want to see that the skill level is being maintained.

Answer: On March 24, 1994, the Secretary approved the new qualification standards for the Vocational Rehabilitation Specialist and Counseling Psychologist positions. The new standard raised the educational requirement to a doctorate degree for the

Counseling Psychologist positions. This standard is fully implemented. The standard for the Vocational Rehabilitation Specialist, which upgraded the minimal educational level to a master's degree, raised several concerns as to the impact this new standard will have on existing personnel. In July, 1996 following an advisory opinion from the Office of Personnel Management (OPM), VA created a new position—the Vocational Rehabilitation Counselor (VRC) in the 101 series and transferred the upgraded qualification standards to this series. The VRC position has been implemented for new employees. However, moving existing qualified personnel into the VRC 101 series is complicated and requires that labor-management partnership conditions be met. VA is working towards fulfilling these requirements and issuing implementing instructions.

We share your concern that only appropriately trained personnel deliver vocational rehabilitation services to disabled veterans. We assure you that the new qualification standards guarantee that only highly trained professionals may be hired or transitioned into counseling psychologist or vocational rehabilitation counselor positions.

Question 12: The budget states that VA will continue to provide effective transition assistance services to separating service members, especially those separating with disabilities.

I was under the impression that D-TAP, the transition program for disabled vets, was all but defunct because of inadequate staff and travel money. Did I misunderstand the situation? Are VR&C personnel still participating in a significant way in the TAP program?

Answer: VR&C personnel are still involved in providing transition services to disabled servicemembers. We focus our efforts on servicemembers in hospitals or medical holding companies. Veterans Benefits Counselors give the general benefits information in transition briefings to separating servicemembers and they do include the vocational rehabilitation program in their briefings. Any servicemember wishing to talk directly to a VR&C staff member is given an appointment for that purpose.

Question: A member of my staff was told at a recent conference that school officials who work with their disabled veteran students often have trouble deciphering the payment documents they receive from VA for these students.

Are you aware of this problem and, if so, what steps are being taken to clarify these documents?

Answer: We were not aware that this was a major problem for school officials. The difficulty in deciphering payment documents may arise when a school bills VA for chapter 31 students. A portion of the bill may be disallowed because of an unauthorized charge. A check is issued to the school, but there is not an itemized description of what has been allowed or disallowed and that can cause confusion.

We have asked the case managers who work with our training and rehabilitation facilities, to contact the responsible facility officials when a charge is in question. Our case managers maintain a close working relationship with facility officials so that questions and confusion may be minimized.

Question 13: The Independent Budget recommends that we enact a cost-of-living adjustment for compensation and indemnity compensation.

Do you support this recommendation? I have some reservations - only because I believe that the Committee review of compensation and D-I-C associated with the annual increases is worthwhile. What are your thoughts?

Answer: The President's budget includes a proposal to enact a cost of living adjustment for all compensation beneficiaries, including DIC spouses and children, at the same percentage as Social Security recipients will receive, which is currently estimated at 2.7 percent, effective December 1, 1997. We believe that, in order to fulfill our commitment to veterans and their survivors, compensation payments should be increased each year in order to counter the effects of inflation.

We do not interpret the Independent Budget as proposing legislation providing automatic COLAs in compensation.

Question 14: Your budget projections related to the timeliness and quality of VBA service delivery are very impressive. In order to "realize this vision" [this is the thematic phrase used throughout the budget documents], however, many changes and improvements must be made - including a lot of personnel training and retraining and extensive and expensive upgrading of information technology.

Does this budget include funds sufficient to guarantee that your "vision" will be achieved? That the retraining will be provided and the necessary technology installed? If not, what are the weakest areas.

Answer: The exact results for 2002 cannot be guaranteed, but VBA is committed to this project and if provided with the requested resources will accomplish the overall mission of Business Process Reengineering (BPR). This mission includes the training and retraining of personnel as well as the information technology initiatives presented. The estimates included in the 1998 President's Budget represent our best effort at projecting future events. Regional and Central Office personnel together with an outside contractor created a computer based model to simulate work flow changes resulting from the successful implementation of the reengineered claims processing system described in the budget.

Sufficient funds to accomplish the BPR Vision are included in the five-year budget estimates. These estimates should hold true provided none of the underlying assumptions change. Workload assumptions could present the largest discrepancies and are the most difficult to predict. The number of claims filed by veterans is one variable beyond our control. We are careful to consider all the information available to us when developing workload estimates, but other variables may be introduced at any time. A change in legislation, for instance, may create a significant increase or decrease in our projected workload. Recognizing this issue, the simulation model can accommodate changes and anticipated changes to workload and provide us with revised estimates as these issues arise.

Question 15: I want to compliment you on the Cemetery System budget. I'm very pleased to see that the construction of several new VA cemeteries is provided for in your request. Our nation has a sacred responsibility to ensure that our deceased veterans rest in peace and beauty and dignity - and this budget will help ensure that we need that commitment. I thank you for that.

Question 15 did not require an answer.

Question 16: I was frankly disappointed that the budget request didn't include the funding necessary to reestablish VA's adjustable rate mortgage (ARM) program. I get countless inquiries about this program.

Did you include the ARM funding in your request to OMB? If not, why not?

Answer: VA did not propose legislation to authorize the guaranty of adjustable rate mortgages (ARMS) in the President's FY 1998 Budget. When authority to guarantee ARMS expired at the end of FY 1995, the Congressional Budget Office (CBO) estimated

the one-year cost of extending the authority at \$36 million. It is generally accepted within the real estate lending industry that ARMS have a higher level of foreclosure than fixed rate mortgages. Therefore, CBO estimated a greater amount of subsidy appropriation would be necessary for these particular loans.

It is clear that ARMS afforded veterans an additional financing option that was utilized to a great extent (approximately 20 percent of all loan activity in FY 1995). However, it was decided within the Department that there were more critical funding requirements for veterans. Offsetting savings from other veteran programs were not available to pay the increased costs of ARMS.

Question 17: I know the entire government is concerned about the effect of the arrival of the year 2000 on computer systems. Where is VA in the process of accommodating this unique situation.

Answer: We are taking numerous steps to ensure that VA's information systems will provide uninterrupted service supporting benefits delivery and medical care. VA's Chief Information Officer (CIO) is closely working with the Administration-level CIOs in leading our Year 2000 efforts. We recently completed a Year 2000 Readiness Assessment of the major VA organizations. Over 80 information systems' professionals and managers were interviewed in Washington, DC and various field locations, including the Austin Automation Center, Benefits Delivery Centers, and medical centers.

We assessed our readiness, plans, testing methodologies, contingencies, inventories, and cost estimates. The Readiness Review focused on National Cemetery System (NCS), VA's Austin Automation Center (AAC), Veterans Benefits Administration (VBA), Veterans Health Administration (VHA). Our findings and Year 2000 activities are summarized below. The use of the term "Year 2000 compliant" means that information systems will function correctly with dates beyond 1999.

#### National Cemetery System (NCS)

The information systems supporting NCS are fully Year 2000 compliant.

#### Austin Automation Center (AAC)

The AAC has been addressing the Year 2000 since 1991 through planning and the required conversion of software. Almost 70 percent of production applications are Year 2000 compliant. The AAC plan is to have all systems compliant by September 1998.

#### Veterans Benefits Administration (VBA)

VBA has also been addressing the Year 2000 since the early 1990s. In 1991, VBA completed an initial analysis of all application systems to determine the extent of the problem. In 1993, work began on fixing our debt management systems, and in 1995 work began on making our Insurance system compliant.

In 1996, VBA set up a dedicated project team to manage the Year 2000 effort. A project manager was appointed, a team chartered, and the first draft of our Year 2000 plan was prepared.

VBA is currently in the Renovation phase of our Year 2000 project. Currently 15 percent of our inventory of approximately 158 applications is Year 2000 compliant.

- a. VA will acquire contractor services to lead a Project Oversight Team (POT). Representatives from Veterans Benefits Administration and the Office of Management will be full-time members of this team responsible for the day-to-

day oversight of VBA's Year 2000 project and will validate the quality of completed tasks. The POT will provide briefings to the Under Secretary for Benefits and the Assistant Secretary for Management (monthly) and to the Deputy Secretary on a quarterly basis.

b. In May 1997, the Project Oversight Team will conduct a program review to determine all activities that need to be completed within the scope of the Year 2000 conversion project. The POT will review the status of VBA Year 2000 code conversion work completed, in progress and yet to be accomplished. The contract that supports the POT will extend through completion, validation and testing of all Year 2000 tasks.

c. Following the assessment of the status of the VBA lines of code, a findings report, an action plan and a proposal for the level of effort required to complete Year 2000 recoding activities will be issued in August 1997.

d. Project Task Teams (PTT) have been assigned to convert the code in all VBA systems. PTTs consist of VA staff and contractor support sufficient to ensure that the Year 2000 code changes are completed by December 1998. The level of effort for the PTTs will be revised once the contractor assessment is completed and the action plan approved in mid-August 1997.

VBA has set a goal of completing all recoding tasks no later than December 1998. The testing and verification of all applications will be completed no later than June 1999. This will allow six additional months to resolve unanticipated problems so that all operating systems, applications and third-party products, as well as hardware and software platforms are compliant by December 1999. We are working diligently to resolve the Year 2000 problems to ensure that no veteran or beneficiary check will be in jeopardy.

#### Veterans Health Administration (VHA)

The primary information system supporting VHA's medical facilities is the Decentralized Hospital Computer Program (DHCP). All national DHCP applications use MUMPS (Massachusetts General Hospital Utility Multi-Programming System) programming language. ANSI (American National Standards Institute) standard MUMPS or M language is Year 2000 compliant.

However, we must verify that programmers followed standard development and programming conventions. VHA is developing a plan to analyze the entire DHCP product line portfolio, to confirm that DHCP applications are Year 2000 ready. VHA's goal is to complete any necessary code conversions by May 1998.

VHA has begun development of a plan that includes schedules and contingencies necessary to mitigate VHA's Year 2000 impacts but has not completed an overall, comprehensive plan. The comprehensive plan will address such areas as biomedical equipment currently in use at VA medical facilities; especially those that input patient data into DHCP systems. This plan will detail how the VHA Year 2000 Project Office will support and assist VHA's 22 Veterans Integrated Services Network (VISN) offices in their efforts to achieve compliance throughout the medical facilities in their networks. The plan will be completed by April 1997.

#### Summary

VA's organizations have developed detailed systems inventories, testing methodologies, individual project plans and contingencies. Our inventories and plans include such key elements as estimated lines-of-code, number of modules, operating

systems and commercial-of-the-shelf (COTS) packages. Additionally, the individual systems and COTS inventories include assessments of Year 2000 compliance.

We are also working with the Year 2000 Interagency committee chaired by Ms. Kathy Adams. We will be working with the Office of Management and Budget and other appropriate agencies to resolve potential issues with biomedical equipment. We are confident that VA information systems will be well prepared for the coming millennium.

**HONORABLE FRANK Q. NEBEKER  
U.S. COURT OF VETERANS APPEALS  
QUESTIONS FOR THE RECORD  
FROM  
HONORABLE BOB STUMP  
CHAIRMAN**

**1. What portion of the FY 98 budget request is for computer equipment?**

A: The Court plans no major computer equipment purchases in fiscal year 1998. The Court has programmed \$45,000 for emergency replacement purchases to ensure that its operations are not affected by hardware malfunctions or breakdowns.

**What is the purpose of these computers?**

A: The Court's computers continue to be used to provide current and archival case management, including docketing, suspending, document generation, and statistical reporting; Courtwide internal communication through electronic mail; internal and external electronic legal research; electronic dissemination of precedential decisions; personnel and payroll transactions; acquisition transactions; and financial management.

**Where will these computers be located?**

A: They are located at the workstations of nearly all Court personnel, on the public office counter, and in the systems manager section.

**Are any government-funded personal computers located in the homes of the Court's judges or staff?**

A: No.

**2. What is your opinion of the requested increase for the pro bono program?**

A: I do not have sufficient facts to form an opinion. However, I understand that Program staff was reduced when wind-down of the program seemed necessary. Since then, the Program has sought many extensions of time to permit initial screening of cases for possible pro bono representation.

**3. In your opinion, would it be feasible for a local law school to initiate an accredited course or courses in veterans law?**

A: Feasibility depends on student interest, and the Court has no way of determining such interest. It should be noted that veterans law is an intensely regulated and specialized field which has not proven to be particularly lucrative because of the statutory restrictions on legal fees. Local law schools have intern programs (for credit), and the Court has had a number of student interns working in judges' chambers.

**4. In your budget request, in reference to an increasing number of appeals filed, you state "an upward trend appears to be continuing." How much of an increase do you expect in fiscal years 1997 and 1998, and to what would you attribute such an increase?**

A: The Court expects that new case filings in fiscal year 1997 will show an increase of 18% over fiscal year 1996 filings. That is attributable to a significant increase in the number of BVA decisions denying some or all of the benefits sought. Any increase in new case filings for fiscal year 1998 will depend on the extent to which this BVA trend continues.

**5. A recent increase in BVA productivity has generated an increase in the number of appeals filed with the Court. From fiscal year 1995 to fiscal year 1996, the number of appeals increased from 1279 to 1620 (up 27%). How many decisions did the Court issue in fiscal years 1995 and 1996?**

A: The Court terminated 1168 cases in fiscal year 1995 and 1252 in fiscal year 1996.

**6. In fiscal year 1995, the average case decision took 393 days. Currently, what is the average time for a case decision?**

A: In September 1996, the average case took 386 days from notice of appeal to decision.

**7. In a February 4, 1997 letter to me, you indicated that there were 1438 cases awaiting decision by the Court. On March 31, 1996, there were approximately 1200 pending cases. Do you anticipate a continued increase in the number of cases pending at the Court?**

A: My February letter indicated that there were 1438 cases awaiting decision as of June 1996. At the end of fiscal year 1996, there were 1632 pending cases. It should be noted that only about 10% of pending cases are awaiting decision by judges. The vast majority are awaiting filings by the parties—primarily by VA counsel. In answer to your question, I anticipate a continued increase in the number of those cases unless and until the funding, staffing, and effectiveness of the VA appellate litigation staff are improved.

**8. How many cases have been pending for more than one year?**

A: As of March 1, 1997, there were 310 cases pending for more than one year. Cases are sometimes held, at the request of the parties or on the Court's own initiative, awaiting a controlling decision in another case before this Court or a superior tribunal. For example, a number of cases were held awaiting decisions by the U.S. Court of Appeals for the Federal Circuit and the U.S. Supreme Court in *Gardner v. Brown*. In addition, some cases are stayed at the parties' request to permit such actions as the reopening of a claim at the regional office or the BVA Chairman's decision on a motion for reconsideration. Many others are delayed at the request of one or both parties.

**9. How many cases have been pending for more than three years?**

A: Seven. Three are awaiting controlling decisions in other cases before the Court and in the U.S. Court of Appeals for the Federal Circuit, all at the request of the appellant. One was delayed for 2½ years awaiting a Federal Circuit decision on an appeal from this Court's decision. The others experienced several delays at the request of one or both parties.

**10. Last year, in response to Congressional inquiries, the Court submitted a legislative proposal which would reduce the number of associate judges from six to four. In your February 4, 1997, letter, you transmitted an identical proposal to reduce the size of the Court. Do you need to fill the associate judge vacancy this year to keep up with the workload?**

A: The Court is presently able to manage its workload, but the workload is increasing. The decision to fill the vacancy created by Judge Mankin's death is for the President and the Senate. However, I point out that an even number of judges on a collegial court can often produce a tie in an important case, a factor which, in the Court of Veterans Appeals, would impede the development of veterans benefits jurisprudence.

**11. Has individual judge productivity declined as a result of the current vacancy on the Court?**

A: Judge Mankin's death in May 1996 coincided with an increase in the number of appeals filed in the Court. The total number of cases terminated since then must be divided by six, rather than seven. This calculation reveals that there has been no decrease in individual judge productivity.

**12. How does the Court's workload and productivity compare with other federal appeals courts?**

A: As of June 30, 1996, U.S. courts of appeal had 236 cases pending for each authorized judgeship. As of September 30, 1996, this Court had 233 cases pending per authorized

judgeship.

**13. What is the average number of decisions produced by a judge per year?**

A: In fiscal year 1995, the Court's judges terminated 544 cases (both appeals from BVA decisions and petitions for extraordinary relief) on the merits, or 78 per judge. In fiscal year 1996, the Court's judges terminated 599 cases on the merits by judges, or about 92 per judge. These figures do not include nondispositive decisions on matters such as jurisdiction or the content of the record, or decisions on post-termination matters such as motions for reconsideration and review or applications for attorney fees under the Equal Access to Justice Act.

**14. How many or what percentage are precedent setting decisions?**

A: In fiscal year 1995, 82 terminations on the merits, or 15%, were precedential. In fiscal year 1996, 92 terminations on the merits, or 15%, were precedential. In addition, on procedural issues such as jurisdiction, or on post-termination matters such as attorney fee applications under the Equal Access to Justice Act, the Court issued 25 precedential decisions in fiscal year 1995 and 22 in fiscal year 1996.

Because of the Court's continuing high pro se rate, we get large numbers of appeals with little or no merit. In such cases, we do not burden VA, the veterans service organizations, and the bar with published decisions which would confuse many as to whether they are precedential. We handle such cases through the single-judge decision process. Cases for which the single-judge decision process is appropriate are those whose outcome is not reasonably debatable, which are clearly and unambiguously controlled by statute, regulation, or existing precedent, and whose underlying facts are relatively simple. See *Frankel v. Derwinski*, 1 Vet.App. 23 (1990). The use of this decisionmaking process has been beneficial because it permits the Court to concentrate resources on cases with merit. Accordingly, in those decisions which do not add to the jurisprudence of veterans benefits, the Court issues prompt and more summary dispositions which, at the same time, permit the Court judiciously to build its jurisprudence with precedential decisions that will be of assistance. Of course, the single-judge process is also used when plain error in a BVA decision is apparent.

**15. In your written testimony, you discuss the Court's voluntary reduction of two FTE positions from the fiscal year 1997 level. Please describe the two positions which were eliminated. What is the estimated annual savings from this reduction?**

A: One staff attorney and one records management clerk, for an estimated savings of \$85,000.

**16. What is your assessment of the quality of representation before the Court?**

A: Appellant representation, when it is obtained, is adequate and is improving as the Court's bar matures. The Secretary, too, is represented by many qualified attorneys in Professional Staff Group VII of the VA General Counsel's office. However, I understand that Group VII lacks sufficient staff and that the attorneys have extremely large caseloads. This affects the work of the Court because these attorneys must perforce seek extensions of time to file the record and the pleadings for the Secretary.

**17. Is it accurate to state that the Court finds the Pro Bono program to be of assistance to the Court?**

A: Yes. It contributes to the reduction of the number of unrepresented appellants before the Court. Its primary purpose is to help veterans generally and specifically in their individual representation. The benefit to the Court, by professional advocacy, is substantial but incidental.

In connection with the representation of appellants, I recently became aware that VA itself has arranged for representation of pro se appellants in certain limited circumstances. The Winter 1997 issue of *Tommy*, the newsletter of the Veterans Law Section of the Federal Bar Association, contains an interview with David T. Landers, the recently retired Counselor to the

Assistant General Counsel for Professional Staff Group VII. In the published interview, Mr. Landers sets out the factors that VA considers important when evaluating a case, pending before the Court, for "merits" settlement. A "merits" settlement is defined by Mr. Landers as one in which "at least one issue on appeal is disposed of on the merits and the grant of some type of benefit (such as service connection, an increased rating, an earlier effective date) is directed by a stipulated agreement." The interview notes that "Professional Staff Group VII only negotiates with represented appellants unless the appellant is a pro se attorney. If a settlement with a pro se is deemed warranted, P[rofessional] S[taff] G[roup] VII arranges for representation, as was done in the *Bond* case [*Bond v. Derwinski*, 2 Vet.App. 376 (1992)]."

I realize that the Secretary has resisted funding of the Pro Bono Representation Program through VA itself, but surely if VA already arranges for representation in certain cases, the inconsistency becomes stark.

Follow-up Question from the  
Hon. Bob Filner from the Full Committee Hearing  
on the U.S. Court of Veterans' Appeals budget estimates  
for Fiscal Year 1998 Budget  
to the Honorable Frank Q. Nebeker  
February 27, 1997

**Q: Judge Nebeker, I'm pleased to see that your budget request includes a request for a 21% increase in the funding for the Pro Bono program. I agree with you that the 72% unrepresented appeals level is far too high. What effect will this funding increase have on the unrepresented appeals percentage?**

**A: I do not know what effect it will have. However, the Court's records over the last few years show that, by the time of briefing in an appeal, the percentage of unrepresented appellants is down to approximately 50%. Representation through the Pro Bono Program plays a substantial, but not exclusive, role in reducing the percentage of unrepresented appellants by the time of briefing appeals before the Court. As I indicated in my testimony, the Pro Bono Program has provided its own supporting statement for its budget request, which the Court has submitted without comment as to its substance. You may wish also to direct the question to the Pro Bono Program.**

CHAIRMAN STUMP TO U.S. DEPARTMENT OF LABOR

**HOUSE VETERANS AFFAIRS COMMITTEE**  
**Questions for the Record**  
**(Congressman Bob Stump)**

1. What is the effect of not having a separate funding line for TAP?

There is no adverse effect from not having a separate funding line. Similarly, we have not been able to identify any definite advantage from having a separate line. In fact, VETS commits resources from a variety of "lines" such as Federal staff personnel and travel, DVOP/LVER staff personnel and travel related charges, NVTI training, costs related to printing and shipping of TAP manuals and a contract to provide workshop facilitator support in certain areas.

2. Mr. Secretary, your budget contains a request of \$157 million to fund DVOPs and LVERs. Title 38 is fairly specific in how you allocate those funds. Does the current formula prevent you from the most effective allocation of those resources?

The current formula for allocation of DVOP staff is based on the population of veterans subgroups within each state. Once state allocations are made, VETS Directors have the flexibility to negotiate with Job Service Administrators for the assignment of DVOPs to specific local offices within the states. The LVER formula, on the other hand, is more prescriptive as it relates to specific assignment of LVERs to local offices. This limits the flexibility of VETS and Job Service to negotiate the assignment of LVERs to address certain workload demands (e.g., TAP sites) or target resources to serve the veteran subgroup populations most in need of assistance (disabled, minority, female, young and recently separated veterans). During the course of each fiscal year VETS conducts quarterly budgetary adjustments which allow for recapture and redistribution of unspent funds to meet DVOP/LVER staffing needs in various states.

3. Last year, the Committee fenced funding for 10 positions to be used for USERRA enforcement. What is the status of those positions and will you require additional FTE to absorb the added workload envisioned in HR 240, Congressman Mica's Veterans Employment Opportunities Act of 1997?

The ten investigators have yet to be appointed since they are new positions which required classification. These positions have now been classified and we are currently in the process of announcing the vacancies. We cannot project the number of veterans preference complaints that might arise if HR 240 becomes law so we cannot say whether or not there would be need for additional FTE.

4. Please describe the outcomes projected for the 1998 budget.

State Grant Programs total \$157,118,000.

Disabled Veterans Outreach Program \$80,040,000

Will assist 156,000 veterans find jobs, including more than 7,000 special disabled veterans.

Local Veterans' Employment Representatives \$77,078,000

Supports 1,339 positions, which will help 152,000 veterans find jobs, including more than 6,700 special disabled veterans.

Homeless Veterans' Reintegration Projects \$2,500,000

Will support about 20 grants serving 4,000 eligible veterans with more than 2,000 being helped into jobs.

Veterans' Employment Programs-Job Training Partnership Act IVC \$7,300,000

Will support about 15 State grants (competitive process) and several discretionary pilot, research and/or demonstration projects serving about 4,000 eligible veterans served with more than 2,000 helped into jobs.

Federal Administration \$22,839,000

Funds will support 254 positions. Emphasis on transition assistance

rights; working with States to promote use of personal computers and electronic tools by DVOP and LVER staff; and making sure priority of services is given to veterans. TAP: About 160,000 separating service members and their spouses will participate in TAP workshops. About 1,200 servicemembers' reemployment rights cases will be resolved.

National Veterans' Training Institute \$2,000,000  
Sufficient to support the training of more than 1,400 veteran service providers.

5. Please describe the outcomes projected for the Homeless Veterans Reintegration Project in the FY 98 budget.

We project that more than 4,000 homeless veterans will be served by these projects and more than 2,000 will be helped into good jobs.

6. Would you please describe how many of the veterans being placed by the state employment agencies are being placed by DVOPs and LVERs, and describe how important these people are to the state employment agencies.

Of the 535,666 veterans that were helped into jobs by the public employment service system in FY 1995, 166,591 (31%) were helped by DVOPs and 160,795 (30%) by LVERs. Similarly, of the 16,957 Special Disabled Veterans helped into jobs, 7,053 (42%) were helped by DVOPs and 6,670 (39%) by LVERs. DVOP and LVER staff are an integral part of the overall service delivery systems efforts and vital in efforts to provide the maximum of employment and training opportunities to veteran customers. DVOP's and LVER's also serve as the human connection between the public employment service system and the military services' separation centers, assisting about 60% of the transitioning veterans beginning their re-entry into civilian life.

7. Mr. Secretary, I am disappointed that the budget does not request sufficient money to fund the DVOPs and LVERs as specified in title 38. I am also aware that the appropriators have not done a good job in this area. Mr. Secretary, would you please describe the funding for DVOPs and LVERs and what outcomes you are projecting.

Much of the requested information is provided in the response to question number 4 above.

In addition, we are concentrating our staff resources on serving those veteran groups experiencing disproportionately higher unemployment rates (disabled, minority, female, recently separated and younger veterans). DVOPs will also focus attention on providing individualized job development assistance to disabled veterans enrolled in or completing a VA Vocational Rehabilitation training program. LVERs will ensure priority services are provided to veterans by the overall delivery system and monitor the Federal contractor job listings and referrals of special disabled and Vietnam era veterans to these openings on a priority basis. Both LVERs and DVOPs will continue to facilitate the delivery of TAP workshops at over 180 military installations.

CONGRESSMAN FILNER TO U.S. DEPARTMENT OF LABOR

**Follow-up Questions and Answers  
House Veterans' Affairs Committee  
(Representative Bob Filner)**

1. Mr. Secretary, first I want to say again how pleased I am that your budget includes funding for the Homeless Veterans' Reintegration Project and the National Veterans' Training Institute. These are worthy programs that should be funded.

I also wanted to take this opportunity to put in a plug for the Veterans' Training and Employment Bill of Rights of 1997, H.R. 167. Among other things, this measure would respond to the Independent Budget recommendation that we make it clear that veterans' readjustment, and related employment and training opportunities, are national priorities. H.R. 167 also accomplishes the Independent Budget goal of clearly establishing veterans' priority for services in DOL programs.

I am disappointed by the D-VOP and L-VER funding levels. Once again, the Administration has not respected the Congressional funding mandate for these very important programs. Is OMB the "bad guy" here? Did Secretary Reich request full funding for these programs?

Statutory funding levels for the Disabled Veterans Outreach Program (DVOP) and Local Veterans' Employment Representative (LVER) program have not been appropriated in this decade. This is due to important bipartisan deficit reduction efforts between the Executive and Legislative branches of government.

We share your positive viewpoint regarding the inclusion in the President's budget of funding specifically for the National Veterans Training Institute and the Homeless Veterans Reintegration Projects program. Overall, we believe this budget request affirms the Administrations' commitment to assist veterans, particularly the most disadvantaged veterans, in securing employment.

2. Mr. Secretary, as you certainly appreciate, it is critical that you and your representatives be full participants in the policy and decision-making processes at DOL. I know you have insisted on this during your tenure and that Secretary Reich understood the importance of veterans' employment programs.

I want to reinforce the Committee's expectation, and insistence, that VETS officials be primary players when decisions are being made about programs that affect our nation's veterans. Let me be clear here. I am not referring only to programs administered by VETS. If a DOL program affects veterans in any way, even indirectly, Secretary Taylor must be at the table in all important discussions.

Let me assure the Committee that this is the case. The Office of the Secretary has worked continuously to ensure that the ASVET is routinely invited to participate in the Department's policy-making processes. For examples, VETS officials designated by the ASVET are integral members of the Workforce Development Performance Measures Policy Committee and the related work groups that were convened by the Employment and Training Administration to guide the development of measures for the evolving One Stop Service Center system; VETS is involved in policy-making regarding the evolution of America's Job Bank, including decisions such as how federal contractors may satisfy the mandatory listing requirements of the Federal Contractor Program; VETS officials have been consulted on unemployment insurance program policy matters; VETS officials are routinely invited to provide input to the Office of the Solicitor on inter-departmental matters that may affect veterans, such as other Department's proposed legislation. You may be assured that the progress you acknowledge has already occurred is valued here and will continue.

MAJOR GENERAL JOHN P. HERRLING, USA (RET)  
AMERICAN BATTLE MONUMENTS COMMISSION  
QUESTIONS FOR THE RECORD  
FROM  
HONORABLE BOB STUMP  
CHAIRMAN

Committee on Veterans' Affairs Hearing - February 13, 1997  
Budget for Fiscal Year 1998

1. General, please describe who has final responsibility for all funds raised and used to construct the WWII memorial.

The final responsibility for all funds raised and used to construct the WWII Memorial lies solely with the American Battle Monuments Commission. Section 3 of the legislation (40 USC 1003) states, "The American Battle Monuments Commission shall solicit and accept private contributions for the memorial." Section 1 states, "The American Battle Monuments Commission ... is authorized to establish a memorial ... ." And Section 4 provides for the creation of a fund in the Treasury "which shall be available to the American Battle Monuments Commission for the expenses of establishing the memorial."

The responsibility of the Memorial Advisory Board regarding funds, as specified in Section 2.(c)(1), is only to, "in the manner specified by the Commission, promote establishment of the memorial and encourage donations of private contributions for the memorial; ..."

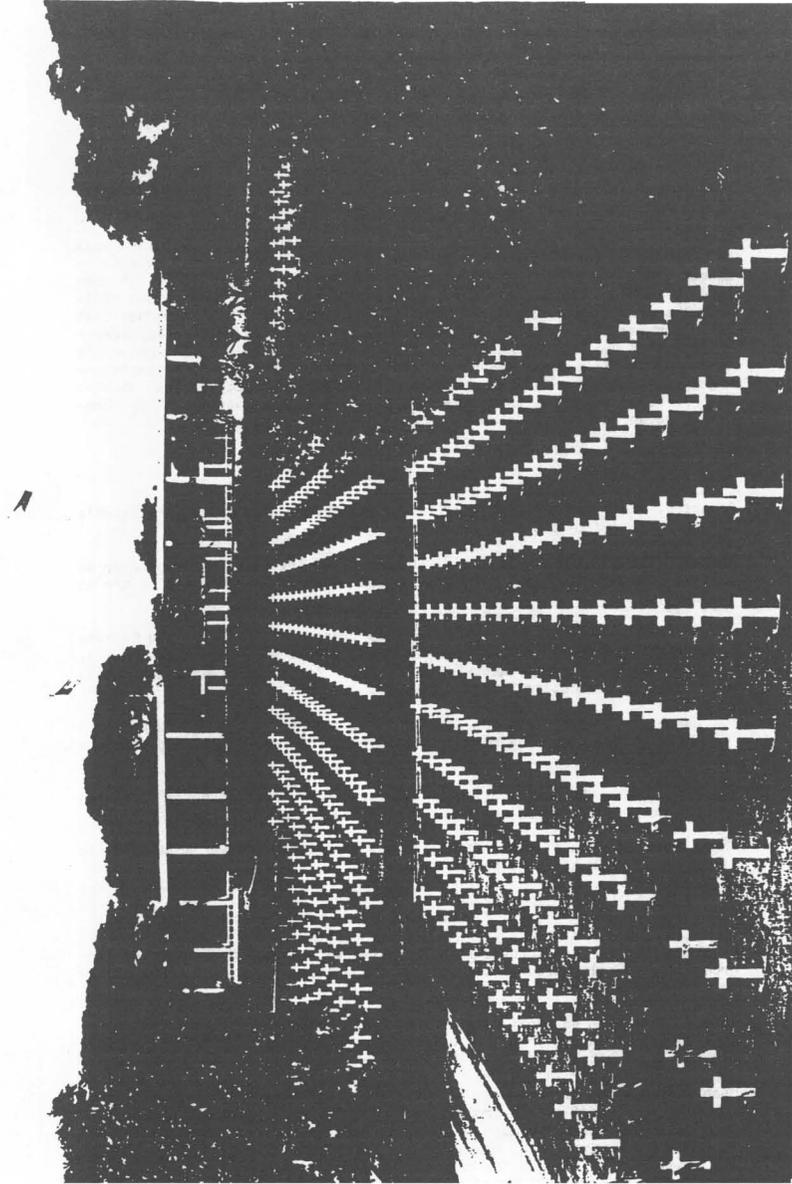
From the above, final responsibility for funds raised and used to construct the WWII Memorial is clearly that of the American Battle Monuments Commission.

**Response from the American Battle Monuments Commission to the  
Follow-up Question from the Hon. Bob Filner  
from the Full Committee Hearing on the  
Administration's Fiscal Year 1998 Budget  
to MG John P. Herring, USA (Ret)  
February 13, 1997**

1. **General Herring, I have a special interest in your cemetery in the Philippines because I am privileged to represent the 50<sup>th</sup> Congressional District of California - which has the largest Filipino population of any Congressional District.**

**What is the status of this cemetery? Is it well maintained? Is adequate funding available to ensure its maintenance?**

- a) **The Manila American Cemetery and Memorial is the largest cemetery under this Commission's care. It is the interment site for the remains of 17,206 of our military Dead of World War II, including the remains of 570 Philippine Scouts who served with the U.S. Forces in the southwest Pacific region. An additional 36,282 American War Dead are commemorated as missing in action, lost or buried at sea on the Tablets of the Missing at the cemetery's memorial. The cemetery is closed to future interments and disinterments, except for the remains of War Dead occasionally found on battlefield sites.**
- b) **On February 18-20, 1997, I completed my planned annual inspection of the cemetery and found it to be in superb condition. (The condition of the cemetery is illustrated by the attached photograph.)**
- c) **Funds for the operation and maintenance of the cemetery, both as appropriated for this fiscal year and as requested in the FY 1998 budget, are adequate to ensure the continuing level of excellence this nation owes to our Honored War Dead, their families and the American image in the Pacific.**



## CHAIRMAN STUMP TO DEPARTMENT OF THE ARMY

## QUESTIONS FOR THE RECORD FROM HONORABLE BOB STUMP CHAIRMAN

## Improved Appearance

Question. Mr. Lancaster, despite an increasing workload, your budget for Arlington National Cemetery proposes a reduction of 4 FTE. The budget also proposes to improve the overall appearance of Arlington. How do you propose to do this?

Answer. The work previously performed by the Civil Service employees will be performed by contractors. In addition, work that was not able to be accomplished before will be included in the existing contracts or new contracts, such as headstone cleaning, tree and shrub maintenance and additional areas in the custodial services contract. While the contract cost will increase, the level of work will also be increased and the appearance of Arlington will be enhanced. The enhanced appearance will be noticeable in two specific areas, headstones and trees and shrubs. A new initiative begun in Fiscal Year 1997 to clean headstones by contract will be doubled in FY 1998. The tree, shrub and herbicide application work done by contract, begun in FY 1996 is being increased in FY 97 and FY 98.

## Land Acquisition

Question. What are the land acquisition requirements to meet Arlington's master plan, and is the land available?

Answer. The land acquisition requirements for Arlington to remain as an active cemetery into the 22nd century and to meet its master plan are as follows:

- > Section 29 land transfer from the Department of Interior to the Department of the Army, as directed by Section 2821 of Public Law 104-201, the National Defense Authorization Act for Fiscal Year 1997. The study specified in Section 2821 is underway.
- > Lands on Ft. Myer from the Department of the Army to be determined at a future time, after the needs of Ft. Myer for installation purposes are satisfied.
- > Lands under the jurisdiction of the Department of Defense identified as the Navy Annex, which are currently in use and not available.

These three parcels of land offer the best opportunities for Arlington to expand and remain active into the 22nd century.

## Cost Comparison

Question. Could you provide the Committee with a cost comparison of in-ground versus columbarium interment, with a special emphasis on land utilization at Arlington?

Answer. Arlington National Cemetery has a finite amount of land - 612 acres total, with 40 acres presently unused but under design for future development as gravesites. When that 40 acres is developed for in-ground interment, approximately 24,000 new gravesites can be made available, depending upon the location of roads and walks. Ignoring the value of land required, the additional cost of in-ground interment is about \$510 per gravesite. This additional cost includes the cost of graveliners and headstones, but it does not include such annual or periodic costs as grounds maintenance and headstone cleaning. The columbarium at Arlington was originally conceived to provide for inurnment of cremated remains for those veterans who lost their eligibility for in-ground burial in 1967 as a result of changed burial regulations. Ignoring the value of the land required, the additional columbarium cost is about \$650 per niche. This additional cost includes the cost of niche covers, but does not include the annual cost of maintenance. However, the cost of annual maintenance for each niche is significantly less than the cost for each gravesite. The columbarium, at full development, will occupy 14 acres and produce up to 60,000 niches.



April 24, 1997

The Honorable Lane Evans  
Ranking Democratic Member  
House Veterans' Affairs Committee  
335 Cannon House Office Building  
Washington, DC 20515

Dear Representative Evans:

Enclosed are answers to your follow-up questions from the February 27, 1997, hearing before the House Veterans' Affairs Committee on the Department of Veterans Affairs (VA) budget for fiscal year 1998. We have answered questions 1 and 2, while Disabled American Veterans (DAV), author of the benefits portion of the *Independent Budget*, has already forwarded to you their answers to your other questions.

As indicated in your letter, each answer is preceded by the original question and printed on legal size paper.

We will be happy to answer any additional questions you may have, or provide other information you may need. We appreciate your support and thank you for this opportunity to make you aware of our concerns with the VA budget.

Sincerely,

Richard B. Fuller  
National Legislative Director

Enclosure

Question 1: The *Independent Budget* reports some VA administrators are “making many much needed structural and operational changes to improve the quality and efficiency of VA health care services.” What structural and operational changes are being made to improve quality and efficiency of VA health care services and where are these changes being made? Are these changes repeated at other VA facilities?

Answer: VA has come to recognize that if it wants to remain a competitive health care player it must provide care in a manner that is attractive to its users. As a result, changes to improve quality and efficiency of VA services are being implemented both system-wide and in individual VA medical centers (VAMCs).

The following are some examples of system-wide reforms:

- As part of its goal to shift from a hospital-based delivery system to one that supports more outpatient care, VA is implementing a system-wide primary care program. VAMCs have set up primary care teams, like those used in private sector managed care organizations. Each veteran will be assigned to a primary care doctor or team who is responsible for managing their care. We share VA’s optimism that this new primary care system will improve access, continuity and coordination of care, and the overall quality and efficiency of services.
- In the past, patients with medical problems or questions often visited VA facilities without appointments and waited in evaluation clinics for hours before they could see a provider. Now, most VAMCs encourage veterans to schedule appointments. This has improved efficiency as well as reduced waiting times at many VAMCs.
- VA has conducted patient satisfaction surveys to identify each VA facility’s strengths and weaknesses. It has established customer service standards that tell patients how long they can expect to wait for VA services and what they should receive from employees with regard to courtesy, accuracy, thoroughness, and quality of service. For example, one national goal is to have veterans wait no longer than 30 minutes to see their doctors.
- Most VAMCs have implemented telephone advice lines. Nurses who advise veterans over the telephone resolve many issues previously handled only in person. This prevents veterans from making unnecessary visits to VA, and reduces VA costs. Scheduling has become more efficient, and many VAMCs have significantly reduced waiting times.
- VA has developed the largest spinal cord injury and dysfunction (SCI/D) registry in the world. The database holds information collected from all VA SCI/D patients on the services and supplies they receive. The registry assists VA in determining where patients receive services and what types of services they receive. It will also allow VA to better assess the future health care needs of the SCI/D population.

The following are some examples of innovations that have been implemented by individual VAMCs:

- The Atlanta, Georgia VAMC is creating a business office in the outpatient care lobby where veterans can complete all their administrative paperwork.
- The VAMC in San Antonio, Texas has implemented an automated patient reminder system. The system calls veterans with a recorded reminder about their pending clinic appointments. A feature allows veterans with a touch tone phone to cancel appointments when called. The system improves the efficiency of clinic scheduling by increasing the number of patients who keep their appointments and freeing up canceled slots for other veterans.
- To decrease hospital admissions, the Ann Arbor, Michigan VAMC pays for patients who meet certain criteria to stay overnight in a local hotel before a scheduled procedure or

appointment. This program has resulted in significant cost savings due to the low cost of a hotel stay (about \$32 per patient) compared to the high cost of hospitalization (average of \$550 per day).

- At the Washington, D.C. VAMC, telephone triage nurses call patients who do not keep their scheduled appointments and ask how they are feeling and why the appointment was not kept. The no-show rate has been reduced from 30% to 20%.

Recently, VA surveyed its medical centers to identify a sample of the most innovative practices related to ambulatory care. The results were published in *VA Innovations in Ambulatory Care*. The book is designed as a tool to share examples of innovative programs in VAMCs with VA ambulatory care managers who may be interested in implementing similar initiatives.

In addition to being highlighted in the *VA Innovations in Ambulatory Care*, VAMC achievements have been recognized and publicized by state and national awards. For example, the Memphis Veterans Medical Center in Memphis, Tennessee recently was awarded the Greater Memphis award for quality, which recognizes Memphis businesses and institutions for their quality improvement initiatives. The award honored the Memphis VAMC for its successful efforts to improve customer satisfaction by reducing waiting times and providing better information to patients and families to help them make informed decisions about treatment options.

Successful programs at VAMCs are often duplicated by other VAMCs or even implemented on a nationwide basis. However, what works in one medical center does not always work in another. Success depends on a variety of factors such as the types of patients served and the facilities' mission. Nevertheless, VA must continue to find ways to foster the sharing of information among VAMCs and encourage program innovations that will improve the quality and efficiency of care delivered to our nation's veterans.

Question 2: The *Independent Budget* states, "VA's attempts to be cost-effective may in some cases be taking precedence over efforts to provide high-quality care to veterans." Please give us some examples of this.

Answer: As budgetary pressures in VA continue to grow, VA administrators may be tempted to cut costs even at the expense of reducing the quality of services. Therefore, VA stakeholders, including Congress and the veterans service organizations, must diligently monitor the changes that are taking place in VA to ensure that veterans receive the high quality care they deserve.

The following are some examples of how VA's attempts to be cost-effective may in some cases be taking precedence over efforts to provide high-quality care to veterans:

- In attempt to reduce costs, some VA networks and medical facilities have illegally restricted veterans' access to over-the-counter (OTC) medications and supplies. In fact, there even have been cases of veterans who were denied medically necessary OTC products for 100% service-connected conditions. Policies restricting access to OTC products contradict recent VA efforts to gain cost-efficiency and improve quality of care by increasing access to outpatient and preventive services. Many OTC products, such as aspirin and suppositories, are vital in managing chronic conditions like spinal cord injury or disease or high blood pressure, which, if left untreated, could become life threatening and more expensive to treat in the long run. If OTC drugs and products are not available through VA, veterans will incur higher out-of-pocket costs, and some may not be able to purchase the products at all.
- The *Independent Budget* Veterans Service Organizations (IBVSOs) have seen cases in which veterans with decubitus ulcers have been inappropriately discharged from hospitals into nursing facilities or their homes. While administrators may be tempted to discharge patients early in effort to reduce costs, patients who are inappropriately discharged often

need to be rehospitalized or develop secondary conditions, making care more costly in the long run.

- The IBVSOs have also seen cases in which hospitals, attempting to cut costs, have ordered low-quality durable medical equipment. For example, at the Houston, TX VAMC, the chief nurse in the Spinal Cord Injury Unit was directed by an administrator not to purchase Clinitron hospital beds, which are designed to prevent decubitus ulcers. This decision was directly related to the high cost of these beds. The chief nurse admitted that, since the SCI unit began using the lower quality beds, the SCI Unit has experienced an increase in the number of patients with decubitus ulcers. The problem has still not been corrected.



Motto: "If I cannot speak good of my comrade, I will not speak ill of him."



## DISABLED AMERICAN VETERANS

NATIONAL SERVICE and LEGISLATIVE HEADQUARTERS  
807 MAINE AVENUE, S.W.  
WASHINGTON, D.C. 20024  
(202) 654-3501

March 27, 1997

The Honorable Lane Evans  
United States House of Representatives  
2335 Rayburn House Office Building  
Washington, DC 20515

Dear Mr. Evans:

Enclosed are answers to your follow-up questions numbered 3, 4, and 5 related to the February 27, 1997, hearing before the House Veterans' Affairs Committee on the Department of Veterans Affairs (VA) budget for fiscal year (FY) 1998. The first two of your questions will be answered by the Paralyzed Veterans of America (PVA), the author of the medical care portion of the *Independent Budget*.

As you requested, each answer is preceded with a restatement of the question to which it responds. The questions and answers are provided on a separate legal-size paper to conform to your printing requirements.

Thank you for the opportunity to present our views. We will be happy to provide additional information or clarification should you need it. We appreciate your continuing support and your interest in these issues.

Sincerely,

DAVID W. GORMAN  
Executive Director  
Washington Headquarters

ANSWERS TO QUESTIONS FROM THE HONORABLE LANE EVANS  
RANKING DEMOCRATIC MEMBER  
FOR THE INDEPENDENT BUDGET PANEL  
REGARDING FEBRUARY 27, 1997, TESTIMONY BEFORE THE  
HOUSE COMMITTEE ON VETERANS' AFFAIRS  
ON THE DEPARTMENT OF VETERANS AFFAIRS BUDGET FOR FY 1998

Question 3: "Please elaborate on your recommendation to reject an economic validation of the [Schedule for Rating Disabilities]."

Answer: The *Independent Budget for Veterans Programs: Fiscal Year 1998 (IB FY '98)*, discusses economic validation of the *Schedule for Rating Disabilities* as follows:

**Integrity of the Disability Rating Schedule**

Congress has delegated to the Secretary of Veterans Affairs the authority to adopt and readjust as necessary a schedule for rating of disabilities. Agencies exist because Congress is not equipped to establish specific rules requiring detailed knowledge and expertise in highly specialized areas. Thus, discretion is granted to VA to supply the details for programs authorized by statute.

The integrity of the VA *Schedule for Rating Disabilities* is an area of special concern for disabled veterans. Formulation of a rating schedule requires a great deal of special expertise and institutional experience in the intent and practical application of veterans' laws. In recognition that VA is far better equipped to understand the nuances and esoteric quantitative and qualitative properties of disability evaluation, Congress exempted the rating schedule, and any action of the Secretary in adopting or revising it, from judicial review, although it made all other rules adopted by the Secretary subject to such review by the courts.

Currently, VA is involved in the complex and laborious process of updating and revising the various portions of the rating schedule to take into account advances in medicine and all other factors that bear on measurement of disability. In this process, VA augments its own expertise by consulting with experts in related fields. Revision of the rating schedule also involves the participation of interested parties, as is required by law.

The General Accounting Office (GAO) has undertaken a preliminary review to determine whether a comprehensive study of the economic validity of the rating schedule is indicated. In the absence of any indication that this is an issue of concern to veterans or that there are problems with the rating schedule, the IBVSOs [Independent Budget Veterans Service Organizations], and we suspect the veterans' community in general, question the advisability of this action. Given past experience, the veterans' community knows quite well that such economic validations are driven, not out of a concern for fairness to veterans, but rather to devalue disability ratings. The IBVSOs submit that disability evaluation properly involves determinations of loss of function and the corresponding levels of impairment. The economic measure of disability should be reflected in the rates of compensation.

The current rating schedule is the product of many years of practical experience combined with special expertise and those valuable intangible

properties that cannot be surpassed by some highly theoretical formulation based on questionable economic premises and assumptions. In periodically reviewing and revising the rating schedule, as VA is now doing, VA is properly exercising the discretion granted it under the law as well as fulfilling its statutory duty. Further review of the rating schedule is unwarranted. Thus, the IBVSOs urge that Congress reject any suggestion to tamper with the rating schedule.

*IB FY '98 at 24-25.* (footnotes omitted).

We also agree with the VA's reasons for objecting to economic validation of the rating schedule. GAO, *VA Disability Compensation: Disability Ratings May Not Reflect Veterans' Economic Losses* App. IV (1997) (GAO/HEHS-97-9).

Question 4. "Please elaborate on the statement, 'However, Congress should reject recommendations that VA revise its rules to negate the Court's enforcement of claimants' rights as contained in current rules.'"

Answer: This recommendation in our testimony is from our recommendation in *IB FY '98* regarding the suggestion of the Business Process Reengineering (BPR) team that VA should undertake revision of its rules to override judicial interpretations of them. While VA rules have been invalidated by the courts in a very limited number of instances, the VA's current rules represent a long-standing interpretation of veterans law and Congressional intent. Indeed, Congress has discussed and generally approved of many of VA's rules and procedures. The Court of Veterans Appeals reverses and remands relatively high percentages of the decisions of the Board of Veterans' Appeals. Some, including the BPR team, have suggested that this is because, in its review, the Court interprets VA's rules in a manner inconsistent with VA's interpretation and that VA's rules are typically subject to multiple interpretations. We disagree. It has been our experience that the Court finds error in such large percentages of VA's decisions, not because of any differences in interpretation of the rules, but simply because VA often fails to comply with its own rules.

Our discussion of this issue on pages 58-62 of *IB FY '98* is detailed and too lengthy to duplicate here. We invite your attention to this discussion, however, for a full explanation of our views.

Question 5: "Have you recommended specific performance standards to achieve improvements in VBA decision-making quality? Can you give us examples of specific performance standards to achieve improvements in VBA decision-making quality?"

Answer: In short, we believe that quality should be measured by: (1) whether the record was properly developed in accordance with VA's statutory duty to assist; (2) whether the claimant was afforded all due process, (3) whether the decision followed from a thorough review of all relevant evidence and a proper application of all pertinent statutes, regulations, precedent, and agency directives; and (4) whether the reasons or bases for the decision were sufficient for the claimant to understand how the evidence was evaluated and weighed and how the law was applied to the facts. In last year's *IB*, we pointed to the contradiction in VA's finding of consistently high quality and the large percentages of cases found on appeal to contain errors. To demonstrate how ineffective VA's current quality review is, we pointed to one example of an error seen regularly in VA decisions that is so fundamental it makes the decision invalid on its face but yet is apparently not detected in VA's quality review:

An example of a frequently seen error is the failure of the rating board member to weigh the evidence for and against the veteran to properly make factual findings. The foundation of any adjudicatory decision is proper consideration and evaluation of the evidence, for that determines the factual merits of the claim and its legal outcome. Without this, the decisional process is unquestionably and invariably fundamentally flawed.

To assess the merits of a claim, the adjudicator must consider *all* of the evidence that bears on the issue and must apply the proper standard of proof. In

VA, the standard of proof is the “reasonable doubt” or “benefit of the doubt” rule. With this standard, the claimant prevails if the evidence for him or her is at least of equal weight as that against the claim:

When, after consideration of *all* evidence and material of record in a case before the Department with respect to benefits under laws administered by the Secretary, there is an approximate balance of positive and negative evidence regarding the merits of an issue material to the determination of the matter, the benefit of the doubt in resolving each such issue shall be given to the claimant.

38 U.S.C. § 5107(b) (emphasis added).

VA’s regulation provides similarly:

When, after careful consideration of *all* procurable and assembled data, a reasonable doubt arises regarding service origin, the degree of disability, or any other point, such doubt will be resolved in favor of the claimant. By reasonable doubt is meant one which exists because of an approximate balance of positive and negative evidence. . . .

38 C.F.R. § 3.102 (emphasis added).

Several VA regulations repeat the charge that all relevant evidence must be considered. *E.g.*, 38 C.F.R. § 4.1 (“Over a period of many years, a veteran’s disability claim may require reratings in accordance with changes in laws, medical knowledge and his or her physical or mental condition. It is thus essential, both in the examination and in the evaluation of disability, that each disability be viewed in relation to its history.”); 4.2 (“It is the responsibility of the rating specialist to interpret reports of examination in the light of the whole recorded history, reconciling various reports into a consistent picture so that the current rating may accurately reflect the elements of disability present.”). In one of its earlier decisions, COVA [Court of Veterans Appeals] reinforced this principle as it applies in reopened claims. The Court held that once a claim is reopened with new and material evidence, VA “must evaluate the merits of the veteran’s claim in light of *all* the evidence, both new and old.” *Manio v. Derwinski*, 1 Vet.App. 140, 145 (1991). The Court explained the essential nature of this rule:

A contrary rule would inevitably lead to absurd results. A veteran who was clearly entitled to disability benefits could be denied those benefits solely because he presented his evidence in the course of two proceedings rather than one. Furthermore, the statutory requirement that the former disposition be reviewed can only be fulfilled if all the evidence is considered. VA regulations appear to recognize this need by stating that “[d]eterminations as to service connection will be based on review of the entire evidence of record. . . .” 38 C.F.R. § 3.303(a). The new evidence may not be sufficient in and of itself, but it may be just enough, when all of the evidence is considered, to create an “approximate balance of the positive and negative evidence” which would entitle the veteran to the “benefit of the doubt.” 38 U.S.C. § [5007(b)].

*Manio*, 1 Vet.App. at 145.

Yet, as clear as the law is on this point, and as basic as this principle is, veterans service organization representatives continue to observe that the great majority of rating decisions in reopened claims or BVA remands involve consideration of only the newly submitted or obtained evidence and contain no mention or discussion of prior record evidence whatsoever. As frequently, these

decisions make no mention of the benefit of the doubt rule, although COVA has held that VA must apply the benefit of the doubt rule or set forth clearly in the decision why it is inapplicable. *E.g., Sheets v. Derwinski*, 2 Vet.App. 512, 516 (1992); *Gilbert v. Derwinski*, 1 Vet.App. 49, 59 (1990). Obviously, however, if all the evidence was not considered, the benefit of the doubt rule could not have been applied. Such gross and primary errors and widespread trends should be easily detected in an effective quality assurance process.

*IB FY '97* at 43-44. Unfortunately, this demonstrates also that VA simply has not been enforcing its own rules. We discussed the concept of quality in general terms in this year's *IB*:

The IBVSOs strongly support C&P's effort to improve quality. However, the Business Line Plan includes very little in the way of concrete measures to impose accountability, a vital element of quality. The Business Line Plan includes training. A knowledgeable workforce is, of course, a prerequisite to decisions that properly analyze factual matters and correctly apply the law. There must, however, be a clear understanding by adjudicators that their future work will be scrutinized to ensure that training on such matters as judicial precedents and General Counsel opinions, for example, is being utilized in practice. There must be an effective quality control infrastructure staffed by highly knowledgeable employees who are committed to enforcing quality standards. The criteria by which quality is measured must ensure that decisions conform to all requirements of law as included in statutes, regulations, judicial precedents, General Counsel opinions, manuals, and all other VA directives. Omissions of such elements as an explanation of how the benefit of the doubt rule was applied to the facts in the individual case or an explanation of how specific contentions of the claimant or representative were addressed in the decision, for example, should result in the decision being rejected as erroneous on its face. Finally, there must be means by which to enforce accountability. Performance evaluations must reward quality decisions and penalize failure to adhere to quality standards. The goal of 97% accuracy must be a goal of genuine accuracy. If not, the BVA reversal and remand rates will continue to expose poor quality, as will poor customer satisfaction.

There is little doubt within the veterans' community, that one of the greatest and earliest challenges in accomplishing real improvement is changing the orientation and perspective of adjudicators. The existing culture is one that has resisted change. The existing mindset is one that places fidelity to the letter and spirit of the law below personal beliefs about the merits of benefit programs and individual claims. Over the years, there has been a departure from the law in many areas. Adjudicators came to follow the unwritten rules that are conducive to the kinds of results the adjudicators personally believe to be the right result rather than the one prescribed by law. Decisions by the Court of Veterans Appeals have rejected many of these perversions of the law. For example, the Court has rejected VA's treatment of testimony as mere argument instead of treating it as evidence as the law does. The Court has rejected VA's practice of not according any weight to lay statements from witnesses who offer facts pertinent to claims. The Court has rejected VA's practice of arbitrarily denying claims for total ratings based on individual unemployability with catch-all, unsupported statements such as "your disability does not preclude you from performing all kinds of work." The Court has rejected the fairly common practice of selective reading of the record, where the adjudicator cites only the evidence that lends support to a denial while ignoring favorable evidence. The Court has ruled unlawful VA's practice of reducing disability evaluations without observance of and adherence to rules protecting veterans against arbitrary or unjustified reductions. Such reductions are void ab initio. Just as institutional denial about quality problems has for years delayed the implementation of a real prescription for solving C&P's ills, continued denial that this mindset and these practices exist within the current culture will hamper VA's efforts to improve quality. There must be an acknowledgment of this problem and an effective plan to correct it or else the

other initiatives in C&P's Business Line Plan have little chance of success. Thus, there must be a genuine resolve to correct these problems at their root, and management must also be held accountable in the event real change does not occur.

The IBVSO's repeat the recommendation in last year's *Independent Budget* that BVA decisions be used to measure and enforce quality standards. One way to make institutional denial more difficult, especially among rating board members, would be to change the way BVA writes its decisions. BVA now plays a patron role toward RO adjudicators, being careful not to be critical or render its decision in a context of reversing RO error. BVA intentionally avoids calling attention to the deficiencies or defects in RO decisions or record development that account for BVA reversal or remand in the case. This contributes to the misperception that rating board decisions are for the most part sound and that the BVA reversal or remand is merely the product of differences in judgment.

When the Court reverses or remands, it articulates precisely why the actions or inaction of BVA require it to do so. The Court specifies BVA's errors, and there can be no mistake that BVA committed error. In turn, BVA is instructed on proper application of law and must be more careful to ensure its decisions conform to legal requirements. As a result, BVA has found it must allow a greater portion of cases than before the advent of judicial review, and veterans receive much better decisions, whatever the disposition.

In its decisions, BVA should also specify the RO errors requiring the different outcome on appeal or requiring remand. This will serve as valuable and free instruction to RO adjudicators. It will confront them with the reality of their errors. It will make their errors known to management. It will provide a tool to measure performance and enforce accountability. Statistical compilations and surveys could identify the worst problem areas, and training or other remedial measures could be targeted to these areas. BVA decisions might themselves become more objective.

Regrettably, the BVA Chairman has resisted such a change. As reported in the *Independent Budget* for FY 1996, the Chairman objected to BVA decisions which specify RO error because that would disturb the fraternity between BVA and ROs. The view that the fraternity between the Board and RO adjudicators is more important than quality decisionmaking is inconsistent with VA's stated vision for change. When interviewed for this edition of the *Independent Budget*, the Chairman's response to this same suggestion was to the effect that BVA decisions specifying RO error were inadvisable because ROs do not pay any attention to what is stated in BVA decisions. The Chairman's reasoning is necessarily illogical inasmuch as it uses existing shortcomings and lack of accountability as justification for taking no action to correct those shortcomings and lack of accountability.

The IBVSOs strongly believe that BVA decisions should specify the errors in fact or law that account for BVA's reversal or remand. We recommend a legislative change to require this in BVA decisions if VA fails to include this in its quality control measures.

In accordance with requirements in Public Law 103-446, the Chairman of BVA formulated performance criteria for Board members "to ensure that high standards of decisional quality and productivity are maintained." The criteria require demonstrated proficiency in all areas of responsibility, particularly legal writing and analysis. Sources of information on an individual member's proficiency include court reviews of the Board member's decisions, quality reviews, statistical data on quality and timeliness, and comments of supervisors, appellants and their representatives, and other interested parties. The IBVSOs

believe that similar meaningful performance standards and a process of oversight and accountability should be established for RO adjudicators. Performance should be tied to merit pay, promotion, and even retention consideration.

*IB FY '98 at 56-58 (footnotes omitted).*

VA's willingness to establish and enforce effective quality standards will determine the success of the BPR plan, because poor quality and VA's past failures to acknowledge and correct its quality problems are the primary causes for VA's current troubles.

## CONGRESSMAN FILNER TO DISABLED AMERICAN VETERANS

Question # 1: "In the area of VBA issues, what do each of you consider the most critical areas of concern? Where should Mr. Quinn and I focus our energies?"

Answer: The area of greatest concern related to VBA is the claims processing system. In recent years, large backlogs of predominantly compensation and pension claims have caused protracted delays in the disposition of those claims. This situation has delayed benefits for disabled and needy veterans. Elderly and ill disabled veterans have died before their claims could be properly decided, resulting in them not receiving benefits they were entitled to.

The DAV has long maintained that the primary cause of this situation is poor quality in the claims decisions. The failure to correctly develop the record, to thoroughly review the evidence, or to correctly determine factual matters and apply all pertinent law in the initial adjudication necessitates multiple administrative actions to properly dispose of the claim.

While VA's past efforts to correct this problem have been disappointing, the DAV is encouraged by and fully supports VA's current plan to improve its quality and efficiency. VA's Business Process Reengineering Plan, incorporated in the budget submission, acknowledges poor quality as the cause of much duplicative work and a consequent overload on the system. This plan would improve quality through better training, better quality control, and accountability.

The success of this plan will depend on many of the details for its implementation, yet to be worked out, and the availability of the necessary resources. We have urged Congress to support VA's efforts and provide adequate funding. We have cautioned, however, that the Administration's proposal to reduce staffing in the Compensation and Pension Service by a hundred FTE in fiscal year 1998 alone is inconsistent with the goals of improved and more personalized customer service envisioned in the plan. Although greater efficiency is a goal of the plan, even VA does not project attainment of that increased efficiency during the early years of its implementation.

We have serious concerns about a related matter, the recommendations of the Veterans' Claims Adjudication Commission. Where VA's plan follows from a comprehensive and introspective review of its claims adjudication processes by professionals who were thoroughly familiar with the legal context and the work processes and who objectively isolated the weaknesses and inefficiencies, the Commission's approach was highly theoretical; but worse, it was seriously flawed and misdirected.

Congress created the Commission out of concern about large claims backlogs and resulting protracted claims processing times. The Commission's mission was to "[c]arry out a study of the [VA] systems for the disposition of claims for veterans benefits." The purpose of this study was to determine: (1) "[t]he *efficiency of current processes and procedures . . . and means of increasing the efficiency of the system.*"; (2) "[m]eans of reducing the number of claims under the system *for which final disposition is pending*"; and (3) "[m]eans of enhancing the ability of the [VA] to achieve final determination regarding claims under the system in a

prompt and appropriate manner.” Accordingly, the Commission was charged with studying the current processes and procedures with the goal of increasing the efficiency for the purpose of reducing the large backlog of currently pending final disposition and enhancing the systems ability to dispose of claims in a prompt and appropriate manner.

Unfortunately, the Commission essentially ignored its statutory mandate. Instead of studying the dynamics of the work processes to identify the causes and solutions for the problems, the Commission pursued its own agenda, one totally beyond the scope of its authority and Congressionally assigned mission.

After studying the composition of a population of veterans filing reopened claims and the typical subject matter of those claims, the Commission concluded that a large portion of the claims were claims for increased disability ratings by veterans already receiving compensation. The Commission also analyzed this population according to period of service, existing level of disability, and other characteristics. None of this had any cause-and-effect relationship to the efficiency of the processes and procedures, and the Commission made no attempt to show that the claims of a group from one period of service, or claiming one typical type of disability, took any more or less time than those of other groups. Rather, the obvious thrust of the Commission’s analysis was to show that a large portion of these “repeat claims” were from what the Commission implicitly portrayed as less deserving veterans. For example, the Commission observed how many were peacetime veterans, how few were combat-related injuries, and how many were seeking increased evaluations for lower rated disabilities. In other words, the Commission injected its own value judgments about the veterans and the benefits themselves rather than addressing the delivery system.

The Commission arrived at several conclusions about the wisdom of allowing veterans to reopen claims, about VA’s duty to assist, and about the benefits themselves. The Commission’s recommendations would solve the VA’s problems by imposing restrictions on claims and benefits eligibility to reduce the future workload to a level compatible with current performance levels rather than seek to raise efficiency and performance to a level sufficient to dispose of the existing pending workload appropriately and to meet the future workload in a timely and appropriate manner.

The Commission recommended that Congress consider several changes to the system and the benefits to limit veterans’ access, rights, and eligibility: The Commission would change the system by:

- relieving VA of some of its duty to assist
- forcing veterans to accept lump-sum settlements for lower-rated disabilities and surrender their future rights to reopen their claims when their disabilities worsen
- reducing veterans’ appeal rights by reducing the time to appeal erroneous decisions from 1 year to 60 days

- reducing veterans' appeal rights by reducing the types of errors the Board of Veterans' Appeals could correct

The Commission would change the nature of benefits by:

- eliminating the compensation eligibility of veterans who do not file their claims within a limited time period following service
- eliminating the future eligibility for compensation and increased compensation by forcing service-connected veterans to accept lump-sum settlements based on the degree of their disabilities when rated at lower levels.

The Commission made other recommendations based on findings that had no connection to the claims backlog or its causes. The Commission frequently offered only bare, sweeping assertions in support of its findings and recommendations as if these propositions were self-evident or as if the Commission spoke with such authority that its statements should be accepted at face value. Other of the Commission's conclusions did not necessarily follow from the data it cited and sometimes were not even suggested by it. Other statements were simply incorrect or involved incorrect assumptions, demonstrating a lack of understanding of the system on the part of the Commission. The DAV will be commenting on the fallacies in the Commission's findings and recommendations in more detail in the future.

The Commission's actions, in our view, constitute a serious disservice to Congress, to veterans, and to taxpayers, whose money was wasted in this misplaced exercise.

We urge you to focus your energies on ensuring that VA is provided the resources necessary to implement its plan to improve claims adjudication; however, staffing levels in VBA should be at least maintained at current levels. The findings and recommendations of the Veterans' Claims Adjudication Commission merit no serious consideration. We strongly oppose them, and we urge you to reject them..

Question #2: "The tradition has long been that VA and veterans should not be adversaries - and that the VA should err on the side of the veteran when making tough decisions regarding issues such as benefits eligibility. Many of your comments and recommendations to the Congress seem to indicate that the quality of the relationship between the VA and veterans has eroded. Did I interpret your testimony correctly?"

Answer: It was not intended that our testimony indicate that the quality of the relationship between veterans and VA has deteriorated. The long-standing tradition has indeed been that the claims process and the relationship between veterans and VA is not adversarial in the administrative proceedings. Moreover, that traditional relationship is prescribed in VA regulations and is inherent in VA's statutory duty to assist.

On the other hand, the relationship between the veteran and VA is necessarily adversarial at the judicial review level. Some who have attempted to blame the

Court of Veterans Appeals for many of VA's problems have argued that judicial review has had the negative effect of giving the administrative proceedings an adversarial flavor. If that were true, it would indicate an inappropriate VA reaction, either as a result of resentment of veterans' ability to seek judicial enforcement of their rights or due to some incorrect belief by adjudicators that they must be guarded and can no longer deal with veterans in an open, candid, and helpful manner. Obviously, such a reaction would be entirely improper for either reason.

The rules require VA employees to assist veterans in fully prosecuting their claims, with the veterans best interests in mind and with the goal of ensuring they receive all benefits to which they are entitled under law. In contrast, as you know, an adversarial relationship requires two or more parties whose interests are in opposition and who seek to advance their own interests while defeating those of the opposing party or parties. Although VA employees can only grant a veteran's claim where the facts and law warrant, their interests and goals are never in opposition to the veteran. Thus, adversarial conduct by VA personnel would be intolerable. We are unaware of any actual deterioration in the relationship between VA and its customers, veterans and eligible family members. The advent of judicial review has not altered this fundamental principle, nor has it affected VA's duty to resolve reasonable doubt in the veteran's favor.

Where two or more parties have opposing interests, the burden of proof must require the prevailing party to have stronger evidence than the losing party, i.e., a "preponderance" of the evidence in most civil actions, "clear and convincing evidence in others, and "beyond a reasonable doubt" in criminal matters. Because there is only one party in VA proceedings, that is unnecessary, and because of the benevolent purpose of VA benefits, the VA's burden of proof is designed to favor the veteran where the evidence is inconclusive, as evidence often is. The veteran therefore prevails where his or her evidence is at least as strong as that against the claim. This long-standing rule has also been codified into statute. VA has no discretion to deviate from it.

## Congressman Evans to AMVETS

Answers to questions about AMVETS Executive Director's testimony regarding the VA National Cemetery System.

**Question:**

Should the VA prioritize its resources and dollars on the expansion of the NCS or should the repair and maintenance of the existing facilities be the first goal?

**Answer:**

It is not possible to prioritize expansion over maintenance. New cemetery projects come out of the major construction dollars and maintenance comes out of the operations dollars. It depends on what conditions and customer demands are locally. We need to fund both. The IB recommendation for major construction projects, which covers the construction of new cemeteries is \$391,499. We also recommended \$4 million in additional funds to reduce equipment backlog.

**Question:**

What should the VA do to meet the needs of veterans in this area?

**Answer:**

We recommend an appropriation of \$85,550,000 for the National Cemetery System in FY 1988, which is an increase of \$1,367,000 over the FY 1998 VA budget request. We believe the VA should do the following:

1. Aggressively pursue an open cemetery in each state.
2. Expand existing national cemeteries wherever possible.
3. Recommit to a policy of maintaining an open national cemetery within 75 miles of 75% of America's veterans.
4. Seek relief from historic preservation requirements at NCS facilities wherever appropriate.
5. Conduct a feasibility study to promote a second national cemetery to ease the demand for space at Arlington National Cemetery.



MAY 02 1997



*Motto: "If I cannot speak good of my comrade, I will not speak ill of him."*

## DISABLED AMERICAN VETERANS

NATIONAL SERVICE and LEGISLATIVE HEADQUARTERS  
807 MAINE AVENUE, S.W.  
WASHINGTON, D.C. 20024  
(202) 554-3501

April 29, 1997

Honorable Lane Evans  
Ranking Democratic Member  
House Committee on Veterans Affairs  
335 Cannon House Office Building  
Washington, D.C. 20515

Dear Representative Evans:

In reply to your March 18, 1997, follow-up to my February 27, 1997, testimony before the committee, attached please find the answers to your questions.

In my testimony, I refer to staffing reductions at the Veterans Benefits Administration (VBA) and Veterans Health Administration (VHA), and our concerns that the delivery of care and compensation to veterans will suffer.

Representative Evans, on behalf of the more than one million members of the DAV and our Women's Auxiliary, I greatly appreciate your efforts and look forward to working with you and your staff in the future.

Sincerely,

DAVID W. GORMAN  
Executive Director  
Washington Headquarters

DWG:lmb  
Attachment

**Question #1:** Could you go into more detail about the problems you believe the staff reductions will create?

**Response:**

The VA's plan to re-engineer its claim processing is included in and linked to its fiscal year 1998 budget request for VBA. Because this plan attacks the core problem of poor quality, it relies primarily on changes in adjudicator responsibilities and job duties, retraining and shifting of emphasis, rather than a fundamental, and probable more costly, reinvention of the system. Therefore, VA's plan does not require infusion of substantial additional resources. Indeed, VA's 1998 budget request proposes reducing the staffing in VBA by 543 full-time employees, and quite frankly, that is one part of VA's plan that concerns us.

We simply do not believe that the benefits programs -- which are already strained -- can suffer these staffing reductions and maintain -- much less improve -- services to veterans as envisioned. It is especially questionable how VA can improve service to veterans and continue to reduce its compensation and pension claims backlog while, at the same time, reducing staffing by 100 in the Compensation and Pension Service alone. Although VA's reengineering plan is designed to increase efficiency, even VA does not expect to realize this increase in the first year. The initial changes will be made in 1998, but the full effects of the initiatives are not expected to be realized until the year 2002 when the plan is fully implemented. Attainment of VA's goals of more timely and accurate claim processing with fewer employees in the near term seems unrealistic.

We are similarly concerned that VHA is unrealistic in its plan for improving health care delivery when it proposes to reduce staffing by 2,135 in fiscal year 1998.

Here again, VA's formula suggests an increase in the level of services with fewer employees through projected increases in efficiency. VHA is, unquestionably, in a state of fundamental transition, with an ambitious plan for the future of veterans' health care. However, such a plan must be supported by adequate and a realistic levels of resources, both fiscal and human. In the near term, significant staffing reductions will, in our view only serve to compromise VHA's ability to proceed with meaningful reform.

**Question #2:** In particular can you cite and describe any areas or facilities that have already been adversely affected by these cuts or will be?

**Response:**

Because the VA's Veterans Equitable Resource Allocation (VERA) system was not implemented until April 1, 1997, data does not exist that would verify our concerns.

The DAV, employs 271 full-time National Service Officers who have regular contact with VA Medical Centers (VAMCs). Additionally, we 168 Hospital Service Coordinators in place who oversee the DAV Transportation Network as well as assist and refer over 24,000 veterans to our core of National Service Officers.

DAV's, Hospital Service Coordinators and volunteers form a hospital-based service program that thousands of veterans and their families have come to know and trust when assistance or problems arise.

As of April 1, 1997, the DAV and our Women's Auxiliary have an accumulated 2,318,536 hours of volunteer service to hospitalized veterans throughout the VA health care system. This figure is the equivalent of approximately 1,200 full-time VA employees.

It is based primarily on our daily contact with these individuals and veterans which causes the ongoing concern that staffing reductions will impact negatively on the health care delivery to our Nation's disabled veterans.

VFW'S RESPONSE TO THE QUESTION  
FROM FEBRUARY 27, 1997, HEARING  
COMMITTEE ON VETERANS AFFAIRS' BUDGET FOR FY 1998

QUESTION SUBMITTED TO THE VETERANS OF FOREIGN WARS  
OF THE UNITED STATES

**QUESTION:**

One of the issues I have addressed in the past has been the provision of long-term and nursing home care to elderly veterans. I was encouraged to see you give this issue so much attention in the Independent Budget and I agree with your conclusions.

No one can argue that the VA population is rapidly aging and will continue to do so well into the next century.

Thus, increasingly Congress and the Department of Veterans Affairs will be forced to find greater resources to provide for elderly and indigent veterans throughout our nation. This fact we cannot avoid and it must be reflected in future VA budgets.

Mr. Steadman, in your opinion has the VA begun to adapt its construction priorities to address the demand for long-term care and what specifically can the VA do better in this regard?

**RESPONSE:**

There is still much to be done by VA in meeting the demand for long-term health care. The Federal Advisory Committee on the Future of VA Long-Term Care shares your concerns and is currently addressing some of the concerns you raise.

One issue the VFW is concerned with is long-term care being funded on a discretionary basis. Until long-term care is a mandated appropriation, we believe VA will have difficulty in meeting its obligation to our aging veterans population. While we are encouraged by VA's plan to provide funding for long-term care, reality dictates that the bulk of construction funds will be for mandated projects.

With respect to where VA can improve, the FY' 1998 "Independent Budget" details a long-term health care strategy to provide for the aging veterans population.



March 19, 1997

The Honorable Chris Smith  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Smith:

At the February 27, 1997 House Committee on Veterans' Affairs hearing on the Administration's proposed FY 1998 budget for the Department of Veterans Affairs you asked for the views of Paralyzed Veterans of America (PVA) on a proposal that would tie the VA research appropriation to a fixed annual percentage of the overall VA medical care account. We do not believe this to be a good idea.

It is true that annual fluctuations in funding for any research enterprise can have a serious impact on the consistency and success of the research product. Constant under funding limits the amount of quality research conducted in the VA. Shortages and inconsistencies in funding also force many outstanding VA clinician-researchers to leave the VA to seek research funding elsewhere. The quality of VA health care and the welfare of the veteran patient are net losers when this happens.

PVA has objected to the constant under funding of VA research in comparison to major increases enjoyed by the National Institutes of Health and Department of Defense research programs over the past decade. However, the problems facing VA research cannot be solved by changing how the research account is budgeted, but by how many dollars are appropriated for the account in the first place.

Successive Administrations have "played games" with VA research, discounting or reducing research funding in their budget requests to use those dollars elsewhere. The Executive Branch has known that support for the program is strong in the Congress and that those funds will be eventually restored in some fashion. Certainly, while yearly appropriations are being finalized, there ensues considerable consternation within the

The Honorable Chris Smith  
March 19, 1997  
Page Two

VA research community, its supporters in the Congress and elsewhere. The main problem with this scenario, particularly in times of fiscal austerity, rests in the fact that the Appropriations Committees must spend all their efforts finding the resources to offset the Administration's cuts, with little left over to give VA research the additional funds that have been enjoyed by other federal research programs. Finding the funds to offset the unprecedented cuts proposed by the Administration for FY 1998 will be an even greater challenge.

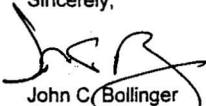
Over the years, certain VA research advocates have proposed the plan you referenced during the hearing to avoid the anxiety of the budget process by tagging the VA research budget to an automatic annual percentage of the Medical Care account. While this would bring a certain amount of "calm" to the process, it would also create serious dangers in the future quest to seek adequate funding and needed increases in the program. Medical Care budgets, too, have seen their ups and downs over the years. As their fate waxes and wanes, so would the fortunes of the VA research program. For example, the Administration's FY 1998 proposal would straight-line medical care appropriations, with a \$56 million cut below FY 1997 levels, through the year 2002. Collection and retention of reimbursements from third parties or Medicare, designed by the Administration to offset future flat medical care appropriations, are far from a legislative reality. These funding sources could also potentially not be adequate to offset the declining value of the appropriated dollar over that period of time. We believe the VA research account would be in far greater jeopardy tied to the uncertainties, fluctuations and administration of the medical care account than it is now experiencing with the heightened visibility and identity as a distinct program receiving annual review and adjustment by the Congress. For these reasons, we would oppose tying research funding to a percentage of the medical care account.

The VA research program is a major national asset. It assists VA in attracting and retaining clinicians of the highest caliber who utilize that expertise in caring for veterans. VA research is responsible for major breakthroughs in medical science that benefit veterans and all Americans. We look forward to working with you and other members of Congress to see the program receive the funding it deserves.

The Honorable Chris Smith  
March 19, 1997  
Page Three

Thank you for asking us to respond to this matter. I request that this response be made a part of the hearing record.

Sincerely,



John C. Bollinger  
Deputy Executive Director

cc: Honorable Bob Stump  
Honorable Lane Evans  
Honorable Cliff Stearns  
Honorable Jerry Lewis  
Honorable Arlen Specter  
Honorable John D. (Jay) Rockefeller  
Honorable Christopher (Kit) Bond

**The  
American  
Legion**



For God and Country

DC

MAR 27 1997

March 18, 1997

The Honorable Bob Filner  
Chairman  
Subcommittee on Compensation, Pension,  
Insurance, and Memorial Affairs  
Committee on Veterans Affairs  
Cannon House Office Bldg., Rm. 355  
Washington, DC 20515

Dear Congressman Filner:

This is to respond to the written question from  
February 27, 1997 hearing.

**Question:** In the area of VBA issues, what do each of you  
consider the most critical areas of concern? Where should  
Mr. Quinn and I focus our energies?

**Answer:** In the view of The American Legion, many of VBA's  
current problems, such as the backlog of pending claims,  
over 70,000 appeals initiated each year, and the fact that  
the BVA overturns about two-thirds of the regional office  
decisions, are directly attributable to inadequate staffing  
resources and the emphasis by VA management on the number of  
decisions produced by the regional offices rather than the  
quality of the decisions.

By "quality", we mean decisions which are fair, proper,  
and understandable, both from the claimant's standpoint and  
the legality and propriety as determined by the BVA and the  
Court. The issues of quality and timely service are  
inseparable. We believe it is difficult to improve quality  
without requiring personal and organizational accountability  
which is something the current system lacks. The Committee  
should examine the impact this has on the way the current

system functions, the resource implications, and VBA's efforts to address the problem.

While we recognize that final action on VBA's staffing requests rests with the Congressional Budget and Appropriations Committees, it will be important that the Veterans Affairs Committee examine what VBA's real staffing needs are currently and over the next five years. Cuts in prior years have drastically changed the experience level of VBA field personnel. This has resulted in a high percentage of trainees and an acknowledged increase in the error rate, appeals and remands. Improve training and communication, along with computer modernization has not been able to make up for these losses or even maintain the prior level of quality. VBA is facing even further cuts which will, in our opinion, seriously undermine VBA's planned improved service goals and waste critically needed resources.

We also believe the Committee should consider the current VA/DOD relationship as it affects individual and VA's ability to process disability claims. We believe it would be beneficial to promote efforts are underway to establish closer cooperation and coordination between VA and DOD to make separation physical examinations "adequate" for VA rating purposes. Historically, the armed services and VA have had very different missions and priorities when it comes to examining and treating individuals about to be separated from the military. DOD has not been very concerned about what happens after someone leaves active duty - that is VA's responsibility. The fact that a veteran may subsequently have difficulty in establishing a claim for service connection with VA because of an inadequate separation physical exam is not a priority for DOD. VA has recognized that this is a very real problem for individual veterans. It also has a very direct impact on the agency workload. To its credit, VA has taken the initiative to begin the process of integrating the separation physical exam process into the claims adjudication process.

It would be our recommendation that Congressional attention be focused on ensuring the success of VBA's various business reengineering initiatives, including efforts to forge a closer working relationship between VBA and BVA in order to reduce the underlying cause(s) of many appeals to BVA and the Court.

**Question:** The tradition has long been that VA and veterans should not be adversaries - and that VA should err on the side of the veteran when making tough decisions regarding issues such as benefit eligibility. Many of your comments and recommendations to the Congress seem to indicate that

the quality of the relationship between VA and veterans has eroded. Did I interpret your testimony correctly?

**Answer:** The VA was established to serve veterans and through the years, The American Legion has always been among the agency's strongest supporters. However, where warranted and necessary to protect benefits and programs for veterans and their families, The American Legion has been among VA's most outspoken critics.

As described in our testimony, veterans are entitled to better service on their claims than they now receive from VA. Likewise, VBA has a variety of initiatives underway and in the planning stages that intended to make the claims process more "user-friendly", efficient, accurate, and cost-effective. Given the severe budgetary challenges facing the agency and long-standing problems in providing quality service in a timely manner, we believe it is imperative that all of these initiatives be successfully implemented within the projected five year timeframe. If this can be accomplished, in general, veterans and other claimants will find it easier to get assistance from VA, speedier claims processing and benefit payments. Such changes should also help reduce the overall appellate caseload and resources on remands caused by poor or inadequate development.

With regard to your concern about a possible erosion of the veteran's relationship with VA, we do not believe there has been any fundamental change in this relationship. The claims adjudication process has always been legally and procedurally complex, and, therefore, adversarial to a considerable degree. Veterans claims have always had to meet certain statutory and regulatory criteria. The difference now is that veterans are becoming aware of these requirements, thanks to the Court of Veterans Appeals. The Court is forcing VBA to provide veterans full due process as well as reasons and bases for the decisions on their claims. This is long overdue. Veterans need to know and are entitled to know the "rules of the game." This is only basic fairness, even though it has meant more work for VBA.

Prior to the enactment of PL 100-687, the "Veterans Judicial Review Act of 1988", VA liked to describe its claims adjudication process as "paternalistic", ex parte, and, therefore, fair and benevolent. As evidence of VA's liberal, nonadversarial, policy, reference was frequently made to the regulation which provided that where the evidence in a case was evenly balanced, the doctrine of "reasonable doubt" was to be applied, or as stated in your question - "VA was to err on the side of the veteran..." However, we believe this portrayal has given veterans and other claimant unrealistic expectations about the adjudication process. In reality, relatively few veterans profited from this type of system, because in many

instances, VA would not or could not do "the right thing the first time." Regional office decisions were often arbitrary with little or no explanation of the reasons for a decision. The BVA, was the sole arbiter of whether or not a regional office decision was consistent with the law and regulations. Moreover, there was no way for a veteran or other claimant to challenge the legality or propriety of BVA decision, except on a constitutional issue.

The enclosed chart of the BVA's activity illustrates the restrictive and conservative nature of the adjudication and appeals process, prior to the advent of judicial review. In the 1970's and 1980's, the decisions of the regional office's were upheld about 70 percent of the time with about 12-13 percent of the appeals allowed and 14-15 percent remanded. The Court has not created "new" law; rather it has required that the BVA and regional offices follow existing law and regulations. As indicated, BVA is now overturning regional office decisions, in whole or in part, about 70 percent of the time. The increased allowance and remand rates are beneficial to many veterans on an individual basis. However, it is also a clear indication of continuing poor quality decisions by the regional offices. Thousands of veterans have been forced into the appellate process needlessly which has wasted the energy, time, and resources of all parties concerned.

Given the nature of the VA's mission, there has always been a fundamental tension between balancing the mechanical/administrative demands of a voluminous workload and the need to render decisions which are fair to the claim and legally proper. Persistent staffing cuts through the years and criticism of claims processing delays have added substantially to that tension. If the primary management goal is to process thousands of claims as quickly as possible, quality is bound to suffer and there are few, if any, disincentives or consequences personally or organizationally if an employee makes an erroneous decision. Rather, employees are rewarded and promoted based on production.

Even though the claims adjudication process is now more formalized, it is not any less complex or adversarial than it ever was, in our opinion. If anything, it is now more open to public, Congressional, and judicial scrutiny which helps promote fairness. We realize this perception may not be shared by all. However, our concern is that the system not become any more legalistic or adversarial than it already is.

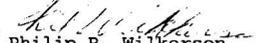
We support VBA's efforts to make the system more accessible, more "user friendly, and more informative for claimants and their representatives. These coupled with initiatives focused on improving the quality of adjudication

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actions should go a long way towards minimizing the negative aspects of judicial review and improving service to all claimants.

We appreciate this opportunity to share these views with you and the Members of the Committee.

Sincerely,

  
Philip R. Wilkerson  
Dep. Dir. for Operations  
National Veterans Affairs and  
Rehabilitation Commission

cc: John Vitakacs  
Steve Robertson

APPEALS STATISTICAL DATA - BOARD OF VETERANS APPEALS

	FY 1977	FY 1978	FY 1979	FY 1980	FY 1981	FY 1982	FY 1983	FY 1984	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	1997	1998		
<b>FIELD WORKLOAD DATA</b>																								
Appeals Filed (000s).....	6278	8644	6107	6370	8812	6658	8021	6128	6505	6350	6370	6708	6820	6104	6127	6142	6062	5878	6132	5719	5757	5810	5757	
% Allowed.....	52.7%	52.7%	52.7%	52.7%	52.7%	52.7%	52.7%	52.7%	52.7%	52.7%	52.7%	52.7%	52.7%	52.7%	52.7%	52.7%	52.7%	52.7%	52.7%	52.7%	52.7%	52.7%	52.7%	
% Denied.....	47.3%	47.3%	47.3%	47.3%	47.3%	47.3%	47.3%	47.3%	47.3%	47.3%	47.3%	47.3%	47.3%	47.3%	47.3%	47.3%	47.3%	47.3%	47.3%	47.3%	47.3%	47.3%	47.3%	
% Withdrawn (and Other).....	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Pending - End of Period.....	23792	35822	36862	43528	46400	47981	49408	48818	44145	43727	46625	49111	48450	48111	48450	48111	48450	48111	48450	48111	48450	48111	48450	
<b>BVA WORKLOAD DATA</b>																								
Dispositions.....	32991	36565	34124	30028	34666	35819	34273	34273	34273	34273	34273	34273	34273	34273	34273	34273	34273	34273	34273	34273	34273	34273	34273	
% Allowed.....	12.7%	12.9%	12.7%	12.4%	13.0%	13.7%	13.9%	13.2%	13.9%	13.2%	13.9%	14.4%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	
% Denied.....	87.3%	87.1%	87.3%	87.6%	86.9%	86.3%	86.7%	86.8%	86.1%	86.8%	86.1%	85.6%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	
% Withdrawn (and Other).....	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Pending at BVA - End of Period.....	11470	12444	11638	7812	8027	12115	14487	12681	14552	14457	16642	22188	18450	17235	21881	33728	29750	13474	12935	13474	12935	13474	12935	
Pending Pending for BVA Review.....																								
<b>MC Receipts.....</b>	129	131	182	147	117	153	148	153	151	178	113	113	64	105	119	160	187	154	379	91	38	0	0	
<b>ADP Receipts.....</b>	43	70	43	64	47	48	76	73	44	13	23	25	12	15	12	15	10	13	5	0	0	0	0	
<b>Reconsiderations.....</b>	225	234	264	262	250	208	265	200	277	264	291	282	217	188	221	161	197	134	78	10	10	10	10	
% Allowed.....	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
% Denied.....	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
% Withdrawn (and Other).....	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
<b>Benefits Granted by AOJ.....</b>																								
Personal (000s).....	498	608	484	482	522	484	587	708	645	645	665	641	620	440	872	1258	3532	1990	553	2445	787	170		
Travel (000s).....	35	38	33	33	34	48	50	48	48	48	51	32	48	38	52	52	56	47	12	53	14	14		
Other (000s).....																								
<b>Complaints of Appeals.....</b>																								
Disability (000s).....	78.2%	78.4%	78.6%	77.7%	78.2%	78.6%	78.3%	75.7%	75.2%	75.2%	77.1%	78.5%	78.4%	81.8%	81.7%	82.2%	83.4%	83.8%	84.7%	85.3%	85.3%	85.3%	85.3%	
Death (000s).....	1.2%	1.1%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	
Non-Disability (000s).....	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	
Death.....	6.8%	7.0%	7.1%	6.4%	6.0%	6.0%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	
Medical.....	2.8%	2.7%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	
Low Country.....	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	
Medical.....	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	
Non-Disability.....	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	
Medical.....	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	
Non-Disability.....	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	
<b>FIELD AND BVA COMPLETED</b>																								
Field (000s).....	60113	58127	58783	56058	61352	61518	60132	61095	61411	61411	60551	60551	60551	60551	60551	60551	60551	60551	60551	60551	60551	60551	60551	
Field (000s).....	23.9%	24.9%	23.9%	23.9%	23.9%	23.9%	23.9%	23.9%	23.9%	23.9%	23.9%	23.9%	23.9%	23.9%	23.9%	23.9%	23.9%	23.9%	23.9%	23.9%	23.9%	23.9%	23.9%	
BVA (000s).....	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	
% Allowed.....	41.8%	41.8%	41.8%	41.8%	41.8%	41.8%	41.8%	41.8%	41.8%	41.8%	41.8%	41.8%	41.8%	41.8%	41.8%	41.8%	41.8%	41.8%	41.8%	41.8%	41.8%	41.8%	41.8%	
% Denied.....	58.2%	58.2%	58.2%	58.2%	58.2%	58.2%	58.2%	58.2%	58.2%	58.2%	58.2%	58.2%	58.2%	58.2%	58.2%	58.2%	58.2%	58.2%	58.2%	58.2%	58.2%	58.2%	58.2%	
% Withdrawn (and Other).....	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
<b>Elapsed Processing Time - Days</b>																								
MC to BVA.....	88	85	84	84	84	84	84	84	84	84	84	84	84	84	84	84	84	84	84	84	84	84	84	
BVA to BVA.....	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	
BVA to AOJ.....	74	77	89	58	128	176	180	151	154	154	154	154	154	154	154	154	154	154	154	154	154	154	154	
Disposition to BVA.....																								
Average Return Time Factor.....	102	122	127	102	101	100	111	117	114	106	130	136	38	38	38	38	38	38	38	38	38	38	38	
<b>Average BVA Review Time</b>																								
Appeals Pending at BVA.....	102	122	127	102	101	100	111	117	114	106	130	136	38	38	38	38	38	38	38	38	38	38	38	
Appeals Pending for BVA Review.....																								
<b>Pending - End of Period.....</b>																								
Field (000s).....	3782	46116	47488	51337	55643	59776	64248	63135	60620	59999	61082	64233	70738	70738	70738	70738	70738	70738	70738	70738	70738	70738	70738	
BVA (000s).....	8118	9818	11640	17157	22773	25835	27889	24582	23454	23289	23078	21688	23265	23265	23265	23265	23265	23265	23265	23265	23265	23265	23265	
BVA - Total (000s).....	11470	12444	11638	7812	8027	12115	14487	12681	14552	14457	16642	22188	18450	17235	21881	33728	29750	13474	12935	13474	12935	13474	12935	

\* Denominator data is unrounded and based on unrounded data to avoid rounding errors. Unrounded data is available for computer use.

1996 JAN 3 1997



## **Non Commissioned Officers Association of the United States of America**

225 N. Washington Street • Alexandria, Virginia 22314 • Telephone (703) 549-0311

Follow-up Questions from the Honorable Bob Filner  
from the Full Committee Hearing held  
February 27, 1997

**QUESTION:** In the area of VBA issues, what do each of you consider the most critical areas of concern? Where should Mr. Quinn and I focus our energies?

**NCOA RESPONSE:** NCOA believes that the Committee's proposed oversight plan, and specifically the plan for the Subcommittee on Benefits, offers an excellent blueprint. Within that plan, the Association asks that you give priority to the following issues.

NCOA requests that hearings be held to comprehensively review the veteran education benefit. As indicated in our prepared testimony and oral comments, the Administration has ignored veteran education programs altogether in their FY98 Budget yet the President has proposed record levels of Federal spending on education. NCOA believes the Veteran's Committees have a duty to restore the veteran benefit to the "flagship" of all federal education programs. The Association also urges the Committee to provide an MGIB enrollment opportunity for those VEAP participants excluded from the legislation passed by the 104th Congress.

The procedures for processing and adjudicating claims for veterans benefits remains a problem. It is NCOA's understanding that the Committee plans to conduct hearings in this area and the Association certainly wants to be a part of that dialogue. The recently released results of the Veterans' Claims Adjudication Commission, along with VA's Internal Business Process Re-engineering efforts would, in our view, be a logical basis for any hearings. The Association also asks that swift action be taken on proposed legislation to allow revision of veterans benefits decisions based on clear and unmistakable error.

NCOA also believes the Committee's attention is needed in the Veterans Employment and Training Service (VETS) (specifically priority of service to veterans as one-stop career centers are further implemented) and VA's vocational rehabilitation program.

**QUESTION:** The tradition has long been that VA and veterans should not be adversaries - and that the VA should err on the side of the veteran when making tough decisions regarding issues such as benefit eligibility. Many of your comments and recommendations to the Congress seem to indicate that the quality of the relationship between the VA and veterans has eroded. Did I interpret your testimony correctly?

**NCOA RESPONSE:** NCOA's testimony on the FY98 VA Budget sharply criticized the Administration in three areas - veterans health care, veteran education benefits, and the National Cemetery System. NCOA is not convinced that this budget represents the best we can do for veterans in context with an overall \$1.7 trillion proposal. New spending and entitlements are contained in the Administration's budget while veterans are being asked to find non-federal revenue sources to fund their programs which were earned through prior honorable military service and sacrifice. Past efforts by veterans to help in reducing deficits and balancing federal budgets seem to have been ignored or forgotten. NCOA will always be critical of any Administration that puts forth a budget proposal such as the one we now have for veterans for FY98 and beyond.

NCOA has a long and proud history of cooperation and interaction with VA and we certainly envision a continuation of that relationship. A quality relationship though does not mean that NCOA will always agree with everything proposed by the Department. This Association simply believes that we can do better for veterans in FY98 and the out-years than what the Administration has proposed in its budget. NCOA would be grossly negligent if we left any other impression with the Committee.

*Chartered by the United States Congress*

**Veterans of Foreign Wars Response to  
February 27, 1997 Full Committee Hearing Questions  
Submitted by Congressman Bob Filner**

**In the area of VBA issues, what do each of you consider the most critical areas of concern? Where Should Mr. Quinn and I focus our energies?**

Instrumental to our future ability for effective veterans' representation will be Veterans Benefit Administration's ability to bring on-line soon VETSNET and its important, inclusive software applications (the complete VBA Information Resources Management Support Plan). Integral to that will be the successful accomplishment of the goals and initiatives espoused in the VBA's Business Process Reengineering (BPR) plan submitted as part of the VA's Fiscal Year 1998 budget. We elaborate in our response to the next question.

**The tradition has long been that VA and veterans should not be adversaries - and that the VA should err on the side of the veteran when making tough decisions regarding issues such as benefit eligibility. Many of your comments and recommendations to the Congress seem to indicate that the quality of the relationship between the VA and veterans has eroded. Did I interpret your testimony correctly?**

In reality, the system was far more adversarial to veterans prior to the Veterans' Judicial Review Act of 1988. Adjudicators and rating specialists were autonomous and arbitrary in their decision-making. The VA has made great strides in changing that historical and entrenched culture and, right now, a veteran stands the best chance ever for a proper and correct decision on a claim, as Congress has always intended the system to be.

We do not believe the VA's present claims processing system is irrevocably broken, as some are suggesting. Quite the contrary, we feel the VA has turned the corner and is now headed in the right direction in resolving the past problems on timely and quality decision-making.

There is still room for improvement. The Veterans of Foreign Wars has long-held that the focus must be on three major issues: quality decision-making at the regional office on benefit claims; reduction of the Board of Veterans' Appeals decision time-lag; and, the high BVA remand rate. (The two appellate review problems are almost entirely integrated in decision quality at the regional office.) Solve these and all other claims processing problems will essentially resolve. But, for certain, these problems hardly describe a situation that indicates the whole system is in need of total restructuring.

That now means concentration more on "symptoms" rather than "causes". The goals and initiatives espoused in the VBA's BPR plan are commendable and should be embraced as the primary means to do that. Implementation is the more important question. VETSNET is the right approach to accomplish that. We feel it vital that excellent congressional oversight on both BPR and VETSNET, as performed in the past by Congressman Everett and his subcommittee, must continue.

In sum, we believe that our present relationship with the VBA is a viable, working professional partnership in service to our nation's veterans.

If you desire, we will be glad to further discuss these issues with you.

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