

DEPARTMENT OF VETERANS AFFAIRS BUDGET  
REQUEST FOR FISCAL YEAR 2000

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HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

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FEBRUARY 11, 1999

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# DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2000

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THURSDAY, FEBRUARY 11, 1999

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

The committee met, pursuant to notice, at 9:33 a.m., in room 334, Cannon House Office Building, Hon. Bob Stump (chairman of the committee) presiding.

Present: Representatives Stump, Smith, Bilirakis, Spence, Everett, Buyer, Quinn, Stearns, LaHood, McKeon, Gibbons, Evans, Filner, Gutierrez, Brown, Doyle, Peterson, Reyes, Snyder, Rodriguez, Shows, and Berkley.

## OPENING STATEMENT OF CHAIRMAN STUMP

The CHAIRMAN. The committee will please come to order. Today we are meeting to hear testimony on the Veterans Affairs budget for fiscal year 2000. We will hear both from the Department of Veterans Affairs and from various veterans' service organizations.

I want to begin the hearing, Mr. Secretary, by welcoming you back for your appearance here. We appreciate you coming down. I know the members will have some questions.

As you know, Mr. Secretary, each year we view the budget as a gauge of how well we are meeting our commitments to our veterans. The VA budget for fiscal year 2000 appears to be adequate for benefit programs and for cemetery administration. However, the administration's proposal to deny even the smallest budget increase for VA health care programs is very troubling.

Mr. Secretary, your budget identified hundreds of millions of dollars needed for existing fixed costs, new advanced treatments, and new initiatives to provide a fuller continuum of care to veterans. Unfortunately, the administration has not included any new funding to address those needs.

As with last year's budget, the VA predicts overly optimistic insurance revenue for non-service-connected care. But more significantly, this budget triples projected savings from unspecific management initiatives.

While the past VA health care budgets have assumed savings of \$200 to \$300 million, this year's budget asks Congress and veterans alike to rely upon VA's stated ability to save an unprecedented \$1.4 billion in fiscal year 2000. We are most anxious for you to be able to expand on this part of the budget, if you would.

At this time, I would yield to ranking member of the committee, Mr. Evans from Illinois.

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

Mr. EVANS. Thank you, Mr. Chairman. I join with you in welcoming Secretary West and the other witnesses here today. I am especially pleased that the Secretary is here to help us better understand the proposed budget.

This budget contains many important veterans' initiatives that I strongly support. When these initiatives are realized, there will be real improvements in veterans' benefits and services.

Unfortunately, this budget provides no more dollars or other resources for these initiatives. This budget may underfund veterans' programs next year by as much as \$2.5 billion, possibly more.

This budget is like building a house of cards. It is trying to add more stories but with no more resources. This may work for a while, but eventually the house of cards will fall.

Having said that, it is important to emphasize some of the commendable initiatives included in this budget. I have been an advocate for a long period of time for improving veterans' access to non-VA emergency care. Last month I introduced the Veterans Access to Emergency Care Act of 1999. The budget takes a small step in the right direction on this important, life-saving issue.

The budget also increases assistance to homeless veterans, expands VA treatment for veterans with hepatitis C, and continues current efforts to improve the quality and timeliness of veterans' claims processing.

It also proposes increasing VA non-institutional long-term care for veterans, providing more funds for the establishment of State veterans' cemeteries, and providing a cost-of-living adjustment to veterans receiving service-connected disability compensation.

It will be up to this Congress to supply the new resources required for this budget to become a real blueprint for improving veterans' benefits and services. I will fight for the needed programs and resources that veterans need.

This budget can be laid on the doorstep of the administration, but only for so long. It is this Congress that determines our national priorities and spending. While the administration proposes, it is the Congress that disposes.

I look forward to working with other members who support our efforts, Mr. Chairman, and I appreciate this opportunity to speak.

[The prepared statement of Congressman Evans appears on p. 67.]

The CHAIRMAN. Thank you, Mr. Evans.

Mr. Secretary, we will turn to you now, and some of the members, I am sure, will have questions after your statement. If you care to introduce those with you this morning, please do so. You may proceed at your own leisure. We will include your entire statement in the record, sir.

**STATEMENT OF HON. TOGO D. WEST, JR., SECRETARY,  
DEPARTMENT OF VETERANS AFFAIRS**

Secretary WEST. Thank you. I will introduce those who are seated with me, starting at my far right with the Acting Under Secretary for Memorial Affairs, Roger Rapp. Next to me, Dr.—

The CHAIRMAN. Let me interrupt you. We need to get one of the microphones just a little closer, if you would, sir.

Secretary WEST. Is this better?

The CHAIRMAN. That is fine. Thank you, sir.

Secretary WEST. Thank you, Mr. Chairman. I will start on my immediate right, your left, by introducing the Acting Under Secretary for Memorial Affairs, Roger Rapp, raising his hand. On my immediate right, closer, Dr. Kenneth Kizer, the Under Secretary for Health. On the far left, Joe Thompson, the Under Secretary for Benefits, and to my immediate left, the Deputy Assistant Secretary for Budget, who, I think is well-known to you and staff, Mark Catlett.

Mr. Chairman, thank you for putting the full statement in the record. If I may, I will just highlight a few instances in it that I would like to call your attention to, and then we can get right to the questions.

Mr. Chairman, Ranking Member Evans, members of the committee, thank you for the opportunity to appear before you today to present the President's budget for fiscal year 2000 for the Department of Veterans Affairs. This is a total budget of \$43.6 billion, and as you pointed out, Mr. Chairman, it is largely in the area of health affairs, a straight line from the previous budget relying on medical collections for our increase.

We build on previous accomplishments to include the savings that we have already demonstrated this Department can make. We seek in the area of health affairs \$18.1 billion, all discretionary, including \$749 million in medical collections, to provide care for eligible veterans. To increase access, the Department of Veterans Affairs will open in fiscal year 2000 89 new community-based outpatient clinics to treat 54,000 more patients than in 1999.

This continues our emphasis to move from inpatient care to outpatient care, but more than that, to bring the care to where the veterans are located, perhaps the single most significant effort we have underway in an effort to assure veterans the quality care from their country that they have earned.

We are proposing \$50 million in additional funding for homeless veterans, those who have served their country but who have at the end of the day no roof under which to lay their heads, including among this \$40 million in medical and \$10 million in mandatory transitional housing subsidies.

We are asking for a \$136 million increase in VA's efforts to combat hepatitis C, and we are proposing to increase our long-term care alternative programs by another \$106 million.

Mr. Chairman and members of the committee, as we proposed last year, the administration supports a Medicare subvention demonstration program, though it is not included in our budget presentation. This will help us to fully utilize VA's medical capacity. Once again, Mr. Chairman, we would like to express our thanks to you

and to this committee for your support and continued leadership in this effort to provide subvention for veterans.

As you have undoubtedly noted, much of the success of our budget in coming fiscal year and after fiscal year 2000 will depend on obtaining that stream of assistance for our veterans and revenue for the Department.

This budget includes a proposal that would authorize VA to cover the cost of out-of-network emergency care for enrolled veterans with compensable disabilities related to military service. Let me just explain one part of that now, Mr. Chairman. Out-of-network is not a term of art that refers to moving between one of our facilities and another. It means any facility that provides care to a veteran in the civilian community other than a VA facility. This legislation would ensure that these veterans have access to emergency care when treatment in VA facilities is not an option.

I know this has been a matter of some concern to you and the members of this committee, and I look forward to the opportunity for Dr. Kizer and me to discuss this with you in greater detail in your questioning.

If there is an increase in our budget or an item of our budget that I think brings great hope to all of us this year, it is what we are doing in the VBA budget in terms of the operating expenses of the Veterans Benefits Administration. For 5 years, I have traveled this country, either as Secretary of the Army or as Secretary of Veterans Affairs. And although often our veterans express to me their belief that the health care they have received is the best—I have the best doctor, I have the best nurse, I have the best technician—if I ask them if something is troubling them, it is that they have a claim pending and that they would like to know what is happening or why we can't get it right.

Our effort in the budget this year is to emphasize Joe Thompson's, Under Secretary for Benefits, desire to make sure that we are on a path that assures veterans that we are not only handling their claims timely but that we are getting it right.

The budget provides \$860 million, \$49 million more in the discretionary part of operating and putting in his improvements. This is a 6 percent increase, Mr. Chairman, and will ensure that compensation, housing, education, and pension benefits to veterans will be delivered, and delivered in a process that we are structuring to ensure that it works for our veterans.

With this budget, we hope to assign 440 new employees to help process disability claims efficiently. This is a combination of new slots as well as reassigned slots that will be devoted to the claims process. I suspect you will have a number of questions about that as well, and we will be happy to entertain them.

We request for the National Cemetery Administration \$97 million, \$5 million more than in the 1999 enacted level, for the operations of the National Cemetery Administration.

Mr. Chairman and members of the committee, we are losing to death—pardon me just a moment, Mr. Chairman. I was going to give you the number of veterans daily that we are losing to death each week. Do you know those numbers?

Mr. RAPP. We are losing about 550,000.

Secretary WEST. That is the one I want, 550,000 per year to death. This means that the workload for our cemeteries is increasing and that the need for improving the ways in which we can operate them and, more importantly, assuring that we will open the new ones on time, the reasons the requirements are increasing. We expect this budget then to provide for the activation of first-year operations of four new national cemeteries. With the opening of these four, we will be closer to our goal of 80 percent of our veterans being within a reasonable distance of a cemetery. The precise number will be 77 percent of veterans within reasonable distance of a State or national cemetery.

Mr. Chairman, with these and other adjustments to the budget, we believe that we are delivering for fiscal year 2000 a budget that is workable, that will provide for continuing increase in access to health care for our veterans, that will continue to see to the maintenance of the specialty programs for which our veterans rely on VA, and know that VA can provide when other medical facilities may not always be there. We are providing the assurance that there will be improvements in the claims processing, not only as to time limits but as to accuracy, and providing the assurance that when their life is ended, veterans will be treated honorably and located in a cemetery within reasonable proximity of their families.

All of these, we think, are worthy objectives. We seek your support of this, and we are ready for your questions.

The CHAIRMAN. Thank you, Mr. Secretary.

Let me remind members that we will follow the same format as we usually do. Those who were here when the gavel went down will be recognized alternating from side to side by seniority. Those that came in after the gavel will be recognized in the order that they came in.

I would now yield to Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman.

Mr. Secretary, in the first paragraph of your prepared statement, you report that the President's budget "acknowledges the Nation's responsibility to provide high quality care and services. In short, we believe that the fiscal year 20000 budget provides better and more accessible service to more veterans." Yet earlier this year, there was a news article entitled "Lack of funds prevents VA from delivering on promises." In that story, an official of one of the VA's premier medical centers bluntly states what too many veterans already know. He cautions that veterans seeking outpatient care may need to be patient; depending on demand, patients have to wait as long as 30 days or more to get an appointment with a primary care physician. If the number of veterans seeking treatment at the VA clinics exceeds their capacity, veterans may be referred to the private sector, which would then bill the VA for its services.

Under the President's budget, how many fewer days will veterans need to wait to get an appointment with a primary care provider? How much will the wait for the veterans' outpatient care be reduced? Is the long waiting time today for outpatient and primary care consistent with the delivery of high-quality care?

My point, Mr. Secretary, is this: The lack of funding already exists, preventing the VA from delivering on its promises to this Nation's veterans. The easy efficiencies have already been achieved,

and this budget requests no more resources to provide veterans better access to improve VA services and no more resources for the new initiatives in the budget. This budget is not about "Saving Private Ryan." It is about saving money, and I would like your response to those particular charges.

Secretary WEST. Well, let me see if I can point out a couple of things, Congressman, and I accept your judgment and also the fact that you have a record of passionately supporting our veterans and of proper funding. But I think for fiscal year 1999 that any innovations, any savings, any, if you will, right-sizing that we have done is less driven by budget, which frankly I think the budget that this Congress approved last year for this current fiscal year was not only adequate, but we were able to do the things we needed to do, but is driven by the shift in our priorities from inpatient treatment to outpatient treatment and a number of other things.

I am not sure about the waiting days you have outlined. I will leave that to Dr. Kizer to address. But my belief is that in fiscal year 1999 under almost any measure of satisfactoriness of the rendering of medical care, whether it is by our own benchmarking or benchmarking by outside authorities, we have provided superb medical care.

Those instances in which veterans have to wait long times for appointments are intolerable, and, yes, each instance that crops up is another marker for us to review what corrections need to be made. But I think our record for as much of fiscal year 1999 as we have been through is sustained not only by my own obvious willingness to stick up for our programs, but also by the fact that others who have evaluated them have said so.

In terms of the ultimate question, whether under the fiscal year 2000 budget we can deliver quality health care with reasonable accessibility for veterans, I think we can. Of course, we are expecting savings. The chairman pointed that out as he addressed one part of our budget. We are expecting \$1.4 billion in savings. That has to do with an assessment of how we operate, where we operate, and with what personnel we operate. But I think we will be able to do our job.

Now, on the specific questions of delays, may I let Dr. Kizer have a chance to respond to that?

Mr. EVANS. Yes, sir.

Dr. KIZER. I would note that we recognize waiting times are a problem in some places. I think the specific statistic that you refer to is the time for a new appointment in primary care. The number that you cite is not consistent with, at least, my understanding of what occurs in most places regarding follow-up appointments, with some exceptions as far as some of the specialty clinics.

There is no doubt that the system is stressed. Last year we had approximately 10 million more outpatient visits than we had 4 years ago. That is a huge increase and shift in care by anybody's standard. Indeed, it is unprecedented anywhere in American health care.

I would also note in the same vein that the number of patients with scheduled appointments who get in within 20 minutes of their scheduled time has increased by 50 percent in the last 4 years. Four years ago, about 40 percent of patients were getting in within

20 minutes of their scheduled time. Last year, this increased to two-thirds or 66 percent, which is still not adequate but it is certainly moving in the right direction.

The last thing I would note in this regard is that we are undertaking a systemwide collaborative effort with the Institute for Health Care Improvement in Boston—I think you are familiar with that entity, Mr. Evans—to see what we can do to improve waits and delays for appointments. We do believe that many of the problems that we have in this regard are process problems that are not solely, or in many cases not even in large part, driven by budgetary issues, but instead the problem is in how we schedule and arrange for the flow of patients.

Mr. EVANS. Thank you, Dr. Kizer.

The CHAIRMAN. Mr. Evans, did you have more of your question that was not answered?

Mr. EVANS. Just one quick question.

The CHAIRMAN. Go ahead.

Mr. EVANS. Thank you, Mr. Chairman.

Is it a 20-minute waiting period that people have after waiting 30 days to get that appointment?

Dr. KIZER. Yes, for the scheduled appointment. The specific index measure that is tracked is how long the patient waits when they have an appointment scheduled. Our goal is that within 20 minutes of the scheduled appointment time all patients will be seen by the caregiver.

Mr. EVANS. Thank you, Mr. Chairman.

The CHAIRMAN. The gentleman from Alabama, Mr. Everett, is recognized.

#### **OPENING STATEMENT OF HON. TERRY EVERETT**

Mr. EVERETT. Thank you, Mr. Chairman. Good to see you, Mr. Secretary.

Before I begin, let me mention something my colleague from Alabama, Mr. Callahan—who is on the Appropriations Committee, I would just add, incidentally—is concerned with the fact that about \$1.5 million was included in the fiscal year 1998 budget for cemetery expansion in Mobile, and I have some questions I will submit for the record concerning that. He is a little concerned that there has been no movement on that.

(See p. 205.)

Mr. EVERETT. Mr. Secretary, as you know, my Subcommittee on Investigations and Oversight has been concerned with how well the VA spends its money from time to time. There are many ways we can commend the VA, and there are other ways that I feel like that we can take another look at saving money. I would particularly urge you to take a look at energy savings and performance contracts, which we have had one hearing on, which would save you \$63 million a year, according to the Department of Energy estimates.

Mr. Secretary, the VA's projected collection for fiscal year 1997, 1998, and the first quarter of 1999 had shortfalls of \$28 million, \$49 million, and \$17 million, respectively. The planned goal for fiscal year 2000 is \$749 million, a great escalation.

How confident are you that that goal can be reached and that we are not talking about money that just won't be there?

Secretary WEST. Congressman Everett, I think we have reasonable confidence. I think that we continue to refine our collection efforts. We continue to learn more each year in terms of the best way to do it. I think Dr. Kizer in a moment will mention some further refinements that we have underway. We are considering some recommendations to include a little bit more centralization of how we do it. So I believe that when we put an estimate in there and it comes from Dr. Kizer's folks, it is a realistic estimate.

Will it be a stretch? Will we have to work hard at making sure that we first of all record our charges correctly, that we bill properly, and that we then follow up properly? Yes. But I don't think that we are dealing in make-believe here, because if we don't have the money, we are the ones who end up stuck with the question of what we do about it. So that is a very important source of revenue. That is roughly three-quarters of a billion dollars that we are counting on. I don't think we put that number in there lightly.

Mr. EVERETT. Dr. Kizer, before you answer, let me further this discussion by pointing out some other things. An April 1990 Coopers & Lybrand study of MCCR shows the following: Systemwide, VA identifies only 16 percent of its new patients having billable insurance while the private sector identifies 100 percent. Private sector clinicians and medical staff close treatment files within 5 days. It takes the VA 41 days to do so. Private industry takes an average of 9 days from the date of care to send a bill to payers while this process takes the VA 83 days. Industry collects \$2 to \$3 million per PTE while VA collects between only \$150,000 to \$200,000.

The same study also states that the most prevalent revenue measure used by health care industry is days in accounts receivable. The industry average is 60 days while the VA's money is tied up for 244 days.

Why would it take—Dr. Kizer, I will address it to you—the VA four times longer than it takes private industry? And also, if you would, address some of those other points that I brought out.

Dr. KIZER. I think the most straightforward answer to your question is simply that it was never important until a year ago. It never mattered to anyone because the money was not something that made any difference to the system. So I think that is the straightforward answer as far as why those numbers are as bad, if you will, as they are.

I would also note that the fact that you have those numbers—the fact that you can cite those statistics—is because I asked for the study and that we recognized that we were not performing well. We sought out expert help, identified where the problems were, and are taking corrective actions.

Indeed, I think Coopers & Lybrand also note in their study that we are being quite vigorous in our efforts to remedy those problems, and that if you took a snapshot today as opposed to a year ago, or so, when that study was done, you would find that there is significant improvement. But there is still substantial improvement that needs to occur. Let's not kid ourselves. Until a year ago, these funds didn't mean anything to the system. They were really on paper. They now make up part of our operating budget, and our

managers have a whole different attitude about it. They have to learn some new skills—some new ways of doing things. They are learning that and better results are being achieved.

Secretary WEST. If I might add, Congressman, you are right, and so is Coopers. We can't achieve the three-quarters of a billion operating the way they identify. As Dr. Kizer said, that is why we asked them to look at it to see if we could do the things we need to do. We don't expect to operate the way Coopers & Lybrand have done that. If we do, not only will we miss our target, but we will have lost the whole purpose of the study.

Mr. EVERETT. Thank you, Mr. Secretary. In light of everything these studies tell us, I would like to ask you which of your medical care collection functions can be immediately improved through contracting out? I would like for you to take a look at that, and, Mr. Chairman, perhaps Secretary West could provide the committee with his recommendations within 3 months. Would that be enough time?

Secretary WEST. Sure.

Mr. EVERETT. Thank you, Mr. Secretary. Thank you, Dr. Kizer.

The CHAIRMAN. Thank you, Mr. Everett.

The gentleman from California, Mr. Filner, is recognized.

Mr. FILNER. Thank you, Mr. Chairman. Just so I can structure some of my time, will we have an opportunity for a second round?

The CHAIRMAN. Yes, sir.

#### OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman.

Secretary WEST. Would you like me to give shorter answers, Congressman?

The CHAIRMAN. Always. If they are answered.

Secretary WEST. Okay.

Mr. FILNER. No. I just want more time for my questions.

Thank you, Mr. Secretary, and all your colleagues with you. We know your commitment to our veterans and, of course, earlier to our active-duty personnel, and we appreciate your service. We know that operating within the context of an administration and a budget process, there are probably things that you would like to do that, by the process that is given to you, you can't. I don't think we as a committee or as a Congress are necessarily constrained by that internal situation because, as I look at the budget and as other people such as the Independent Budget folks have looked at it, there is a consensus that our commitment to veterans is not being kept in this budget. And I think we have an obligation as a committee and as a Congress to restructure priorities nationally to make sure that the programs that you administer are funded properly. I would hope that this committee accepts that responsibility, accepts that opportunity, and does the right thing for veterans. We can establish our own priorities in a budget, and we ought to do that.

Saying that, we are going to, again, hear a presentation on what has been called the Independent Budget. Are you familiar with that?

Secretary WEST. Yes, I am.

Mr. FILNER. Aside from the fact that you may have not been able to recommend an increased amount of dollars, do you have any problems with any of those recommendations?

Secretary WEST. Congressman, I don't have any problem with the fact that a group of people who care deeply about our veterans, as do we all, have sat down and put their best brains to work and come up with what they think is a proper funding. But it does not represent my views, no.

Mr. FILNER. Well, I am very impressed with the Independent Budget. I think, by and large, this committee ought to adopt it as a framework as opposed to your own recommendations. They find a little over a \$3 billion shortfall, and I think that is an appropriate point of departure for this committee.

Let me just try to highlight some of the areas to back that up, especially in the benefits area, but also, of course, in the health area.

As I understand the budget, the backlog of cases that you spoke of and we hear from our constituents all the time ought to be better addressed. I look at the budget, and it looks like there are only 164 new positions. From the studies I have seen, it seems we ought to have 340 new adjudication positions to address the backlog of cases.

We have heard horror stories of waiting times. People have, it looks like, not only many, many months but up to years of waiting for a decision. I think it is reasonable that veterans ought to have a decision within 90 days, and that ought to be our goal. And we can't do it with 164 new positions. A couple hundred more would bring us closer to that goal.

We know—and you may be defensive about it, but there are decisions that are not being made accurately because they are overturned in other processes. In fact, more than one-third of the cases are being incorrectly decided. If I were in my former career as a college teacher, that wouldn't be a passing grade, in my opinion. And yet we only have nine new full-time employees to oversee the program that assures the quality of those decisions. Why not 50, as I think is recommended by other perspectives, so we can get that rate of failure down?

You don't underestimate that problem, I know, but you haven't put the dollars in to take care of it. Hepatitis C is not mentioned in the benefits side of the package. There is no additional funding for people who have been applying for compensation benefits as the results of being diagnosed, and even on the health side, the thing that bothers me the most—and I will come back to it if I have a chance in a second round—you say in your statement you are asking for \$136 million more, and you have a whole lot of other things you are asking. I don't find that in the budget particularly. Where is that going to come from? If your health dollars are the same, where is this money coming from? Something has to give. And you are not clear about that, so it is not convincing that that money is going to be there or that we are not hurting something else.

Can you just address that last point? There is no new money, so where are these programs that we all support, for hepatitis C, for homeless, for other things? I don't see any place where that funding is going to come from.

Secretary WEST. To parse through it with you, obviously the easy answer is to say that if we are expecting three-quarters of a billion in collections, then \$134 million out of that is easy to see. That doesn't completely address your point, Congressman, because there are so many other things that I think you would say we also have to look at.

Mr. FILNER. But you can't rely on that, as we have seen.

Secretary WEST. Oh, surely. Surely we can rely on enough of it to get—

Mr. FILNER. Is that part of the budget process, those dollars?

Secretary WEST. Well, we need your authorization to spend it. We are collecting it, but it is part of your authorization to us to spend it.

Let me just say quickly, I take your point that a question, when we take slots from somewhere else, is are we harming something else, but I would surely ask you to let us address those two things separately. First of all, if we are putting 440 new positions into processing, that is a lot better than just 300, wherever they come from, whether they are new or not. And then the analysis is for the 200-plus that we are taking them from elsewhere in VBA, are we harming something there? But I must say—

Mr. FILNER. Well, that is the question.

Secretary WEST. But I must say to you that I think our idea to add 400 into processing is better than the idea than to just add 300 into it because it will improve processing.

Mr. FILNER. Yes, but the trade-off is as equally important.

Secretary WEST. Yes.

Mr. FILNER. We want to know what you are taking that from.

Secretary WEST. Yes, and I think we have a good answer for you. If I can have a minute, I will let Joe Thompson address this.

Mr. THOMPSON. Primarily, the folks that would be transferred into claims would come from two areas. One would be the home loan program; the other would be information technology. We are moving in a different direction in both of those areas. With the home loans, we are looking at a way to better administer our property management part of the business, and we are doing an A-76 study this year. And in information technology, we are, in fact, moving to where we are using more and more commercial products and doing more and more contracting out versus doing it all with in-house staff. So that is where we expect to gather most of the transfer into the claims process.

The CHAIRMAN. The gentleman from Florida, Mr. Stearns, is recognized.

#### OPENING STATEMENT OF HON. CLIFF STEARNS

Mr. STEARNS. Thank you, Mr. Chairman. And good morning, Mr. Secretary.

Let me just echo the comments of Mr. Evans when he says this budget is a house of cards. And, of course, Mr. Filner just told you that he doesn't believe the budget is really committed to serving veterans or their real needs.

You mentioned earlier that you support Medicare subvention, but it is not in your budget. You mentioned you want to add 400 new employees, but your budget calls for cutting 7,000 jobs next year.

You have been in office since January 1998. Let me just ask you, and if you would be courteous to answer this question yes or no. Have you or your staff given instructions at any time during your tenure to the effect that the VHA or VHA officials should not send you proposed reductions in force or staffing adjustments? In other words, have you instructed your staff not to propose staffing adjustments or reductions in force, yes or no?

Secretary WEST. No. To the best of my knowledge, no. But I need to know what the basis for that question is, Congressman. Is there a suspicion that I have, that at some point that I have said that, that I have given that sort of general—

Mr. STEARNS. Take a look at this graph.

Secretary WEST. Because, I tell you, we are sure doing them. I mean, I am sure getting those proposals.

Mr. STEARNS. No, no. Our graph shows, if you look at it, that prior Secretaries in 1996 had staff reductions and in 1997, but since you have been in, there have been no staff reductions.

Secretary WEST. Well, that doesn't mean I haven't received the proposals. It may mean that I have asked for them to be better coordinated, that I have asked questions about them. I am not a rubber stamp.

Mr. STEARNS. If you have been in office a year and you are proposing in your budget to save \$1.4 billion by reducing 7,000 employees, and in one year you haven't reduced one person, how credible is to this committee that you are going to actually—

Secretary WEST. Well, is that true? Is that a true representation that we haven't reduced any people in one year? I mean, maybe we haven't RIF'd anybody, but the staffing has certainly gone down, Congressman. I am sorry, but I can't accept that.

First of all, no, I have given no such instructions. Secondly, I think we have continued to reduce substantially in the year that I have been there. And, thirdly, the proposals for continued reduction are still coming forward. If there is anything credible about what is happening in our Department, it is that the continued process towards reductions continues where they are reasonable and where they contribute to the mission.

Mr. STEARNS. Have you signed off on any RIFs since you have been in office for one year?

Secretary WEST. I am not partial to RIFs.

Mr. STEARNS. Not partial to RIFs—

Secretary WEST. I may have not—but that only would mean—

Mr. STEARNS. I am just asking you the question. Have you signed any—

Secretary WEST. Congressman, I don't—I have seen several proposals. I suspect I may have or I may have not.

Mr. STEARNS. You should know. Yes or no?

Secretary WEST. No, no, no. Here is the point, Congressman. What we have done is reductions. RIFs, which in my mind are an effort to lay people off without keeping their jobs, are different from buyouts and from other efforts at reductions.

Mr. STEARNS. So have you signed any personnel—

Secretary WEST. I will look and find it and give you the information.

Mr. STEARNS. Okay. See, the—

Secretary WEST. But can I say something else?

Mr. STEARNS. Oh, sure.

Secretary WEST. Nor will I, after this conversation, feel more obliged to sign off on the first one that comes before me. I insist, in my prerogative and responsibility as Secretary, to look and make sure that what we are doing is in the best interest of our veterans and of our ability to do our jobs.

Mr. STEARNS. All of us have the same objective. But our problem is when members on both sides of this aisle look at this budget, I mean, smoke and mirrors is too light a term for it. Mr. Evans has pointed out it is a house of cards. And Mr. Everett has pointed out that you expect to get \$749 million from medical collections. That is not going to happen. You are saying you are going to cut 7,000 jobs. You have been in office one year, and we don't see any reductions.

Secretary WEST. Wrong. That is wrong, Congressman. I just said that is wrong. There have been reductions——

Mr. STEARNS. In RIFs——

Secretary WEST. Substantial reductions.

Mr. STEARNS. Personnel RIFs.

Secretary WEST. The difference, the effect on our budget is the same. If we reduce in whatever manner, the costs go down, the savings exist. And, in fact, if we can do it that way, it is more humane. Employees are not trash just to be thrown away when we are through with them.

Mr. STEARNS. Well, I think the facts are you haven't approved a single reduction in force at any medical center during your tenure, while your previous VA Secretaries have approved reductions in 1997 and 1996 and I would just encourage you——

Secretary WEST. I don't think that is true, Congressman.

Mr. STEARNS. Well, then, what you have to do is say that the staff which provided me this information is patently false.

Secretary WEST. No. What we will do is we will provide you the information right away, and if it turns out you are right, then I apologize. If it turns out you are wrong, you will have the correct information.

Mr. STEARNS. The larger issue here is that this committee, veterans, people who are interested in the veterans, Democrats and Republicans, independent, just don't find the budget credible, whether it is medical collection or reduction in force or talking about your desire to have Medicare subvention but it isn't in the budget. We are just having a credibility problem, Mr. Secretary.

I don't know what to tell you other than we just got to go back and do this budget in a bipartisan way all over again. And yet your job is to really present us with a credible budget.

I think my point is made, and I don't mean to emphasize it too much. But I think the frustration on both sides is that this budget is not credible.

Thank you, Mr. Chairman.

Secretary WEST. Mr. Chairman, may I make one further comment? If there is anything that I expect to be attacked by, it is not that we are not reducing fast enough.

Mr. STEARNS. Reducing what?

Secretary WEST. Fast enough.

Mr. STEARNS. The figures show you are not reducing anything. Secretary WEST. I hear you. I hear you.

The CHAIRMAN. If you would, then, respond for the record.

Secretary WEST. Dr. Kizer wants to add something.

Dr. KIZER. I would just note for the record that last year our staffing did drop by about 3,600 FTE.

Mr. STEARNS. Now, is this a RIF, a personnel RIF that the Secretary signed?

Dr. KIZER. I don't know what the composition of that is. I just know the figures from 1998—the drop was over 3,600 FTE. I would have to go back and look as well.

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

The effective FTE reduction in VHA in 1998 was 3,606 FTE. The net employment reduction of 1,367 in 1998 (186,135 in 1997 compared to 184,768 in 1998), is the difference between the actual reduction of 3,606 FTE being offset by the transfer of 2,239 FTE from the old MCCR account into Medical Care. The Balanced Budget Act of 1997, Public Law 105-33, shifted the retention of medical collections along with the administration expense (2,239 FTE) to the Medical Care appropriation starting in 1998.

Mr. STEARNS. Well, we would just like to verify that because our staff is not showing anything in terms of this.

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

#### OPENING STATEMENT OF HON. MICHAEL F. DOYLE

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

Mr. Chairman, I have a statement that in the interest of time, I would like to submit.

The CHAIRMAN. Mr. Doyle, and without objection, all statements will appear in the record if members have any. And if you have any written questions you want to submit to the Secretary, they will be accepted.

Mr. DOYLE. Thank you.

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

[The prepared statement of Congressman McKeon appears on p. 72.]

[The prepared statement of Congresswoman Brown appears on p. 73.]

Mr. DOYLE. Mr. Secretary, welcome. I guess you can tell by the questioning today that members of the committee on both sides of the aisle have serious concerns about this budget, and when we look at the increased cost of just to maintain the existing programs we have in this budget, it is going to necessitate some \$870 million of increase, and to fund the new initiatives in this budget, over \$500 million of new funds are needed.

It seems that there is a shortfall in this budget of almost \$1.5 billion, which is planned to be met by these management efficiencies that you talk about. You expect to get some \$1.4 billion from that, and then you are increasing your medical collections by \$124 million. Yet we know last year your goal, you fell about \$50 million short of collecting what you projected last year.

We have great concerns that when these goals aren't met and these efficiencies may not bring in the type of projections that you

have in this budget, those costs have to be cut somewhere in that budget. You have to go to plan B when those numbers don't materialize, and that many times that directly affects veterans.

This is a very restricted medical budget you have here, and I see that you have made a decision to expand service to priority 7 veterans. A lot of us are concerned that priority 1, 2, and 3 veterans are experiencing long waiting lists. I know from the area that I am from, I have talked to people in our facilities, some veterans waiting up to 4 months to get an appointment. And I just wonder, number one, have you really got a firm handle on what it would cost to treat priority 7 vets, what that is going to cost you? And do you still stand behind the decision to enroll priority 7 vets when we have so many problems just meeting the needs of much higher priority veterans?

Secretary WEST. I think you raise a good point, Congressman, as has everyone. We made the decision on priority 7's, and Dr. Kizer may want to add a comment. We make that decision on an annual basis. We made that decision for fiscal year 1999. When we have more data, I guess this summer, we will know better whether we will continue, whether we will do it again, priority 7's in fiscal year 2000.

So if you ask me if I stand by our decision, yes, it was a decision for fiscal year 1999, but I think you are also asking me do I predict that we will do it again in fiscal year 2000. I think Dr. Kizer doesn't have the information yet to make his recommendation to me and won't until some time this summer.

Mr. DOYLE. I would like you to expand a little bit further, too, on where you hope to gain this \$1.4 billion in these efficiencies. You talk about a reduction of the workforce of some 7,000 employees, and the concern a lot of us have with the facilities, a lot of those reductions are coming on the front lines, the people that are directly serving veterans.

I have watched consolidations take place, and it seems like the people at the top of those consolidations—you know, when you merge a service division and there used to be three service chiefs, and now there is one. Those two other chiefs don't disappear. They are somehow still in the system, but a lot of the front-line people, the nurses, the people that are providing the more direct care to the veterans, they are swamped. I mean, I don't know how some of them are performing their jobs, quite frankly. I think we are not only putting veterans at risk in some instances, but these employees, too, that are being asked to just take on incredible workloads.

How are we going to beef up the front lines? You know, I hear this talk about how many people you have RIF'd or didn't RIF. I am not for a lot of reductions in the workforce. I think we need to increase employment at the front lines of serving veterans and do a much better job there. And many of us are prepared to fight for more money for you to do that. I know that you represent the administration, and this is the President's request, and you are here to defend that request. But I can tell you many in the President's party would like to see more money, guaranteed real dollars in this budget, to meet some of these very good initiatives that we all support. And we are concerned that when you don't meet these goals, they are going to go by the wayside.

I hope that these reductions that you are looking at, these 7,000 positions, aren't coming from the front lines. I would like to know where you see these reductions coming from.

Secretary WEST. I am not sure we have those plans formed yet. Do we?

Dr. KIZER. You asked multiple questions. I am not sure which one to start with first, but let me perhaps address the one that you started with on the priority 7's.

What has been made clear to everyone throughout is that this was a one-year decision for fiscal year 1999 and that it would be revisited this summer for the year 2000. In fact, Public Law 104-262 requires that this determination be made annually.

There is some absolutely critical information that we need to gain during this first year of enrollment because it is not only a matter of the increased number of users, but also, what services do these veterans use. We know already, for example, that the costs of the new users is about half or less than existing users, which is not altogether surprising since we are dealing with marginal and variable costs here. Also, the other side of the coin, what revenues do they bring with them. It is from the priority 7 veterans that we get the MCCF collections, which have already been talked about here by several members. We have to review the combination of those three variables—numbers, utilization, and revenues that they bring with them. We are trying to get a better handle on this experience this year and we just don't have all that information yet. We know some bits of it, but as the year evolves, we will know more. And by the late spring and summer, we will have enough information and will make the determination at that time.

Shifting gears to some of the things you asked on the management efficiencies, it is clear in my mind that the budget sets out a very ambitious goal. One of the areas that we are focusing a very concerted effort on this year is the procurement and inventory side, things that would be largely invisible to patients as well as caregivers. We are looking at how we manage the \$6 billion worth of supplies and materials that we need, and we do believe that there are substantial efficiencies that can be achieved through better materials management.

I would not profess, though, that better materials measurement can make up the entire amount by any means, but we do believe there are substantial savings that can be achieved if the plans that we have put in effect now come to fruition over the next year.

Mr. DOYLE. I see my time is up, Mr. Chairman. I will wait for the second round.

The CHAIRMAN. We will get back to you, Mr. Doyle.

The gentleman from New York, Mr. Quinn.

#### OPENING STATEMENT OF HON. JACK QUINN

Mr. QUINN. Thank you, Mr. Chairman.

Mr. Secretary, welcome. I am sorry I had to step out for a minute, but we have a lot of things going on here today in and around the Hill.

I have a couple of specific questions as to your testimony, but I first want to more than anything inform you of some activities of the Benefits Subcommittee. Of course, Mr. Filner and I—in the

subcommittee meetings, we say "co-chair," but I guess we really don't. We work very closely together on the Subcommittee on Benefits. In fact, just this past week, we met with Mr. Principi. Both of us and our staff met with him and representatives of the Commission to talk about some of the recommendations that they have made, and we are encouraged by some of the suggestions in the report and expect to follow up with some legislation that we will welcome your input on during the course of the year and some of the things Dr. Kizer has talked about even this morning relevant to the report.

I also want to let you know that I think the week after next or the first part of March I will be traveling over to see Under Secretary Joe, a fellow New Yorker somewhere in his past. I have done that once or twice already to meet with the staff and find out what is going on. We will be doing that again in the next week or two. I think you have been kind enough, Mr. Thompson, to set that up, and we appreciate that. We will keep you informed of what we see and what we hear and what we might suggest. So thanks for allowing us to do that.

In terms of your testimony this morning, I want to deal with two parts: one is the education component on the Benefits Subcommittee, and then the comp and pension claims. This goes back a little bit, too, to Mr. Principi's report. As the Secretary of Army, of course, your experience there and now at the VA, just your thoughts on the current Montgomery GI bill in terms of its use as a recruiting tool and usefulness to keep our enlisted people in the service. Can you comment just briefly for a minute or two on that?

Secretary WEST. Yes, sir, I can. I don't have numbers in my head, but, frankly, during my experience we relied on it heavily. We thought it was a very useful tool.

In fact, as I recall, in the 1993, 1994, 1995 time frame we thought it was so useful we included it in the Army advertisements that show up on Super Bowl Sunday or whenever. We found that education was a powerful inducement for our youngsters, surely. We would prefer to be able to say to you that most of them enlist because they are motivated by patriotism and a desire to defend their country. But at the age of 17 and 18, when they are finishing high school, they are trying to figure out what they are going to do with themselves.

Mr. QUINN. Do you think a return to a World War II-like GI bill, which is what the Commission suggested, will help or hinder in the long run?

Secretary WEST. It is hard to say at the moment. I haven't read the report. Even though you have asked me for my personal experience, I am going to be required to submit a report and comment jointly with DOD. I don't want to get out ahead of that.

Mr. QUINN. Sure.

Secretary WEST. But my instinct is that for the larger underlying question education has always been an important selling factor—and the opportunity to get it, to those who decide to seek a career or some time in uniform. It may be one of the largest. It means that they will not only serve for however long they are in, but, when they leave, they will be able to do something more with their lives than they could do when they entered.

Mr. QUINN. Thank you. And I think that is a huge issue for this committee, Mr. Chairman. As we talk about education in and around the Hill in general, I want to make certain and with your help we all can make certain that education for our veterans and the members of the service isn't given short shrift here, that while the rest of the country and the administration and this building, the Congress and the Senate, talk about education, education, how important it is, and we see all kinds of visits to schools at all levels that all of us make, I haven't seen too many visits to talk about education as it relates to our veterans. And I hope we can raise that discussion all of us together in the next few months.

Quickly, while I still have some time, let me move to the comp and pension. The budget, certainly when we talk about adjudicating claims in a timely fashion, we have not been able to do that. We know all that. But you suggest an additional 440 FTEs. Let me just get your opinion today about our ability, your ability to train those 440 additional. We have had some discussions that even existing staff aren't trained properly to do what needs to be done, as Mr. Doyle points out. I, too, am not particularly proud talking about RIFs and how many people we are going to cut unless we know it is not going to hurt us. But not to follow up on Mike's question because I agree with him, but to talk about the training if we get the 440 additional, do you think we are okay with that? Are you going to be in a good spot?

Secretary WEST. Well, it is going to be a big deal. I think the training is the heart of it. When we start to use people differently, which is what this is all about, then how well trained they are is going to make all the difference in the world.

If I could, I would like to have the Under Secretary Joe Thompson say a word about that?

Mr. THOMPSON. Training is the key for us.

Mr. QUINN. I agree.

Mr. THOMPSON. We do make too many mistakes in adjudicating claims, and one of the primary causes of that is that folks are not as well trained as they should be. We have devoted a fair amount of money in this year's budget and we have a significant amount for next year to develop computer-based instruction for claims examiners, as well as we have a number of folks here in Washington developing packages that we expect to have out and ready. And the goal is, if we are given this opportunity to bring on additional staff, we want to make sure they are equipped, that when they make a decision, they make the right one every time. So training is the key for us. I promise you that if we cannot train the folks, I will not bring them on board. I would rather not hire them than bring them on and not be able to adequately train them.

Mr. QUINN. Precisely my point. It is great news that they are in there, and we don't want to this to be a "use them or lose them" situation. But they are going to cause us more harm than good if they are put in positions that they are not trained and ready to do the job. Maybe when I visit next week or the week after, Joe, and, Mr. Secretary, I would say to you, if there is anything that we can do here from the committee or the Congress to help you get that training, let us know and we will try to move it along for you.

Thank you, Mr. Chairman. I yield back.

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

**OPENING STATEMENT OF HON. COLLIN C. PETERSON**

Mr. PETERSON. Thank you, Mr. Chairman, and, Mr. Secretary and your colleagues, we appreciate your being with us today.

I guess I share the frustrations of some of the other members around here with this budget, and I know that you are doing the best you can with what the reality of the situation is. And I think we ought to all step back a little bit and briefly remember how we got into this situation.

Some of us put a budget forward in 1995 that we think would have kept us out of this situation, and we finally passed a building in 1997, which I very much support and want to maintain, that put in some tough spending caps. And now we are bearing the fruits of that budget. I believe the spending caps are \$30 billion less this year than they were last year. So you don't have to be a rocket scientist to figure out what kind of situation that puts us in.

I serve on the Agriculture Committee. We have got shortages there of \$1 billion or \$2 billion that we absolutely need to address. You know, we have got needs in the military that I think all of you understand. And we are going to be confronted here shortly with a decision about what we are going to do with these caps and whether we are going to respond.

So I hope that everybody understands that the Secretary I don't believe should be blamed for this. I believe that the administration and the President did the right thing by sticking with the caps, and now we have to decide, all of us collectively, whether we are going to do something about this. And I just hope that we all, you know, don't get mired down in partisanship and work together to figure out how to get through this, but I also hope that we are careful about what we do because I for one believe that we ought to take—that the Social Security trust fund ought to be set off completely by itself and we ought not to be using that money for anything. And if we are going to accomplish that, it is going to be very difficult for us to deal with these spending priorities that we want to deal with if we are going to start giving up revenues.

So I just hope everybody keeps in perspective how we got here and that we don't get ourselves in a situation where we can't work through this. We are going to be confronting this shortly.

I guess I have a question either to you or Dr. Kizer, Mr. Secretary. Out in my area—you know, you are moving, as you said, to more of an outpatient type situation which we appreciate out in my area because it is long ways between anything, which it is in a lot of places in the country. But I am concerned, I guess, if we keep this lid on things and keep trying to make everything work, how we are in the long term going to provide that outpatient service and still maintain the bricks and mortar. Are we going to come to a point where this is going to get to be a problem? Nobody wants to talk about it, but up in my area where we are trying to do this reorganization and we have all these hundreds of miles between everything, now I understand there is a shortfall in the Fargo hospital that they are trying to make up from the other hospitals. We

are having a hard enough time just keeping our things together with the budget that we have got.

So I am concerned how this whole thing is going to work. I mean, I understand that you legitimately think that you can squeeze this savings out, but the reality is that I have got this one hospital that there has been a good part of it that has been sitting empty because they don't have the resources to staff it and to keep it open, and that same hospital has a great big waiting list of people that want to get in there. And the thing is sitting empty, and so we are going to try to take some money from other places.

I don't know how we are going to get through this thing unless we address what I talked about earlier. And I don't know exactly what my question is, but I guess maybe all I am asking you to do is—I haven't really been able to look into this situation with what is going on in Fargo and in that region. Maybe rather than taking up the time of the committee if you could, Dr. Kizer, or whoever, take a look at that and give me an analysis of what is happening there and what you think the impact is going to be on the other hospitals.

Secretary WEST. If I can make two points——

Mr. PETERSON. I think you have been up in that area.

Secretary WEST. My Deputy Secretary, Hershel Gober, is going out next week specifically to look at that situation. On the first point, yes, sir, it is true that one of the ways we bring health care closer to veterans, 89 new outpatient clinics, is that we use some of the savings from the reduction in the inpatient treatment. That is part of the shift, the shift from one kind of treatment to another. Whether it leads to further considerations down the pike, we are constantly trying to evaluate what we are doing. But it is true that as we carry the service out to veterans, then that will mean a shift of resources from larger bricks-and-mortar places to outpatient clinics. I don't think that is a completely false statement about what you are doing, is it?

Dr. KIZER. No. It concerns me that you don't want to talk about—not referring necessarily to you, Congressman—this notion that we have to do something about all the bricks and mortar we have, because the reality is that we can do a better job, we can provide more health care, we can take care of more individuals by shifting how we take care or—how we provide care.

Last year we took care of 520,000 more veterans, more than half a million more persons who actually got care than 4 years ago by some of the changes that we are doing in how we provide care. It is expensive to maintain hospitals that today we may not need, and in the future, we may need less because of the changes that are going on in the technology and how health care can be provided.

We have to get beyond the notion that hospitals are the only way to provide health care. Today we can do more. There are so many other options and ways to provide health care that we have to look at the total continuum of care—the whole gamut of care. We need to have that discussion.

The CHAIRMAN. The gentleman from Mississippi, Mr. Shows, is recognized. No questions?

Mr. SHOWS. No questions.

The CHAIRMAN. Dr. Snyder from Arkansas.

**OPENING STATEMENT OF HON. VIC SNYDER**

Mr. SNYDER. Thank you, Mr. Chairman. Thank you, Mr. Secretary, for being here. I just have one comment.

In the first week of December with four other members of the National Security Committee, I visited one of our American cemeteries in the Ardennes Forest in Belgium, and it was the only person I ever talked to, when I asked them, you know, how is your funding, and he said it was fine for the cemeteries, which is probably good since they don't have a whole lot of constituents to advocate on their behalf. It was a very wonderful visit there, very respectful, and I appreciate the efforts you all have put into maintaining those cemeteries overseas for our American troops.

Dr. Kizer, would you talk for me please about the 30/20/10 proposal? When I was first beginning on this committee in 1997, we had those proposals. You make reference to it, Mr. Secretary, in your statement. But would you give me a year-by-year—in 1997, for the fiscal year, how did we do in fiscal year 1998? How did we do in fiscal year 1999? And then how do you see—I don't know how you have your numbers here, the 30/20/10 over what period? Could you review that whole thing?

Dr. KIZER. Sure. As I have said before, people have particularly fixated on the 30/20/10, but those three indices are part of ten indices that are our goals for the system—our targets for the 5-year period.

Mr. SNYDER. If I might interrupt, I don't think we are fixated on it. You spent a lot of time discussing those in 1997, and it was a big part of how you are going to find money that is scarce.

Dr. KIZER. Well, let me answer you quite directly—

Mr. SNYDER. Very quickly, if you have the numbers.

Dr. KIZER. Okay. Compared to fiscal year 1997, in 1998 the reduction in cost per individual treated was about 10.3 percent. On the 5-year goal to reduce the expenditure per patient by 30 percent, we achieved over  $\frac{1}{3}$  of that in the first year. Over a 4-year period, there was an 18 percent drop. Specifically on the 20 percent, we were up over 9 percent, so from 1997 to 1998 we achieved almost half of that 20 percent goal. And for the 10 percent goal which has to do with the percent of our funds that come from non-appropriated sources by the year 2002, we were about 4.3 percent, as I recall in fiscal year 1998.

Mr. SNYDER. I think it would be helpful to me if you would respond in writing for the record with maybe a chart analysis of that evaluation.

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

The 2000 budget continues the course initiated in 1995 that emphasizes and supports a dynamic, more business-like healthcare system that is innovative and cost effective and that improves the health and well being of veterans. Using 1997 as a base against which we could measure our performance, by 2000 we estimated that we would reduce the cost per patient, in constant dollars, by 18 percent. In 1998, we had already reduced the cost by over 10 percent. This was accomplished in large measure by continuing to shift to more appropriate care settings, including the shift from excess acute inpatient resources to expand and enhance outpatient and long-term care services for veterans. Continuing efforts to re-engineer our health delivery systems and our commercial practice initiatives have also contributed significant savings. As a result of management efficiencies, in 1998 we were able to increase total patients served and outpatient visits by over 9 percent, while at the same time we improved our customer satisfaction scores and quality of care performance.

Since the implementation of 30/20/10, the VA has closed over 7,000 beds, and has used these savings to open an estimated 112 new outpatient clinics. Bed closures and new clinics have allowed VA to treat more patients at lower costs. By FY 2000, unique patients are expected to increase by approximately 503,000 from 1997. VA will maintain its current strategy, challenging the status quo and providing corporate incentives for effective management of healthcare services and costs.

**30%**

**Reduce the average costs per patient by 30 percent in FY 2002. (FY 1997 baseline = \$5,458)**

	Fiscal Year				
	1997 Actual	1998 Actual	1999 Estimate	2000 Estimate	2002 Estimate
Average Costs per Patient	\$5,458	\$4,897	\$4,739	\$4,455	\$3,821
Percent Decrease	N/A	-10%	-13%	-18%	-30%

The measure for this goal is total expenditures systemwide divided by the total number of patients.

**20%**

**Increase the number of unique patients treated in the healthcare system by 20 percent by FY 2002. (FY 1997 baseline = 3,142,000)**

The measure for this goal is a calculation based on the number of patients in the given year minus the FY 1997 patients treated baseline as divided by the FY 1997 patients treated baseline.

**10%**

**Increase all alternative revenues to include medical recoveries, Medicare, and other sharing revenues as a percentage of the Medical Care operating budget. (FY 1997 baseline = reimbursement % to total Medical Care funds.)**

	Fiscal Year				
	1997 Actual	1998 Actual	1999 Estimate	2000 Estimate	2002 Estimate
Alternative Revenues	76,041	758,890	771,770	934,958	1,421,265
% of Alternative Revenues to Medical Care operating budget	0.44%	4.3%	4.3%	5.1%	7.6%

Note: The percentage in 1998 would be 3.4% when excluding collections credited from the last quarter of 1997 and the one-time Treasury supplement, both made available per PL 105-33.

Although the goal is 10 percent, delays in passage of the Administration's Medicare subvention pilot legislation are estimated to result in a lower percentage by FY 2002.

The measure for this goal is revenues from each VISNs general ledger as divided by the total Medical Care budget (i.e., appropriations plus all non-appropriated receipts).

The following chart provides selected performance measures and other indicators that describe the shift in care provided and outcomes:

	1997 Actual	1998 Actual	1999 Estimate	2000 Estimate
<b>Acute hospital care:</b>				
Decrease bed days of care (BDOC) per 1,000 unique patients.....				
	1,782	1,333	1,330	1,328
Number of hosp. patients .....	497,547	441,735	388,947	338,874
<b>Outpatient care:</b>				
Number of outpatient clinics.....	439	551	722	811
Number of outpatient visits.....	30,436,000	33,417,000	35,857,000	37,645,000
<b>Service indicators:</b>				
Unique patients .....	3,142,065	3,431,393	3,591,066	3,644,624

	1997 Actual	1998 Actual	1999 Estimate	2000 Estimate
Unique patients.....	3,142,065	3,431,393	3,591,066	3,644,624

	1997 Actual	1998 Actual	1999 Estimate	2000 Estimate
<b>Service indicators</b> (continued):				
<b>Customer Satisfaction –</b>				
<b>Increase the percent of</b>				
<b>customers rating VA</b>				
<b>healthcare service as very</b>				
<b>good or excellent.</b>				
Inpatient .....	65%	65.3%	79%	83%
Outpatient.....	63%	64.8%	79%	83%
<b>Increase percentage of</b>				
<b>spinal cord injury</b>				
<b>respondents to the</b>				
<b>National Customer</b>				
<b>Feedback Center (NCFC)</b>				
<b>who rate their care as very</b>				
<b>good or excellent.</b>				
Inpatient .....	55%	55.2%	78%	82%
Outpatient.....	57%	55.2%	78%	82%
<b>Increase the scores on the</b>				
<b>Chronic Disease Care</b>				
<b>Index. ....</b>				
	76%	85%	91%	93%

Secretary WEST. Can I say that we won't get to the final goal without Medicare subvention?

Mr. SNYDER. I understand, and I agree with you on that. The issue that was brought up earlier with regard to the waiting times when—you know, I talked with people who work in VA hospitals in early 1997, they were very concerned that the goal of increasing the number of veterans was going to cause problems for them to provide the services. And part of your defense of the waiting lines was the number of additional veterans that you have treated in the last year, the additional numbers, which I think is great in terms of providing care. But it is also a way of saying that the predictions that were made 2 years ago were true, that we did not have the resources to do as good a job as we would have liked to have done with those additional veterans we bring on board if we are using that as a defense for our inability to get the waiting times down at the clinics.

Do you have any thoughts there?

Dr. KIZER. I think that we are making progress on our waiting times. When I came into the system, as I recall, one of the biggest complaints then were the excessive waiting times. So I don't think we should assume that 4 years ago before we started these changes, everything was fine and that it has deteriorated. In fact, if you actually look at the metrics, there has been significant improvement.

Do we have a ways to go and is there further improvement that needs to be done? Absolutely. And as I mentioned before, we are taking some very specific steps to move in that direction.

Mr. SNYDER. My experience as a family doctor is that no matter what level of medical care we all get, we want a little bit more. If it is a \$10 copay, we want it to be \$9. If the waiting time was 3 days, we want it to be 2 days. And I think that is a challenge. I think your waiting time numbers are getting up a little bit.

The final question, Dr. Kizer, with regard to hepatitis C, I had a friend of mine who was well and got sick and 2 weeks later was dead and did know that he had hepatitis C. That happened just a few months ago, and it really brought home that issue.

Do you foresee that we have a potential time bomb sitting out there? Some of those numbers I see on some of the surveys you have done of veterans with 18 to 20 percent positive hepatitis C on the screens. I notice you have added extra money for hepatitis C. What do you see as years go by? Do you anticipate that that number will have to escalate as the hepatitis C kicks in with some of these people? Or how do you see that at this point?

Dr. KIZER. I think hepatitis C is a much larger problem than is generally recognized, and it is not only going to be a larger problem for veterans. We happen to have data that shows what the prevalence is in some of our populations. We are expanding that data to present a more complete picture.

I think one of the real concerns I have as a public health-oriented person is that we don't know very much about hepatitis C in the general population. There is an emerging database from inner-city populations and underserved populations that the infection rates there may be as high as they are in the veteran population, in the

12, 15, 20 percent range. Indeed, we have data from one of our domiciliaries that over 40 percent of individuals are infected.

So we are very early, in my judgment, in the recognition and the understanding of the epidemiology of this disease. That is not surprising since the testing ability is fairly recent. I believe that this is going to be a much larger problem for the general population, as well as for veterans, and that we are only at the beginning of the epidemic. And I would hope that our experience with HIV and other diseases in the past would orient us to take a very vigorous and active approach to this early on.

Mr. SNYDER. Thank you, Mr. Secretary. Thank you, Dr. Kizer.

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

Mr. REYES. Thank you, Mr. Chairman.

#### OPENING STATEMENT OF HON. SILVESTRE REYES

Mr. Secretary, good to see you again, and I wanted to first thank you because I represent a district that has about 60,000 veterans that live there, and as we all know that serve on this committee, veterans are very much concerned about the issues that you are hearing here today and you have heard before in previous opportunities to come before the committee.

I do want to thank you for sending Deputy Secretary Gober to our veterans' town hall meeting last August, and I know that you weren't able to make it yourself, but I would hope that you can make it this August. We had a turnout of over 500 veterans at the town hall meeting, and it was a very successful meeting because Secretary Gober, as you know, is a straight shooter, and he explained to us some of the very things that Dr. Kizer is talking about today and all of you have talked to us about both in the hearing and in private about thinking outside the box and the fact that bricks and mortar take a lot of money to sustain from the budget.

So some of the things that I think are critical that we speak about and that we inform our veterans of are some of the changing programs of hopefully giving them better service, a higher quality of service, and more timeliness in providing that service. And one of the ways that I believe we are going towards that is by referring veterans to medical facilities within the community and not necessarily restricting it in the traditional sense to the facilities that are there.

Having said that, I am always concerned when I heard—I believe it was Mr. Thompson talk about the A-76 program and contracting out. I am always concerned when I hear those things because, in my experience in the Border Patrol, those things didn't always save money, and those things didn't always provide better service, more timely service, and in a more efficient or effective way. So I would ask that as you go through these A-76 studies and the contracting out of services, first, do you keep a record of those studies? And is that available to us so that we could review them? I personally am very interested in that, and I would want to—although I am from Texas and not Missouri, I still like to see it to believe it.

Secretary WEST. I don't think an A-76 is any kind of protected document. I think it is available to you as soon as we have it.

Let me say something about this particular one to which you referred, Congressman. This should not—in fact, I think it won't—affect any benefit program. This has to do with something that, frankly, we don't necessarily have the best expertise at, we think. Part of the A-76 is to determine whether that is true. This has to do with disposing of properties. So I don't think it affects any delivery of services or benefits. It is a straight question of can it be done better one way or another, to address that question you raise, in terms of results and also cost.

Do you want to say something?

Mr. THOMPSON. That is quite correct. This is not a direct service to veterans. It is simply when we have taken properties back in foreclosure, how best do you dispose of them, and the study is to determine whether VA, whether our costs can be improved upon by some other third party who can do it faster and cheaper. But it won't impact veterans in any way, regardless of whether we do it in-house or externally.

Secretary WEST. But we are happy to make the study available to you once it is done. I don't think we have even started that process yet. Or have we? Just started it?

Mr. THOMPSON. We will let the contract within a month.

Mr. REYES. All right. And I would be interested in getting anything related to the contracting out or the A-76 studies.

I want to switch quickly to a couple of other things that I am concerned about. As you mentioned yourself, Mr. Secretary, with 550,000 veterans dying every year, we have an aging veteran population, and that requires, I think, some special transition programs to provide for them. Veterans' home health care programs, programs that provide them nursing care, and those kinds of things are very important, and the thing that I think we are most concerned about, at least that I have heard in the district and that I want you to comment on, is why is it that we persist in having third-party payers as part of the funding mechanism.

I think we have an obligation to our veterans to provide up front the budget that will take care of all our veterans, and we should not rely—because of all the things you have already heard, we should not rely on third-party payers when we know that inevitably there is a shortfall there. So if you can comment on those two areas, veterans' home health care and also why is that we use this technique of not fully funding a veterans' health program? And then if we get third-party money in, you can always return it or keep it in abeyance for an aging veteran population.

Thank you.

Secretary WEST. My instinct is that we don't ask, in terms of the third-party payment, what any other health provider would ask. We don't ask anything different, and in some respects, if we are going to be able to provide this service to veterans, including those who have no third-party access, we actually wouldn't be, I guess, good stewards if we didn't seek that third-party payment.

I understand your point, which is forget that, every veteran has served and has built up this entitlement to have the country look after them. But we don't even treat every veteran in our hospitals. You have only 3.5 million, I think, that are getting health care out

of some 26 million veterans, more than half who have served in the history of the country still living.

So I understand your question and your philosophy, but I am not troubled by seeking recovery of third-party payments. I think it is simply part of good stewardship.

Do you want to comment?

Dr. KIZER. There are a couple of things I would add. One of the reasons that we use non-VA sources is we just don't provide access in some places, and we spend about \$1 billion a year on fee-basis care simply because there are veterans who we care for when they are near our facilities, but when they are some place where they don't have access to VA care we provide it on a fee basis.

In other cases, for example, home care—you specifically mentioned that—we have 71 home care programs right now. But the type of home care that we offer is quite different than what is available commercially in that we provide a much more sophisticated level of home care. Indeed, we call it home-based primary care. It is also on a much longer-term basis. Frankly, it is a way of providing long-term care in the home for the veteran. We have expanded that. I think last year we expanded by almost 20 percent the number of patients who were taken care of by that. But we are contracting with other home care providers for the more short-term post-acute care that is typically provided, say, under the Medicare program or commercially available.

Secretary WEST. The only other distinction that might be useful, Congressman—and maybe I should have said this—we, of course, don't collect third-party payments for service-connected disabilities. This is only for non-service-connected.

Mr. REYES. Well, I am only concerned in that there is always a shortfall, and we ought to just get beyond that and take care of the veterans flat out and not depend on third party to continue this myth of a collection to include it in the budget like this.

Secretary WEST. You mentioned the shortfall, but, you know, in the last recorded time—what was our percentage? I mean, we collect—we may have missed our target in the past, but we are well above 90 percent. What did you say it was?

Dr. KIZER. We were 6 percent short of our target in fiscal year 1998. In other words, we collected 94 percent of our target last year. The year before, as I recall, we collected about 91 percent. Again, this is something that only had relevance to us in the last year. Prior to a year ago, a little over a year ago now, we couldn't use these funds, so it was, in essence, meaningless for the system to put the sort of effort into it that is now occurring. During the last 2 months of fiscal year 1998, we actually exceeded the monthly targets.

So we are moving in the right direction. There is still room for progress, but I wouldn't ignore the fact that in the last 2 years we have exceeded 90 percent of our target, and almost 95 percent last year.

Secretary WEST. More significantly, we are determined to make our target. But 95 percent of three-quarters of a billion dollars is a lot of money. It is worth going after.

The CHAIRMAN. Mr. Reyes, I think you raise a valid point. I think before, as you are well aware, this money went straight to

the Treasury. When we fought to allow the VA to keep that, we envisioned that to be bonus monies, not monies to offset within their budget. Anyway, thank you, Mr. Secretary.

The gentle lady from Nevada, Ms. Berkley.

#### **OPENING STATEMENT OF HON. SHELLEY BERKLEY**

Ms. BERKLEY. Thank you, Mr. Chairman. Mr. Secretary, I have never had the opportunity to meet with you before today, but I have been very impressed with what I have heard, and I can see that you share the same concerns that I do regarding our veterans and the need to help those that saved us at a time of critical need in this country.

I would like to share with you some of the issues in my district and tell you something about my district that I represent. To give you some idea how important veterans' issues are to the State of Nevada, I think it is instructive to note that although Nevada only has two Representatives in Congress, we both sit on this committee.

I have the fastest growing district in the United States. I represent Las Vegas. I have the fastest growing senior population, and I have the fastest growing veterans population in the United States. I spend a great deal of time with my veterans, and they have made certain that they have adopted me and made sure that I know what their issues are and how important and serious they are.

I have brand-new medical facilities in Las Vegas. We have got brand-new equipment. We don't have enough personnel. We don't have enough doctors and nurses to care for the number of veterans that we have pouring into southern Nevada. And I have 5,000 people pouring into southern Nevada every month.

I don't have any technicians to operate that wonderful equipment, so oftentimes they sit idle when the needs are there. If a veteran has a problem after 5 o'clock, the only voice they hear is that on an answering machine. There is nobody to address their problem. If somebody gets sick or needs help after 5 o'clock on Friday, they can't get a hold of anyone until 8 o'clock Monday morning.

In May, I met with a group of veterans that came to my office to share with me many of their experiences. Perhaps the most poignant was a gentleman that spoke to me about finding a lump and going to the VA clinic to have a biopsy and being told that he could not be seen until September. And I know Mr. Evans speaks of a 30-day wait. I am speaking of a 5-month wait.

Now, when I had a lump, I was able to see my doctor that very same day and knew within 48 hours what my diagnosis was. I can tell you that that 48 hours was the most horrific that I have ever experienced. I can only imagine what it is like waiting 5 months to see if that lump is benign or malignant and seeing your life and your loved ones in front of you waiting for that. That is something that no American should have to experience, least of all a veteran who has sacrificed so much for this country.

I receive a lot of complaints from the doctors and nurses that staff my VA clinic, that when they complain about the shortage of doctors and nurses and personnel and technicians, that there is hostility that develops in the administration and that they are re-

taliated against for bringing these problems to the attention of those running the VA clinic. And I think that is a very serious concern because I admire anybody that could stand up and speak out for those that have no voice. That should never happen.

Nevada has the fourth highest remand rate in the United States, which leads me to believe we don't have enough people processing these claims.

I overheard—that is one of the beauties of being last in seniority, is you get to hear everybody else. I don't know what that little repartee between you and Mr. Stearns was about. I suspect there are some underlying currents there. But I can tell you that my experience is not cutting, although I admire anybody in your position that can cut positions and save money. But my experience in my own district is we have a desperate need for more personnel in almost every area: processing claims, seeing our veterans, providing the adequate, necessary benefits, and Medicare subvention is one of the issues that my vets talk to me constantly about. So all of these issues are very important, and I am here to help you and to help my vets because they are crying out for needs that we need to address, and if your budget isn't big enough, then I will stand with Mr. Filner and work as hard as I can to make sure that the budget is adequate for the needs of our veterans.

Thank you very much.

Secretary WEST. Is it possible for me later to get details from your staff about the one veteran?

Ms. BERKLEY. You can get it from me directly, if you would like. We are pretty new around here.

Secretary WEST. I need to follow up on that, along with all the other things.

Ms. BERKLEY. We are in desperate need of your help.

(The information follows:)

The Veterans Health Administration has contacted the House Veterans' Affairs Committee to obtain additional information concerning the veteran mentioned. An insert may be provided at a later date if needed.

The CHAIRMAN. The gentleman from Illinois, Mr. LaHood, is recognized.

#### OPENING STATEMENT OF HON. RAY LAHOOD

Mr. LAHOOD. Mr. Secretary, thank you for being here. A few months ago, you and I met about the cemetery in Illinois, and I wonder—I am not going to ask you to bore the rest of the committee. I wonder if you could provide a status report to my office on what is happening there. Also, if you could give us a status report on your commitment to the things that we talked about in terms of signage and other things that you committed to doing so that there is no confusion about what is happening there, I would appreciate that.

Secretary WEST. We will provide it, sir.

Mr. LAHOOD. And let me just say that I have a VA clinic in my hometown of Peoria, and there are many, many very fine, dedicated people whom all of you would be very proud of. They work very hard, and they do a very good job at taking care of the veterans in central Illinois. And I want you to know how proud you would be of the work that they do there because they really do a fantastic

job, and they have limited resources and limited space. So we are trying to work with them a little bit on trying to get an expansion there.

I want to pick up just for a minute—and you don't have to comment on this. I don't expect you to. But I want to comment on something that Mr. Peterson said. He and I both service on the Agriculture Committee together, as well as this committee, and there is a lot of heartburn on this committee about the budget that has been presented. My feeling about that is that the President has traveled all over the country touting a lot of new programs. In his State of the Union address, which I observed, like many of you, I think he proposed 75 new programs. And I think the expectation really is that you will come in with a budget that is far short of the dollars that are needed, knowing that there are a bunch of people on this committee and in the House and Senate that will try and find the dollars to take care of it.

The President talked about reforming crop insurance, which has nothing to do with what you do, but didn't put one dollar in his budget to take care of it. And I know that he will go around the country and talk about the importance of veterans and taking care of veterans, and then have all of you come up here and present this lousy budget that doesn't do anything about what you need to do. And I don't fault you for that. I am sure the recommendations that you sent down to OMB don't look anything like what OMB sent back to you. And you don't have to comment on that.

I have every reason to believe that what you probably sat down and talked to OMB about was a heck of a lot more than they gave you. And in the end, the President likes to talk a good game about all these things and promise a good game about all these things, then send them up here and expect us to take care of them.

I think, you know, we resent that, but we realize that is the era of politics that we are in today. You promise a lot, don't provide the money, and then come up here and have us do it. Because there are a lot of committed people, including Lane Evans from Illinois and Bob Filner and the chairman and others, and in the end we are going to try and find the money to do what you need to do—not because the President provided it, though. But he talks a good game about it, and then he lets all of you come up here and have to put up with the kind of stuff you have had to put up with today. And I think we resent that.

I find the same thing on the Agriculture Committee. He talked a good game about reforming crop insurance, which is very important, and not one penny in the budget to do it. You know why? Because he knows we are going to find a way to do it because it is important for ag country.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. LaHood.

The gentleman from Texas, Mr. Rodriguez, is recognized.

#### **OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ**

Mr. RODRIGUEZ. Thank you very much.

First of all, Mr. Secretary, let me thank you. I know you went to San Antonio, and I think everybody was real pleased with your

visit, and it was great. The turnout was good. Everybody loved you there. You did a great job.

I also want to thank Hershel Gober who also came down for the town hall meeting and got a chance to hear a lot of the veterans and the complaints and stuff, and I think that worked out real well, and the follow-up that has been done.

When I first got here about a year and a half ago, I know that I had some real frustrations with the administration there and the operations of the caseloads that we had. And it seems like we are making some progress there, so I just wanted to thank you, and I think we are moving forward. There are still some little problems there that we need to correct, but I think overall it has been real positive.

One of the things that I wanted to kind of share with you, I represent a district that goes all the way to the Mexican border, and we have four Congressmen in San Antonio. We go over 200,000 veterans in that area. And as we move forward south, there are no cemeteries for anyone. We have Congressman Ortiz from Corpus all the way to the border. We have Congressman Hinojosa, don't have any place in terms of any cemeteries, and I know I have talked to the administration about trying to see what we can do in that area. And I am real pleased that we have been able to expand the cemetery in San Antonio, and we need some additional expansions because we are getting a lot of people.

I have a community that is about 100 people that live there, and it goes from 2,000 to 3,000, you know, because of the winter birds that come in, the snowbirds, and a lot more veterans that come in. And so I was hoping that as we move forward, we will continue to work on maybe some access to some additional cemetery plots as well as some additional work in one specific area.

From a VERA perspective, I sent you some letters, and I am very pleased with the final results, but I would hate that that might come up again, and that is that in Texas, as the money is distributed, we saw disparity between some regions and others. The region that I represent that have both Hinojosa and Ortiz and myself and Lamar Smith and Bonilla, we were getting a disproportionate amount of resources from the State there. And as I got it, it was mainly because of a local distribution in the State where it was going to other regions. But the disparity came about to almost 1,000 per patient difference. I was glad that you responded to it and kind of took care of that last time. I just hope that that doesn't come up again.

Again, I just want to thank you for your visit. I want to invite you again to come to San Antonio and my area, and Hershel Gober was great also when he came by. I want to just thank you again and thank you for your hard work. And I know that one of the dilemmas is that we don't provide enough resources.

So I would ask that you also talk to us as to how we can make that happen. One of the difficulties, and I know from the lady from Nevada, we also experience the fact that we have growth and there is a need for clinics. And I want to thank you for the opening of those clinics because I know as you move south to Corpus Christi, to McAllen—and those two areas are not mine. They are my fellow Congressmen. There is nothing there, and there is a need for us

to kind of reach out in South Texas and see how we can help out overall, especially with the growing population. All of our congressional districts have 100,000 or 200,000 people more in our areas in terms of redistricting and the growth that has occurred, and a lot of them are veterans coming in from the North and deciding to stay down there.

So thank you very much for being here, and hopefully we will continue to get your help and support as you have been doing. Thank you.

Secretary WEST. Thank you, sir. You asked me to lay out how the committee can be helpful. I think that the committee is in the process of making up its mind about that, but I would just use this as an opportunity to say again Medicare subvention, we are requesting buyout authority to continue our reductions, whatever my RIF record is. There are all sorts of things that are important to us as tools, in addition to what you are considering.

If I may, also, let me say that there should be no doubt—I cannot let pass the opportunity to say that there should be no doubt about this President's, this Vice President's, this Secretary's, this administration's, all of our commitment to our veterans. We do the best we can to put together a budget that exists within the circumstances in which we find ourselves, and we will do our best to use this budget to provide improvements in claims processing, continued reforms in health care to bring more health care to more veterans. And your support in that is always useful to us. We have had it, and we are grateful for it.

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

#### **OPENING STATEMENT OF HON. LUIS V. GUTIERREZ**

Mr. GUTIERREZ. Thank you, Mr. Chairman. Welcome, Mr. Secretary.

Let me just make a few points. As we examine President Clinton's fiscal year 2000 budget request for the VA medical services, the VA health care budget contains, as far as I can see, no money for increased costs of existing programs, and the VA health care budget contains no new money to fund administration initiatives. In all probability, the VA health care budget significantly underestimates the cost for necessary treatment.

The President has recommended a fiscal year 2000 appropriation of \$17.306 billion for veterans' care, exactly the same as provided this year. And so I was watching on C-SPAN the Secretary of Energy yesterday, Bill Richardson, talk about his 5 percent increase as modest, 5 percent increase in his budget, and after him was coming the Secretary of Agriculture talking about his modest 6 percent increase in his budget. So it really worries me that we have a veterans—I haven't examined all the budgets, to be quite honest with you. I just happened to have seen that yesterday as I was preparing for today's hearing.

I am wondering. You know, it seems as though the Veterans Administration, especially given the fact that, as Dr. Kizer has spoken so eloquently about your ability to increase receipts of third parties and you are really going to gung-ho this year because you have got a 20 percent increase—that is your target to increase 20 percent

those collections to \$749 million in fiscal—that is pretty aggressive if you can get 20 percent more.

I agree with you, Mr. Secretary. Let me just add quickly that if you can get the money, get the money. But that is pretty aggressive. What we are talking about is a budget that is flat, where we all know we have problems, in critical areas, and it is flat compared to everything—compared to at least two other budgets that I have examined thus far and really is—its predictions in terms of its funding possibilities are based on a very, I think, optimistic 20 percent increase all the way up to 749, because, you know, it usually gets—once you get up to 96 percent, it is always real hard to get that—I mean, it would seem to me it is always hard to get that last 4 percent. You kind of maximize yourself out.

So those are my concerns, and I would suggest simply that the members of the committee not just give a cursory review to this budget and that we spend some time as a committee of the whole, not necessarily with any witnesses, Mr. Chairman, or once we have received all of the information so that we can respond with a budget of our own, as I am sure other committees are doing, so that we can actually help the Veterans Administration. Because I think what we are going to find is that we are—the Secretary and all of the people that work in VA are for veterans. We are obviously on this committee not because of the huge PAC money that comes our way for serving on this committee and t largesse. We are here for other reasons.

So I don't want to pat ourselves on the back, you know, too much, but I mean, there is a reason it sometimes gets hard to fill some of these seats on this committee from both of our sides of the aisle, Mr. Chairman. It isn't like people are jumping over the aisles begging the leadership on either side to please put us on the Veterans' Committee.

So now that we are here and we know that we don't have some of those other reasons for being on this committee, as we all know the politics of being a Member of Congress, then I think that we should just take that on a little more seriously and with a little more energy and vigor so that we can come back and kind of ask the Secretary, Is this enough or would you like more? And where is it that we can do it? Because I think that we have a responsibility to do it, and we can work in a bipartisan fashion, and we are just going to have to go after the people and our appropriators. We are going to have to stop, of course, I think, Mr. Secretary and Mr. Chairman, simply saying, well, you know, we did everything we could and those darn appropriators, the Appropriations Committee—everybody wants to be on that committee, of course. But those darn appropriators just wouldn't give us the money.

So I think, you know, we have to be as proud and as valiant as the veterans who served this country and be forceful and, you know, kick some people around, whether it is those big powerful cardinals of the Appropriation Committee, once we come up with a budget that is real and break whatever kinds of agreements and deals in the past that have shortchanged the veterans in this country.

Thank you very much, Mr. Chairman, and thank you very much, Mr. Secretary.

The CHAIRMAN. Thank you. Let me just remind members that we do have two more panels to go, the veterans service organizations that are presenting the Independent Budget, and also the military alliance people.

The gentleman from Florida, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you very much, Mr. Chairman, and I think all of us on this committee endorse Mr. Gutierrez's remarks. Certainly under your leadership, and even prior to that, we have always improved upon the President's submittal of the veterans' budget.

I want to welcome Mr. West, Secretary West. As I understand it, sir, your submittal on behalf of the Department of Veterans Affairs, is \$19.6 billion, but the President's request cut that by approximately \$1.2 billion. Is that correct?

Secretary WEST. I am not sure to what you are referring, sir.

Mr. BILIRAKIS. I am referring to the medical programs: the OMB submission, is \$19.6 billion; the President's request, \$18.4 billion—a difference of approximately \$1.2 billion.

Secretary WEST. Are you reading from something about my submittal to OMB.

Mr. BILIRAKIS. To OMB, yes, I am.

Secretary WEST. Well, I would have to check on that. I am here to support the President's budget, sir.

Mr. BILIRAKIS. You are here to support—so you did not submit to the OMB \$19.6 billion—

Secretary WEST. No. Whatever you have there I am sure is accurate, but I don't think I am going to talk about what I said to OMB and to the President.

Mr. BILIRAKIS. All right. I am giving you credit. I am saying that you wanted \$1.2 billion more than the President put in his budget.

Secretary WEST. And I thank you, but it may be credited. By my position, I am constrained from not accepting—constrained not to accept. (Laughter.)

Mr. BILIRAKIS. Well, I guess it really leads into the question that I am asking. Others have all touched on this very, very strongly, Mr. Gutierrez, so many others, the gentleman from Illinois. But how much have you fought for these additional dollars? I know you are here on behalf of the administration, and you are here to support the President's request. But, by gosh, if you initially felt that the President's dollars were not adequate to do the job, how much have you fought in that regard? And how can we help you here in the Congress to get closer to those particular dollars and, as we will hear regarding the Independent Budget, even more?

Secretary WEST. Congressman, I think the fairest thing for me to say and the most accurate thing is to say that I gave an honest assessment, but I also think that I don't fault those who worked with me to come up with what you now have before you.

I am not up here as part of a sham or a required show. I actually believe that we can achieve this budget and that it will allow us to do well for veterans. If I did not believe that, I would not be here. I think that is the fairest answer I can give you.

I understand that may not be your judgment or anyone else's who is seated there, but I hope that it won't be.

Mr. BILIRAKIS. Well, the—

Secretary WEST. I want to say one other thing, and that is, I don't think that the only measure is what the top line is. I think another measure is what are we doing within the budget. And now I am through.

Mr. BILIRAKIS. Well, sir, others have spoken on both sides of the aisle about the additional programs that appear in the President's budget for which there is no financing for them. Now, you are saying that you can meet those additional programs, the long-term care areas and all of these others that are here somewhere that I am just looking at—

Secretary WEST. I am saying we have several things we need to do. First of all, we have to look for the \$1.4 billion in efficiency, and I think we know how we will have to do that. Secondly, we have to see whether Congress is going to give us the authority to do emergency care, which is a \$200-plus million of the increase. Thirdly, we need to know more about what the associated costs will be and also what the experience with priority 7's is going to be.

There are several unknowns just yet. But do I think that we can do the job for veterans within our budget? I could not have presented it to you if I didn't think so. Will it be a strain? Will it be a stretch? Yes, it will.

Mr. BILIRAKIS. As I understand it, the President's budget doesn't even take into consideration inflation increase.

All right. My time is up, Mr. Chairman, and I know that I would like to—I don't know whether it would be to speak with you, or maybe Dr. Kizer, or whoever, regarding the spinal cord injury center in Tampa, FL, if I may, sometime after you finish up.

Thank you, Mr. Chairman.

Secretary WEST. We will both be available.

The CHAIRMAN. The gentleman from New Jersey, Mr. Smith.

#### **OPENING STATEMENT OF HON. CHRISTOPHER H. SMITH**

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

Mr. Secretary, current law, as you know, provides clear direction to the VA not to provide infertility or abortion services. I am advised, nevertheless, that the VA as a matter of policy is likely to make IVF, invitrofertilization, a expensive service available. Could you please explain why, given the proscription in law, the fact that the health plans around the country do not routinely cover IVF and that you are working within a budget that has about a \$1.4 billion deficit, how can you look to expand by including something that is explicitly proscribed by law? We had a very clear argument, discussion, and debate on that legislation, and how your general counsel or anybody else in your office can misread the intent of Congress is absolutely mind-boggling. If you could respond?

Secretary WEST. I don't have an answer for you. I am not aware of this particular concern. I will certainly look into it and give you a response, but I just don't know that we are about to do something that, as you say, is prohibited by statute because if we are prohibited, we won't do it.

Mr. SMITH. I would appreciate that, and as soon as possible, because if there is going to be a misreading of the law, I can assure you many—not all, but many members of this committee and others will take very forceful action, including, perhaps, a lawsuit. To

say that this section—and that is what your staff was advising our staff in December, somehow gave them the flexibility to expand a service—and IVF is very controversial—is misguided and wrong. The routine disposal of human embryos which is part of that method is very controversial. I believe it is the loss of human life every time an embryo is poured down the drain, and it is especially wrong given the parameters of our funding.

We are looking to boost VA funding, but I can tell you the consensus cracks if that money is going to be used for that kind of purpose.

Secretary WEST. We will look into it and provide you whatever information we have on it, Congressman.

Mr. SMITH. I would appreciate that very much, Mr. Secretary.

Mr. Secretary, let me ask also you, in my district there is an outpatient clinic that I worked for over ten years to establish in Brick Township which now faces the prospect of specialty care cutbacks. What was once a list of more than a dozen services that were to be transferred, we have whittled that down to four or five. Now, it looks like, given the cutbacks, we may see a loss of those services. Perhaps now or for the record, if you could provide us an update on where you expect that to go. I know that the veterans in that part of my State, New Jersey, are very disturbed that what was there is now in the process of being lost. If you could provide that for us as well.

Secretary WEST. Do you want to say anything? We will provide it for the record.

Dr. KIZER. I would like to say, Mr. Smith, that we have talked about this, and as you know, some of the proposed reorientation of services has been changed and some of the services that you are most concerned about have been restored at the Brick clinic, and they are continuing to look at some of the others.

Mr. SMITH. I appreciate that.

Secretary WEST. We will give you a further status.

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

The VANJ Health Care System continues to support initiatives it has taken over the past four years to expand eligibility and services at the James J. Howard Clinic (JJH) in Brick, NJ despite reduced funding levels. In an attempt to identify areas where VA services could be provided at a lower cost, changes in service availability at the JJH Clinic were proposed late last fiscal year. After considerable review and discussion, together with input from Congressman Smith's office, most services are now being retained at the clinic. VA personnel provide most of these services, but when appropriate, some services may be offered through local contracts. Mammography, PAP tests and Optometry are currently offered through local, private providers.

Recently, primary care was expanded at the clinic with the addition of a full-time physician. Ophthalmology patients are now being transported to the East Orange campus to take advantage of a state-of-the-art facility. The VANJ Health Care System is only one of three facilities in the country to offer the sophisticated low vision services available at that location. For less specialized eye care needs a new, local, optometry contract was signed that will greatly improve access for Brick area veterans. The table below lists services offered at Brick, along with changes in service availability since 1996:

Available Services	Availability 1996	Availability 1998	Availability 1999
Allergy	Yes	Yes	Yes
Audiology	Yes	Yes	Yes
C&P Exams	No	No	Yes
Dental	Yes	Yes	Yes
Dermatology	No	Yes	Yes*
ENT	Yes	Yes	Yes
General Surgery	Yes	Yes	Yes
Mammography	No	Yes	Yes
Neurology	No	Yes	Yes
Nutrition	Yes	Yes	Yes
Ophthalmology	Yes	Yes	No
Optometry	Yes	Yes	Yes
PAP Tests	No	Yes	Yes
Pharmacy	Yes	Yes	Yes
Physical Therapy	Yes	Yes	Yes
Physiatry	Yes	Yes	Yes
Podiatry	Yes	Yes	Yes
Primary Care	Yes	Yes	Yes
Prosthetics	Yes	Yes	Yes
Psychiatry	Yes	Yes	Yes
Psychology	Yes	Yes	Yes
Radiology	Yes	Yes	Yes
Rheumatology	No	Yes	No
Shuttle Service	No	Yes	Yes
Social Work	Yes	Yes	Yes
Speech Pathology	No	Yes	Yes
Urology	Yes	Yes	Yes

\* Note: There has been a temporary break in dermatology services while we renegotiate a contract for service delivery.

Mr. SMITH. Thank you, Mr. Secretary. I yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Smith.

Mr. Secretary, I want to comment on something that Mr. Bili-rakis was saying. I think the reason that many of us on this committee who fought to create the Secretary—or elevate the Veterans Affairs to the secretarial position—was so that we would have somebody on the inside, so we would have a strong advocate in there perhaps to get to the President. And I realize your position. I realize politically you are certainly constrained about some of the remarks you want to make. But we need that help, and we need somebody to get to the President. It is obvious that we have to add millions of dollars, I think almost \$300 million in health care alone last year, to this budget. And it is obvious that we are going to have to do it this year.

I wish you a lot of luck in being able to make that billion and a half savings, but I don't know that there are many people on this committee that think that can be done.

Anyway, let's go for a quick second go-round, if you would, Mr. Secretary, if you have the time. Mr. Evans?

Mr. EVANS. Thank you, Mr. Chairman.

Mr. Secretary, the President's budgets for fiscal year 1999 and next year, fiscal year 2000, propose to merge VA accounts into DOD or other appropriate functions. As the chief executive officer of the DVA, is this a concept you support?

Secretary WEST. I am sorry. Propose to do?

Mr. EVANS. To merge VA accounts into DOD or other appropriate functions.

Secretary WEST. I don't think it is—if you are referring to what I think you are referring to, that recurring page that I was asked about last year, I don't think this concept has even been discussed with me. So I certainly couldn't support it.

Mr. EVANS. It is in the budget. Page 172 of the budget. Would you like us—in the interest of time, I will submit to you a copy of the budget.

Secretary WEST. Could you give me a cite to it? Do you have a page cite there?

Mr. EVANS. Page 172.

Secretary WEST. Which volume is it in?

The CHAIRMAN. Of the President's budget.

Secretary WEST. Same answer. It has not been discussed with me.

Mr. EVANS. Sorry?

Secretary WEST. It has not been discussed with me. It is not a concept that has been discussed with me by anybody in the administration.

Mr. EVANS. Do you support it?

Secretary WEST. It is hard to take a position on something that I haven't been informed about.

Mr. EVANS. All right, Mr. Secretary, I will submit it for the record and ask for your response to the record in the interest of time if you can elaborate on that. It is rather lengthy.

I do find it kind of curious that——

Secretary WEST. If this is the same thing that was presented to me last year at this hearing, the answer this year is the same as last year, which is I didn't support it then and I don't know enough about it to support it this year.

Mr. EVANS. What can you do to get it out of the administration's budget?

Secretary WEST. Excuse me?

Mr. EVANS. What can you do to take it out of the administration's budget?

Secretary WEST. Apparently nothing. I mean, this is the second straight year it has shown up.

Mr. EVANS. Who is writing this?

Secretary WEST. I have no idea how this gets in here. But I do not—

Mr. EVANS. Does anybody on this panel know? This is rather significant—

Secretary WEST. It does not represent a position taken with consultation with the Department of Veterans Affairs.

Mr. EVANS. Why weren't you in the process? Going to what the chairman said, that is why we fought to have a Secretary of Veterans Affairs with Cabinet level status.

We are in a little bit of a short time period, so if I could get you to respond for the record, I would appreciate it.

Secretary WEST. Well, as I read it, it simply seems to be a statement that this would be a good way to measure the true cost of our national defense by looking at these in concert. But as I say, it is not a concept that has been referred to us for review, that has been raised with us for discussion.

Mr. EVANS. If you would review it and get back to us, we will put it in the record.

The CHAIRMAN. Mr. Evans is asking that you respond in writing, if you would, Mr. Secretary. There will be other questions submitted. We are trying to save a little bit of time here.

Secretary WEST. I will do it.

The CHAIRMAN. Thank you, sir.

Mr. Filner?

Mr. FILNER. Just a few follow-up things, and I thank the chairman for his remarks earlier. All of us share your advocacy for veterans, and we see ourselves, even though you see a frustration here, working in partnership for them. We want to help you, and we hope that you don't feel defensive because we want to work as a team.

Chairman Quinn of the Benefits Subcommittee mentioned that we take very seriously the Transition Commission's recommendations on expanding the Montgomery GI bill, and we will be looking at that very seriously. I think it is a very good proposal, we have studied it together, and we will be looking at that report in our committee.

As we have said many times in hearings before this committee, we ought to be focusing more on the situation with our Persian Gulf veterans. In particular, for example, I don't find in the budget any new initiatives to compensate those veterans who are receiving different decisions depending on whether or not identical symptoms are classified as undiagnosed illnesses or, say, chronic fatigue syn-

drome. There is a different way of compensating based on undiagnosed versus diagnosed. I think regulations which might clarify eligibility, for example, on the basis of a rating for fibromyalgia have not even been issued. So we have a lot of work on just the technical side there. I think we have a lot of work in dealing with some more honesty about that whole situation.

I couldn't let a hearing go by without mentioning, of course, the situation of the Filipino veterans of World War II. I am sorry that you don't have more in the budget for this group. You do have a proposal to pay full compensation for those veterans who live in the United States, and I think that is a good start. I would like to go further, as you know—we have discussed this many times—because we owe a debt to these brave soldiers.

Last year, when you had that item in your budget, you didn't have full funding for it. What is the situation on this year? Does the proposal have funding associated with it? Does it require enactment of other legislation?

Secretary WEST. I think if you authorize it, we are going to do it.

Mr. FILNER. Okay. Your recommendation last year depended on the tobacco settlement, if I recall.

Secretary WEST. Aren't we proposing in here \$5 million a year for this?

Mr. FILNER. Right. I just want to be clear—it was very unclear that the proposal last year depended on new funding.

Secretary WEST. It is now out of some—it is out of the appropriation. We are not depending on some other event to be able to fund it, Congressman.

Mr. FILNER. All right. I thank you. Just sort of a conclusion, but also as an introduction for the next panel, the Independent Budget which is going to be presented adds over \$3 billion to your proposal. I think that is the responsible position for us to be starting from on this committee. The administration recommends that the Congress is the body that authorizes and appropriates, so we ought to take that responsibility very seriously.

I think on both the benefit side but also on the medical care side, we have to have a higher level of care. The Independent Budget gives that. It improves the timely adjudication of claims and other decisions that have to be made. It brings in the kind of money that is necessary to make progress on all the issues that we discussed here today. So I will be recommending to the committee that we use that Independent Budget as our basic starting point, thanking you for your recommendation and for your implementation of whatever is decided here. So thank you, Mr. Secretary and your colleagues, for being here.

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

Mr. DOYLE. Thank you, Mr. Chairman.

Mr. Secretary, I think what my colleague, Congressman Reyes, was saying and what many of us feel on this committee—whether it is \$1.5 billion or \$3 billion—many of us who would like to just up front fund what we see as at least a \$1.5 billion shortfall encourage you to go ahead with these efficiencies and other cost savings where possible, where it doesn't negatively impact service to the veterans, and that money could be returned back to the Treas-

ury. You know, and if you don't get the whole \$1.4 billion back—we have not heard the veterans. We have just returned, you know, whatever you meet on your goals, and we would all probably feel a little more comfortable if it were done in an up-front manner that way as opposed to having to depend on these things.

I just wanted to give Dr. Kizer some extra time to expand on my original question about the reduction of 7,000 FTEs. I am curious to get a little more information on where you see these reductions taking place. In what areas of the VA health care do you see these reductions? And how did you arrive at that number? What plans do you have in formation that makes you arrive at that number of 7,000? And where are likely those reductions to take place, in what areas of the VA?

Dr. KIZER. The intent would be for as few front-line caregivers to be reduced as possible and that any cuts would come from support personnel, administrative personnel, others that would have the least impact on care that is given. Indeed, I acknowledge that there are more than a few places where we may need to bolster our front-line caregiving personnel, and we are doing that through some of the changes in personnel that are occurring at those sites.

The manner or the specifics of that are going to have to come from the field, from the individual facilities and from the networks, and those plans have not yet been developed or received in headquarters. So I really can't answer your question with the sort of detail that I know you would like to have.

Mr. DOYLE. Might I just state a concern, then? What we have seen to date in many of the facilities where these plans have been started, you know, instead of it being a pyramid where the primary caregivers are the wide part of that pyramid, it seems to be upside down; that some of the people on the front lines, at least from my experience, have been paying the price and that a lot of the top management in some of these areas, they seem to find other positions. They are not doing what they used to do, but they are still there, and we are paying the price down at the front line where the direct care to the veterans is.

If we are going to be asking our various directors to come up and formulate these plans for how they are going to effect these efficiencies, I hope there is clearer direction that, you know, they should be looking at the people who aren't giving the direct care as the first line and work their way down, because it doesn't seem to be happening that way by some of our experiences.

Dr. KIZER. Clearly that is the goal. As you know, we are bound by law, and the law does specify various considerations that have to be given whenever these reductions occur. One of them is seniority and other factors that are attendant to the civil service system. That doesn't always result in the mix or the outcome that you might like, and you can't predict that until you actually go through the reduction-in-force or staffing adjustment.

Mr. DOYLE. Thank you, Dr. Kizer. Thank you, Mr. Secretary.

The CHAIRMAN. The gentleman from Mississippi, do you have any questions? The gentleman is recognized. Flip your mike on there, if you would, sir.

Mr. SHOWS. Thank you, Mr. Chairman.

Mr. Secretary, it is a pleasure to be here and meet with you this morning. To give you a little history about myself, I am quite a frequent visitor to the VA in Jackson, Mississippi. My Dad used the facility three times one year for major surgery, and I can tell you that it was very successful every time. We appreciate the care and attention that the doctors and nurses and the staff give us there.

I guess I am concerned, like most people, that we feel like you may be underfunded, and we do want to help you. And I like to think of this effort as a team concept on both sides of the aisle. You have heard from both sides, and I think both sides are willing to help you, and I know that I am personally.

But one thing I want to ask you about, in Mississippi, at the Jackson facility, it is a long ways for a lot of our veterans to travel. I understand we are going to expand and try to put some satellite areas out there. Are you going to be able to do this throughout the country with your cut in funding that you are looking at and extend it to other parts of the country? Where veterans have to travel 2 or 3 hours by automobile to get to a facility, are you going to make this—I know in Jackson, I don't know if it is because our guys are doing such a good job over there with the money that they are able to expand it in the rural areas more so for the ability of people to reach the facilities. Is this going on nationwide?

Secretary WEST. I think it is a central thrust of Dr. Kizer's innovations. We have in the budget for fiscal year 2000, the one we are talking about, 89 new outpatient clinics to be spread around the country in various places. So, yes, we continue to do that, and we have to because that is essential to what we are trying to achieve.

Mr. SHOWS. Well, I think it is a good cause because a lot of times men and women—my Dad is a World War II vet, and their age now is getting where it is hard for them to drive to get there, and if they have to stay overnight, it is kind of a problem for them. So we appreciate that effort, and, again, I would like to say I appreciate the dedicated men and women who do work at these facilities.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

The gentleman from Arkansas, Dr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman.

Mr. Secretary, when you were in Arkansas, I guess it was last year, I very much appreciated being there and visiting our VA center there, and part of what you saw there was a facility that does a tremendous amount of medical research, literally that the whole world benefits from, not just American veterans. If I might, I want to ask Dr. Kizer a couple of questions with regard to medical research. But first I would like to say that when you respond in writing about the 30/20/10, would you also describe the baselines and how you arrived at your baseline numbers and how much confidence you have in your baseline numbers, too, if you would.

We were talking a little while ago about hepatitis C, and it is my understanding that you all may well be ahead of the rest of the world in terms of looking at this whole problem of hepatitis C. As you alluded to, there are not good numbers or the numbers are not well understood yet in the non-veteran population, which is just an indication there is just a whole lot of research that is going to have to go on. And I appreciate all the work that you all are doing and

are probably ahead of the curve on this whole thing with hepatitis C.

But I have two specific questions. In terms of your trying to achieve the efficiencies given the financial constraints you are under, one of my concerns is that people that are doing research may well be transformed more into clinicians than they want to be, that the doctors that are doing research may be having, you know, to say you are going to have to start staffing two clinics a week. I would like you to comment on that reality.

Then, if you just take the remainder of my time and amplify your answer about hepatitis C, what you see as the problem, describe the problem for us, the latency period, the potential explosion down the line, if you would, the cost of drugs, the diagnosis, those kinds of issues.

Dr. KIZER. Do I have an hour or so?

Mr. SNYDER. You have about 3 minutes. (Laughter.)

Dr. KIZER. Specifically to your first question, research is clearly an issue and is one that we are trying to work through. It is an issue that academic medicine throughout the country is also wrestling with. We have clinician investigators, all VA research is nested within the clinical delivery system. This is one of the VA's unique assets and one of the reasons why we believe that the VA research program has been so productive. It is clearly, if not the most, one of the most productive research programs in the world. It is highly successful, and we certainly appreciate the support that it has gotten. The fact that we accrue so much extramural support I think is another measure of the productivity of our investigators.

Having said that, in some cases, some researchers who might prefer to spend more of their time in the lab are being asked to do more clinical work, and we are trying to sort through what is the right balance. If they are in a system that is designed, first and foremost, to provide direct care. We have to find the right balance between them being not only an investigator but also a teacher, because we are so much involved in the medical education system as well, as well as a direct care provider. We are sorting through that.

As I talk with my colleagues and cohorts in the academic world, they are wrestling with the same issues, and I am not sure that we have arrived at the solution yet. We are trying to find that right balance.

Shifting gears and talking about hepatitis C, as I commented before, one of the reasons why we know so little about this is that the reliable testing has only been available in the last few years. It used to be known as a non-A/non-B hepatitis. It now has its own letter, and we know more about it. It is the leading cause of liver transplants in the country. In the VA, 52 percent of our liver transplants are due to hepatitis C.

It is acquired through many of the same routes that hepatitis B is acquired, parenterally or through the spread of blood, whether that is historically through blood transfusions; or, in the case of veterans, in combat situations where there may have been blood-to-blood contact, for example, among our Vietnam veterans; through use of illicit drugs, whether that be through injection or, intranasally, as in the case of cocaine. So there are many of the same mechanisms. It turns out it is not as efficiently spread sexu-

ally as is hepatitis B, and while it certainly can be spread that way, it is not as common.

It has a very long latency period, many years. The disease is certainly exacerbated by things like alcohol use or other physiologic insults to the liver. And many of those specific behaviors we are just now learning about, indeed, many celebrities who were formerly thought to have had cirrhosis because of alcohol, it turns out, in fact, had hepatitis C. So there is a lot to be learned about this disease.

I think one of the big concerns right now is we don't know very much about it nationally, and we particularly don't know much about it in some particular populations that would appear to be at the most risk. And I think there is an urgent need to do more investigation, not just within the VA setting but across the country, particularly in the populations which historically have been at high risk for other types of hepatitis, for HIV, and for other infections acquired by some of these same mechanisms of transmission.

Secretary WEST. Mr. Chairman, there is an impact on the benefits side of our house, too. Joe, could you please say a word about this?

Mr. THOMPSON. As the statistics come in, we will see more claims for service-connected disabilities as a result of this, and while we don't have a large volume right now—just as with health care, we are at the beginning of this—we do expect to see additional claims and additional grants of service-connected disabilities flowing from this.

Dr. KIZER. Let me just add one other thing that I think is important for the committee to be cognizant of. Hepatitis C is the second major disease that is somewhat different in that the expense of treatment, in ballpark figures, is probably around \$15,000 a year just for the pharmaceutical treatment. It is not unlike HIV, where protease inhibitors, which recently have become available, and very expensive involve prolonged treatment; there really is a new era, if you will, in drug therapy for chronic diseases like these. I expect that we will see a number of other treatments become available for conditions which historically have not been treatable in the past, which will have very hefty price tags associated with them. This is one of the concerns specifically related to our pharmaceutical budget, which is increasing disproportionate to all other elements of the budget.

The CHAIRMAN. Thank you, Doctor.

We have just a couple more quick questions, Mr. Secretary. Mr. Bilirakis?

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Mr. Chairman, you have been more than gracious, and in the interest of time and because I was late, being in a Commerce markup, I am not going to take up any time with questions. I have some that I wanted to submit to these gentlemen. One of them has to do with VERA. I would ask unanimous consent that the article which has triggered really my questioning regarding VERA might be made a part of the record.

The CHAIRMAN. Without objection.

[The information follows:]

The Palm Beach (FL) Post, 2/3/99

## Loophole in a new law hurting VA center, vets

**T**he Veterans Affairs Medical Center in Riviera Beach took an unnecessary \$1 million hit this year and needs help from Florida lawmakers and veterans officials.

Two years ago, Sen. Bob Graham, D-Fla., sponsored a bill to distribute veterans' health-care money more fairly. Most money had been going to Northern states while thousands of vets were moving to Florida. In 1997, Sen. Graham's legislation, the Veterans Equitable Resource Allocation Act, became part of the spending bill for the Departments of Veterans Affairs and Housing and Urban Development. For the 1998-99 budget year, Florida got a \$44 million increase.

But there was a hitch. While the law moved operating money to where vets were getting treatment, it did nothing about capital costs. Florida had lots of those. A new VA medical center in Brevard County will open this year. That will require more one-time money for "activation" — equipment, furniture and staff. The same is true in Orlando, where a VA nursing home is under construction. Other parts of the country don't have major activation costs because they're not opening new facilities. In Florida, those costs were \$18 million this year.

Until two years ago, the VA in Washington would have paid those costs. Same with the \$8.5 million in leases for VA outpatient clinics. This year, they came from Florida's health-care budget, and the Riviera VA center's slice was \$1 million. After 2000, when a \$25 million VA spinal-cord center opens in Tampa, the state should have less new construction.

Then there was Puerto Rico. "There was \$5 million in hurricane (Georges) damage at our San Juan center," says Dr. Robert Roswell, director of the VA network that includes Florida and Puerto Rico. "Despite re-

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*The Riviera Beach facility lost treatment money because the bill allowed officials to spend it on capital costs.*

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peated requests from my office to find other funds, we were directed to take that out of money for health care. The cuts were fairly consistent across all Florida VA centers."

But the Riviera Beach center was an especially obvious target. When it opened in June 1995, it was designed for 520 beds and received staffing for 520. Like most hospitals, however, the center did more outpatient care; the total is up to about 300,000 visits a year. Today, the 120-bed nursing home is almost full, but only 145 acute-care hospital beds are in use. So when Dr. Roswell studied staff-to-patient ratios at Florida's six VA medical centers, Riviera Beach looked ripe for cuts.

The Riviera Beach VA center serves Palm Beach, Martin, St. Lucie, Indian River, Okeechobee, Hendry and Glades counties. The area includes more than 275,000 residents — plus many winter visitors — who are veterans. Since last fall, 70 positions have been cut, mainly through attrition and by reducing temporary workers, said the associate director.

Florida lawmakers need to close the loophole that omits capital costs from the Equitable Allocation Act. Future repair work like that in Puerto Rico should come from federal emergency money. And to prevent future financial unfairness, new state Veterans Affairs Director Robln Higgins can improve communication to make sure that all of Washington's policies are in line with Florida's needs.

Mr. BILIRAKIS. I would just merely say very quickly, Mr. Secretary, that I am just very pleased that the chairman hitchhiked upon my comments regarding the reasons why we fought so very hard to upgrade, if you will, your position to that of Cabinet level. And I understand that there are constraints and restraints upon you. You have got to be here to support the President's budget. But, we, all of us work for the American people. And on this committee, when we are functioning as members of this committee and you in your capacity and Dr. Kizer, et cetera, et cetera, et al., all work for the veterans. That is our job. This is the real world. When you have had an administration that has reduced what you think is really necessary to care for our Nation's veterans that you will fight for additional dollars. I am not trying to belittle your role in trying to fight for the higher amount of dollars.

Anyhow, we hope that you will be available to help us in the process of increasing the dollars for various programs.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Smith?

Mr. SMITH. Thank you, Mr. Chairman. I will just ask one final question and ask that some other questions be made part of the record and submit them for response.

Mr. Secretary, activation of the new national cemeteries mentioned in your statement is indeed good news for veterans in those areas of the country, the Saratoga, Abraham Lincoln, Dallas-Fort Worth and Cleveland area. Those veterans I think will be most appreciative for that effort.

As you know, however, the committee is very concerned about the prospects for additional cemeteries being established after the year 2000. Your previous assurances regarding further progress on this matter has been very helpful. However, there appears to be nothing in the budget documents indicating a commitment to the planning that is necessary to go forward with construction of additional cemeteries beyond 2000.

Could you explain where the administration is heading on this very important issue?

Secretary WEST. Well, I think in several directions. One, Congressman, is I reaffirm what I have said before, which is that we will look to the needs as our veterans and you and others and we are able to sort them out. We will look at the death rate. We will look at where they are occurring. You know what our measurement is, that we want burial space to be reasonably available to all of our veterans. And as I said, we are nearing 80 percent.

In terms of one part, I know, of your question, when are we going to identify and build new national cemeteries, the answer to that one is at the moment our plate is full, and we need to see how we do with these before we identify more.

The second part of that is we continue to support the State grant program. I think there is money in this budget for that. I think that is an important part in many locations where the State-size facility, that kind of facility, can be more appropriate. So we are not backing off from our commitment. We have raised the budget a little bit in cemeteries, and we intend to keep pursuing this. This is an important part of our mission.

I don't know if you want to add anything, Roger, to this, but the answer is we are not shutting down at all.

Mr. RAPP. We are challenged with the ones that we are working on right now. It is unprecedented for us to have four new cemeteries under construction at one time, and we are doing a number of other things as an adjunct. We have a number of columbaria projects that are under construction and will soon be available soon. We also have significant expansion projects underway at some of our higher-volume cemeteries like the one in Arizona.

We still have an awareness of places in the country that have been documented by our reports as being underserved, and I think we will be working with the Secretary to take a look at those in the next budget cycle.

Mr. SMITH. If I could, given the lead time that is necessary for establishing new national cemeteries—what is it, a few years, 4 years, 5 years?—that is why we were looking in the budget to see if there is anything in the offing in terms of planning as to where we might be in the year 2003, 2004, or beyond. Is there nothing being looked at as a potential site?

Secretary WEST. Well, I think we have lists that were developed a while back. Those lists are still actively present before us. It is not as if we have nothing on the horizon. But we will want to see a little bit more clearly how those needs are developing. But in terms of actual dollars you can identify for some kind of planning, I think that is not what we have there. No planning dollars. Is that your question? No, sir.

Mr. SMITH. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Secretary, we thank you and the gentlemen for your time today being with us. We do have some questions, and if you could respond. Do you care to make a closing remark?

Secretary WEST. No, just a note. Congressman Snyder was kind enough to compliment us on the cemetery in Europe, and as I think you know, those are not our cemeteries. Those belong to the American Battle Monuments Commission, which is reputedly the best financed executive agency in the Government. (Laughter.)

The CHAIRMAN. Thank you. Thank you, gentlemen.

[The prepared statement of Secretary West appears on p. 77.]

The CHAIRMAN. If we could get our second panel to come up, we will try to move right along here.

I am sure we all want to get through as rapidly as possible. Those that are leaving, if you would please do so as expeditiously as possible.

[Pause.]

The CHAIRMAN. If we could resume, please, our second panel consists of the four veterans' service organizations who have prepared the Independent Budget: the PVA, the DAV, AMVETS, and the VFW.

Gentlemen, we congratulate you for all the work you do. I don't have to tell you that the members of this committee do appreciate it, although, looking around, you might not believe that right now. I apologize for the absence of the members, but we do sincerely appreciate all the work and effort you put into this, and it is you, believe me, against the administration's budget.

You gentlemen may proceed in any way you wish. I will give each one of you 5 minutes. Mr. Steadman, they are pointing to you, if you want to start off.

Mr. STEADMAN. Thank you, Chairman Stump, Ranking Minority Member Evans, and members of the committee.

Mr. Chairman, if I can for just a minute welcome and thank the new members of this committee, new members of Congress to this committee. I am Ken Steadman from VFW. I am acting this year as Independent Budget Policy Council chairman. I want to thank you, Mr. Chairman, for the opportunity accorded to the Independent Budget to make our case before this committee of the Congress, because, Mr. Chairman, we have not been able to make the case for veterans with this administration, but it is not for want of trying. We carried our case to DVA. We carried our case to OMB. We tried to carry our case to the White House repeatedly, but we were ignored.

Mr. Chairman, to make our strongest case for an adequate budget for veterans, let me introduce my Independent Budget colleagues, beginning with Mr. Gordon Mansfield, the executive director of Paralyzed Veterans Association, to be followed then by Mr. David Gorman of the Disabled American Veterans, and Veronica A'zera of AMVETS. Finally, I will finish with our portion.

Thank you.

The CHAIRMAN. Gordon, before you start, I neglected to recognize the ranking member, if you would give me a minute, please, sir.

Mr. EVANS. Thank you, Mr. Chairman. I am going to have to leave soon for an appointment that conflicts with this hearing. But I do appreciate what you are doing in proposing the Independent Budget. It gives us a good starting point as far as where we can go as a committee, and I appreciate it very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Lane.

Mr. Mansfield?

**STATEMENTS OF GORDON H. MANSFIELD, EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; DAVID W. GORMAN, EXECUTIVE DIRECTOR, DISABLED AMERICAN VETERANS; VERONICA A'ZERA, NATIONAL LEGISLATIVE DIRECTOR, AMVETS; AND KENNETH A. STEADMAN, EXECUTIVE DIRECTOR, VETERANS OF FOREIGN WARS**

**STATEMENT OF GORDON H. MANSFIELD**

Mr. MANSFIELD. Thank you, Mr. Chairman and members of the committee. My name is Gordon Mansfield. I am the executive director of the Paralyzed Veterans of America, and on behalf of the Independent Budget groups, I will address the impact of the President's fiscal year 2000 proposed budget on the provision of health care for our Nation's veterans. I would like to include this copy for the record, if the committee would so desire.

The CHAIRMAN. All of your statements will be included in the record in their entirety.

Mr. MANSFIELD. Thank you, Mr. Chairman.

I want to express our appreciation to you, Mr. Chairman, for your swift response in condemning the inadequacy of the adminis-

tration's budget request. For the third year in a row, the President is proposing a straight-line appropriation for VA health care. In so doing, he is ignoring the true cost of health care for veterans, especially the more costly care needed by the most vulnerable veterans—our older veterans, our poorer veterans, and our veterans in need of specialized services, such as spinal cord dysfunction medicine.

For example, in last year's budget submission, the administration proposed cutting rehabilitative care, including spinal cord injury care, by \$34 million. This year's proposal calls for an additional \$21 million cut. We greatly appreciate the action of this committee and the Congress last year in reaffirming, by statute, that VA must maintain its core specialized services, such as spinal cord injury care and other specialized services. But how can capacity be maintained with fewer beds, fewer staff, and fewer dollars each year?

The balanced budget agreement 3 years ago straight-lined the VA appropriation. With soaring medical inflation, with World War II veterans reaching the age of maximum health care utilization, the administration's design is to downsize, curb, and limit services based not on need, but on how much money the administration wants to give the system.

To attempt to make up for this shortfall, the budgets have counted on the gimmick of third-party reimbursement to allow the VA to squeeze reimbursements out of the private insurance policies of veterans. They have relied on "pie in the sky" estimates of third-party reimbursements, overcounting how much they intend to collect each year. In many respects, these estimates are a ruse to cover the fact that they are not providing any new Federal dollars to the system. The budget estimates that the VA will collect \$151 million more in 2000 than in the current year, a surprising estimate when the Department has never met its collection projections in the past. And I might add also that we have to include in these dollars the fact that it costs approximately 22 or 23 percent of the total for overhead to collect them, so that is not usable for health care. It is already spent before you get the money.

The VA's aggressiveness in trying to reach the goals has many dangers. Increasing numbers of veteran patients will be hounded for collections of any kind. And we are greatly concerned, Mr. Chairman, by recent reports in the press and elsewhere that the VA may be forced to refund more than \$600 million in overpayments to insurance companies due to potentially questionable billing practices. If true, such a penalty could clearly wipe out any net gain to the system from the entire collection program for one year.

Mr. Chairman, the President's Office of Management and Budget could care less whether VA meets its collection targets. But from my own experience, I can tell you that sick and disabled veterans care a lot when they do not get the health care they need and deserve.

At the same time the administration has proposed flat-lining VA medical care funding, it has also produced a list of new initiatives. These improvements to the VA health care are appropriate and long overdue. Unfortunately, in asking VA to perform these services, the budget does not provide the dollars to pay for them. In all,

the cost of these programs is well over \$1 billion which VA must pay for out of increased and unobtainable efficiencies. VA has always been asked to do more with less. This budget asks VA to do more and more and more with less and less and less.

Among other new initiatives, the administration asks for a \$250 million program to expand treatment for hepatitis C-related illnesses. The budget calls for \$50 million improvement programs for homeless veterans, and the budget also calls for \$106 million for expanded long-term care programs in home and community-based services. The budget calls also for \$244 million in needed emergency care services. To pay for the emergency care services alone, which the President promised in his Patient Bill of Rights last year, the budget calls on the VA to reduce 1,500 health care personnel. This scheme forces the VA to rob from one veteran to care for another, and we believe that this is intolerable.

This year's Independent Budget recommends that Congress appropriate just over \$20 billion for VA medical care. This figure represents a core appropriation of \$19.7 billion, which is approximately \$3 billion more than this year's appropriation. The figure is large, but it represents what it would take to overcome the cumulative losses the VA budget has suffered over the past several years and meet the challenges of medical inflation rates that are currently back in double digits.

The administration has proposed significant increases for medical research conducted by other Federal agencies, such as the National Institutes for Health. But yet this year's budget straightlines the VA research. The Independent Budget recommends \$375 million for VA research appropriation, an increase of \$59 million. The Independent Budget would also boost VA's medical administration and miscellaneous operating expenses account from \$61 million this year to \$69 million to help boost the VA's quality assurance programs.

Mr. Chairman, as we have in the past, we are asking for your support and the help of this committee to set this budget right. The President is proposing billions of dollars in new spending for new programs and new initiatives in nearly every aspect of the Federal Government. VA health care programs have been left out of this plan. We need your help to bring the needs of American veterans back to the table and to the attention of this Congress.

Thank you, and I will be pleased to respond to any questions you may have.

[The prepared statement of Mr. Mansfield appears on p. 87.]

The CHAIRMAN. Thank you. Mr. Gorman.

#### STATEMENT OF DAVID W. GORMAN

Mr. GORMAN. Thank you, Mr. Chairman.

First, Mr. Chairman, on February 1, when you released, your press release, I read it with interest and agreed with what you had to say. I have to say, though, that after sitting here all morning and listening to the various questions from the committee and the responses from the VA, I think that you are probably more on target with your news release as far as the inadequacies of the VA budget and the administration's request on a non-priority basis of veterans than we all may have realized back on February 1.

The CHAIRMAN. Thank you, sir.

Mr. GORMAN. My remarks today, Mr. Chairman, will focus mainly on the benefit program because that is the DAV's primary area of the Independent Budget. The President's budget recommends a cost-of-living increase for compensation as well as dependency and indemnity compensation. The Independent Budget also recommends an increase because compensation rates must be adjusted annually to avoid loss in earning power. If the value of compensation is to keep pace with inflation, then the COLA must be equal to the annual rise in the cost of living. However, again this year the President's budget again recommends legislation to permanently require rounding down the increases to the nearest dollar. With rounding down year after year, the value and buying power of compensation simply erodes. There is simply no justification for making temporary deficit reduction measures permanent and, in effect, reducing the compensation for those who rely on it for the necessities of life.

It is bad enough to reduce benefits to disabled veterans in the name of deficit reduction, Mr. Chairman, but it is indefensible to reduce benefits to disabled veterans merely for the sake of doing it. We urge you and the committee, Mr. Chairman, to adamantly reject this unwarranted proposal by the President.

Also, we have mixed feelings about the administration's proposal to increase staffing for claims processing. This year, and for the past several years, we have recommended a substantial increase in personnel to adjudicate compensation and pension claims. The President proposes an additional 440 FTE for claims processing, but almost two-thirds of that increase would be attained, as we heard this morning, by shifting staff or staff positions from other benefit programs. This continuing cannibalization of the Veterans Benefits Administration raises two concerns. First, can these other benefit programs really take the losses without diminishing their own services to veterans? And, second, are the employees who will be reassigned properly suited for the complexities of claims adjudication?

Unfortunately, we know from experience that VA sometimes makes these staff reductions and transfers that are unwarranted and adversely affect the timeliness and quality of its service to veterans. We were heartened, however, to hear the testimony by Under Secretary Thompson that if these people weren't adequately trained to do the job, then he really wouldn't want them working in the C&P service. After all, that is exactly what has gotten them into their current predicament with the claims backlogs. With the near crisis situation in claims processing, this is no time for questionable moves or makeshift solutions. Claims adjudication, Mr. Chairman, in our view could be made less burdensome for VA and claimants by legislation by this committee to override existing judicial interpretation of the well-grounded claim requirement.

Throughout VA's history, it has had the duty to assist veterans in gathering the evidence necessary to substantiate their claims. Veterans are not required to prove their claims to a certainty, but only to submit enough evidence to demonstrate that their claims are indeed well grounded. Congress thought that the preservation of this burden of proof and the duty to assist so important that it

included them in the Veterans Judicial Review Act. However, the Court of Veterans Appeals has interpreted the statute as requiring a veteran to submit enough evidence to establish that the claim was well grounded before VA has any duty to assist. This in our view defeats the purpose of the duty to assist because for the veteran to obtain VA's assistance, the veteran must first do the very things he or she needs assistance with.

When veterans unknowingly fail to meet this preliminary requirement, the VA or the Board of Veterans' Appeals summarily denies the claim on the technicality that it was not well ground. This court-imposed formality is, again, in our view counter-productive and contrary to the intent of Congress, and that is why the Independent Budget recommends remedial legislation.

Mr. Chairman, in the budget process, we always look for ways to most efficiently and effectively use VA resources. Unfortunately, at least in our view, some masquerade schemes to reduce veterans' rights, benefits, and services as ways to increase efficiency, and there have been many in the past. The most recent example perhaps is the Commission on Servicemembers and Transition Assistance, which recently recommended legislation to retroactively change the status of military service after February 28, 1993, from wartime to peacetime service, even though we have continuously been engaged in hostile military action in the Persian Gulf since the beginning of the war with Iraq.

Although the costs of our national defense have always been viewed as a Federal Government responsibility, the Commission recommended shifting the cost of treating service-connected disabilities to the private sector. Finally, the Commission has recommended combining VA and DOD's disability compensation programs and health care programs.

While we agree, as has been stated today by some, that there are many, many commendable and positive recommendations in that report, there are also some that we don't think do well and right for veterans, and we are going to strongly oppose those as strongly as we will support others.

Mr. Chairman, I was struck, sitting here, by a lot of things, and I have two comments in particular, one from Secretary West regarding Mr. Evans' question about the merging or bringing together the function that was contained in the budget of DOD and VA, not so much that he was unaware that they were there but there was obviously no consultation by anybody in the Administration, DOD, White House, or OMB with the VA on that. If these kind of recommendations are going to be made with the VA left out in the lurch, it leaves even more importantly the comment that you made, Mr. Chairman, about the work of this committee trying to elevate the VA to a status of Cabinet level and the very importance of why that was done.

The other thing that I was struck by was the Secretary's comment that he, in the context of Mr. Bilirakis' comment about trying to give the Secretary credit for increasing the budget request for health care, Secretary West's comment that he supported the President. And I understand also, as was made, the comment made by someone on the committee that that is his job and that is his position and there are political overtones to all of that. But, really, we

are all here to do one job, and that job is to do right by veterans. And if we can't advocate for veterans, then I am afraid we are not doing our job correctly. And we all need to look at exactly what we are doing and how we are doing it and where we are doing it in order to make the job that you have and that we have all that much easier and to do the right thing for veterans.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Gorman appears on p. 94.]

The CHAIRMAN. Ms. A'zera.

#### STATEMENT OF VERONICA A'ZERA

Ms. A'ZERA. Thank you, Mr. Chairman. We appreciate the opportunity to join with our distinguished colleagues from the Independent Budget to provide testimony to the House Veterans' Affairs Committee on the Department of Veterans Affairs budget for fiscal year 2000.

As you may know, AMVETS' portion of the Independent Budget is the National Cemetery Administration section, and this is my third year personally of working with the IB. To me, it may be a small section, but it is also a very important section. And if you don't believe me about that, we have tons of letters—and I know you receive letters also—from family members whose loved ones were refused to be placed into a cemetery because it was too full or even refused military honors because they could not be provided. So that gives proof that, although a small section, it is also a very important section of the IB.

Expansion of the VA cemeteries over the next 10 years is critical to meeting the burial demands that will be placed on the system. NCA projects that interments will peak at approximately 107,000 in 2008. It has, however, no strategic plan in place beyond the year 2000. The IB recommends NCA establish a longer and successive planning period to develop strategies for obtaining funds, acquiring land, and assessing veterans' burial preferences so that the system is responsive to the needs and demands of veterans and their families. And as Congressman Smith brought up earlier, the time it takes to get a cemetery on line is about 5 to 10 years. So we don't have the time right now to wait for that to happen to meet the critical needs in 2008.

Of the 115 national cemeteries, 22 are closed to new burials and 36 are only open to cremated remains. Although there are three new cemeteries that will be open this year in Texas, New York, and Illinois, there are no plans to address the burial needs of major population centers such as Atlanta, Miami, and Sacramento. To date, VA has built or initiated construction of new cemeteries in only six of the ten areas most in need, as identified in the congressionally mandated study of 1987.

The IB partners would like to acknowledge the ability of the dedicated staff who continue to perform the burial mission of the VA, despite the budgetary shortfalls, inadequate staff, aging equipment, and the increasing workload of new cemetery activations, development of gravesites, and land acquisitions. With the emphasis on a smaller and more efficient government workforce, the staffing needs of NCA have become more critical as the interment rate has increased. And I personally have toured a couple of the cemetery

systems, and I can tell you that they are very prideful of their cemeteries and the staff works very hard to make it work.

In 1978, Public Law 95-476 authorized VA to administer the State Cemetery Grants Program, under which States receive financial assistance to provide burial space for veterans and eligible dependents. State veterans' cemeteries are operated and primarily maintained by the States. Recently passed legislation by last Congress allows States to receive 100 percent funding from VA to establish a State veterans' cemetery. The newly funded grant program should encourage States to establish cemeteries to meet the demands of the aging veteran population and the rising interment rate. The expanded grant program will also create new funding demands of the program. The IB recommends an increased funding level to ensure that all approved State cemetery grant applications will be funded, and currently right now we don't believe there is enough money in there to meet the needs and the demands on this program.

I also would like to touch a little bit on the military honors. As you know, with the DOD Authorization Act, DOD and VA were asked to come together as a task force, and we participated in that task force at the meeting that was held November 17 at the National Guard Association Headquarters, and Secretary Guber participated in that also. We are waiting to see what the recommendation of DOD is back to Congress. They are supposed to make their recommendation, I believe it is by April, so we are waiting to see what happens with that.

Whether or not Congress accepts their recommendations, according to the law, the current law will take effect that after December 31, 1999, all requests will be honored. And while we are waiting to hear what they have to say about it, I think one thing that definitely has to be added to that is a directive to the service Secretaries themselves. At the conference, we found out from the Marines that they don't have a denial rate. They make it happen regardless, and that is because their commitment from their service Secretary says it will happen. And I think that that needs to play a part in all the others, too.

In summary, the addition of new cemeteries, coupled with the increased interment rate of the aging veteran population, has intensified the NCA's budget problems. In order to address all these funding issues, our recommendation is that Congress fund the NCA account at \$106 million for fiscal year 2000. This amount is \$9 million more than the Clinton-Gore administration budget proposal. It accounts for the higher cost of administrative expenses due to increased programmatic workload, general inflation, and wage increases.

In conclusion, long-range planning and adequate funding are crucial to addressing veterans' burial needs during the peak years and beyond. Shortfalls mean reduced services to veterans, cemetery neglect, and disrespect to the memory and honor due to our Nation's servicemen and -women.

Mr. Chairman, I will be happy to address any questions from the committee.

[The prepared statement of Ms. A'zera appears on p. 102.]

The CHAIRMAN. Thank you. Mr. Steadman.

## STATEMENT OF KENNETH A. STEADMAN

Mr. STEADMAN. Mr. Chairman, members of the committee, the VFW is glad to be co-author of the veterans' Independent Budget. Our contribution lies in the construction portion, but we are obviously concerned for all aspects of the VA's budget, and I feel compelled to mention a few grave concerns about this budget.

The administration's proposed budget for DVA is devastating, we feel, to our Nation's veterans. This proposed budget will seriously undermine VA's ability to provide quality, timely, accessible health care for veterans.

The VFW hears daily complaints of increased waiting times for veterans to see specialty providers, such as orthopedic doctors or dermatologists, and this seems to be happening throughout the country. More egregious, however, is the 1-year wait for hip replacement surgery in Ann Arbor, the 1-year wait for dentures in Maine, and the 1-year wait for a dermatology appointment in New Orleans. These are only a few examples, unfortunately, of what we think is a nationwide epidemic—an epidemic of increased waiting times and delays in getting appointments which, in these examples, can only be interpreted as a denial of care. And it will get worse this year and next year because of this proposed budget.

For a fourth year in a row, the health care appropriations is flat-lined at just over \$17 billion, absolutely no increase to cover new programs or inflation. The administration's budget is worse than a flat-line budget. It is a "negative growth" budget that threatens the health and well-being of veterans.

This proposed budget does not provide any real increase in personnel desperately needed for important projects needed to correct quality problems in the processing of veterans' claims. The funding proposal is unrealistic and unfair. It is unfair that, in the presence of the largest budget surplus in recent history, veterans are once again being asked to sacrifice with essentially a "negative growth" budget.

Let me now address our primary responsibilities, VA construction.

The VA construction budget consists of major construction, minor construction, and grants for construction of State extended-care facilities, grants for States veteran cemeteries, and the parking garage revolving fund. The VA construction program must face the serious challenge of modernizing and replacing major patient care facilities as well as repairing rapidly aging infrastructure.

The ongoing transformation of the VA health care system from an inpatient hospital system to a system of outpatient community-based clinics has taxed the system's aging and antiquated infrastructure. In the 12 previous editions of the Independent Budget, we have strongly advocated budget increases to ensure that patient care, safety, and privacy needs are met. The construction needs have consistently exceeded the authorized construction budget. This has created a growing backlog in projects that are needed to meet critical patient care needs and safety requirements. This practice is totally unacceptable and must be stopped.

We believe that the VA's construction program must emphasize expanding primary care access, making facilities more modern and attractive, and increasing long-term care capacity in non-institu-

tional setting and institutional settings. Not only does this make the VA more efficient, but it also raises the quality of life of our veterans. Veterans deserve nothing less than what is available in the private sector, both medically and by utilizing modern and up-to-date facilities. Too often, however, the quality of life that is afforded veterans who utilize the VA health care system is compromised by inadequate funding, overworked staff, and decaying physical plants.

The need for additional outpatient and extended-care facilities and infrastructure improvements are now the most important construction needs in the VA health care system. Unfortunately, many renovation projects are threatened because the costs exceed the minor construction project ceiling of \$4 million. Therefore, we recommend that the minor construction cost ceiling be adjusted annually, using an inflation-adjusted matrix, so funding shortfalls due solely to inflation of any costs do not continue to occur with each passing year.

An independent study by Price Waterhouse concluded that over 42 percent of all Veterans Health Administration facilities are at least 50 years old. The study concluded that major and minor construction accounts were significantly underfunded and that the VA has not been able to make a significant investment in its aging properties. This has created a backlog of maintenance and repair projects. Inadequate construction funding will make it difficult for VA to entice paying patients into aging and inefficient structures.

We recommend major construction funding at \$176 million and minor construction funding at \$185 million.

In conclusion, Mr. Chairman and gentlemen, this epidemic must stop. We must turn this flat-lined, negative-growth budget into something that the VFW, the Independent Budget, your veterans, and you can agree will be beneficial to veterans. Nothing else will do.

This concludes my statement, Mr. Chairman. May I ask that the Independent Budget Executive Summary be entered into the record?

The CHAIRMAN. Without objection, certainly.

[The summary appears on p. 107.]

Mr. STEADMAN. Thank you, sir.

[The prepared statement of Mr. Steadman appears on p. 105.]

The CHAIRMAN. Thank you, Ken.

The members of this committee are going to do all we can. It is obvious this morning that no one on this committee, I believe, is happy with the administration's budget. But when the administration doesn't come out and request some of these things, it makes our job extremely difficult to go to the appropriators or the other committees and say we need this money. Their response is, well, the administration didn't ask for it. So you know what position we are in, and we are going to do all we can. We are going to need your help more than ever, and we thank you once again for all the work you do on this budget, and in other areas, in helping us to fight for the veterans.

The gentleman from Pennsylvania, Mr. Doyle.

Mr. DOYLE. Thank you, Mr. Chairman.

I would just reiterate what our chairman just said. You are preaching to the choir here, but our real job is going to be amongst our other colleagues in the House, and that is where the VSOs can play a major role of lobbying Members of Congress that don't sit on the Veterans' Affairs Committee, and especially those appropriators, that this budget just is unacceptable and does not serve the needs of veterans. So we will ask for your support in the days to come, and I think you will find most members of this committee, if not all, will be championing increases in this budget.

The CHAIRMAN. The gentleman from Mississippi, Mr. Shows.

Mr. SHOWS. No.

The CHAIRMAN. The gentleman from Arkansas, Dr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman. I just want to make a comment. It seems like—this is my second term here, but we get ourselves in this pattern of the President probably knows that there is a tremendous constituency for adding money to the budget, but no matter what budget he comes out with, there is going to be those of us who will say it is not adequate. You have obviously presented us very eloquently the need for additional dollars. So they come out with a budget knowing we probably will fix it, and we get ourselves in this pattern. And I don't think it is a very healthy pattern on either side.

I don't know how we get out of it. I know Mr. Hefley on our MilCon, he got dissatisfied a few years ago with the National Guard Bureau not asking for armories because he knew that we would do add-ons, and he just refused to have any add-ons. So 2 or 3 years went by, but finally they started putting it in their budget, which was good.

I appreciate your time. I think your Independent Budget is going to get a lot of study, and it is going to be helpful in the process this year. I appreciate your doing it.

The CHAIRMAN. Thank you, Doctor.

Mr. Bilirakis?

Mr. BILIRAKIS. Just to reiterate and endorse all of the other comments and to commend this group of the Independent Budget. I really am pleased with the way you present it, too, the way you kind of break down various areas and each one of you concentrates in a certain area rather than basically repeating everything. So I just wanted to commend you, Ken, and all of the others, for your great work.

Thank you, Mr. Chairman.

The CHAIRMAN. The gentleman from New Jersey, Mr. Smith.

Mr. SMITH. I, too, want to thank the VSOs for their excellent testimony, and I really believe the Independent Budget is absolutely invaluable in terms of giving us a blueprint to look at the administration's request and figure out where we go with funding, and you just give us a great marker to work with, and I want to thank you for it. And I want to thank the chairman for his leadership.

I have been on this committee now for 19 years, and through successive administrations we have always had this problem, although it has gotten worse, I believe, in the last couple of years, and perhaps more so this year than any other year, with gross underfunding of the VA and, by extension, our veterans. So hopefully at some point—and I think the point was made just a moment ago about

letting them kind of stew in their own juices, but we can't let that happen, obviously, with the VA. And we will respond, and I think respond in a bipartisan way, to make sure there is enough money there.

I think Bob Stump, our chairman, has put it well. Unfortunately, when there is a low-ball figure, as you know so well, we have a real devil of a time with our appropriators who are loath to go above earmarks and levels of funding that have been suggested by the VA.

I would hope that the VA itself would fight much harder with the others within the administration who are putting together the budget. And when the Secretary says he doesn't know how something got in there, I quake.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Any closing comments, gentlemen?

Mr. STEADMAN. Mr. Chairman, on behalf of my colleagues here, I would like to thank you and the members of this committee for your words of encouragement. We started this process early on this year. Back in November we issued a critical issues report, which I commend to every member of the committee. And we have taken this battle as far as we could. Now we must make our case to the Congress. We are ready to work with the Congress to help America's veterans.

Thank you, sir.

The CHAIRMAN. Thank you, gentlemen. Thank you.

If we can proceed rapidly on with our last panel today: Mr. Williams of the American Legion and Mr. Rhea of the Non Commissioned Officers Association, testifying on behalf of the National Military Veterans Alliance.

Gentlemen, we welcome you today, and you are each recognized for 5 minutes. I don't like to limit you. If you need to go over, please do. We appreciate your waiting until the last, but your entire statement will be included in the record, and you may proceed in any way you see fit.

**STATEMENTS OF LARRY D. RHEA, DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS, NON COMMISSIONED OFFICERS ASSOCIATION, AND ON BEHALF OF THE NATIONAL MILITARY VETERANS ALLIANCE; AND CARROLL WILLIAMS, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION**

**STATEMENT OF LARRY D. RHEA**

Mr. RHEA. Thank you, Mr. Chairman. Good morning. NCOA always appreciates this opportunity, Mr. Chairman. We thank you for that, and we thank you for including our prepared statement in the hearing record.

As you have read that statement, you know that it reflects our concerns and that our concerns parallel many of those that have been expressed by the chairman, Mr. Evans, and other distinguished members of this committee. Rather than rehash some of that which has already been said, permit me please to just take a few moments and make some overall observations and comments.

Veterans were pretty straight lined in the Balanced Budget Act of 1997, and those caps are now translating into real reductions. Last year veterans lost nearly \$20 billion in budget cuts and have lost that much again over the previous 10 years. Yet overall Federal spending continues to grow, and the President has proposed nearly 100 new programs or initiatives in fiscal year 2000, yet he proposed no relief for important, worthy veterans' programs and benefits.

Two years ago, this committee and the Senate Veterans' Affairs Committee joined the House and the Senate Armed Services Committee in establishing a congressional commission to examine veterans' benefits and programs. NCOA was honored to have worked with former Senator Dole and his staff in the legislation that mandated that review, and we salute the distinguished members of this committee for the tremendous work you did that resulted in that initiative becoming law.

Mr. Chairman, it would take the restoration of only a small amount of the cuts over the next few years to make up for the neglect of recent budget cycles. It would also take the restoration of only a small amount of past cuts over the next few years that would also allow Congress to address and possibly enact many of the tremendous improvements proposed by your own Transition Commission.

Our message to you this morning is this: We urge this committee to work with the Budget, the Appropriations, and the Armed Services Committee to establish a funding plan that would allow us, beginning this year, to provide for a newly enhanced GI bill, a substantially revised employment program for veterans, an affordable program of medical benefits for veterans, and for some of the dozens of other new and revised program initiatives contained within the report.

In addition to establishing a funding plan, the association would recommend that we also establish an aggressive timeline to get the job done.

The Commission's final report presented a road map, and as someone observed just a few moments ago, the Independent Budget has presented you a road map. Together we believe they can be used in many instances to repair important programs and benefits that have become outdated or seriously deficient.

As we close out this century, Mr. Chairman, I think Congress has a unique and a rare opportunity before them. They have an opportunity to deliberate and possibly enact improvements to these programs in a surplus budget environment. It is NCOA's belief that your Commission did its work that you, the members of this committee, assigned them to do.

Mr. Chairman and distinguished members, NCOA and other veterans must now rely on your leadership to ensure that those efforts were not in vain. We stand ready to work with you throughout this session to help get that job done, sir.

Thank you.

[The prepared statement of Mr. Rhea appears on p. 128.]

The CHAIRMAN. Thank you. Mr. Williams.

**STATEMENT OF CARROLL WILLIAMS**

Mr. WILLIAMS. Yes, sir. Thank you.

Mr. Chairman, I would just like to add, before I present my oral remarks, that we are in this together. This committee, like the American Legion and our sister organizations, are advocates for veterans, and I know this committee will do it darnedest to ensure that proper funding is initiated to ensure that the services that we provide our Nation's veterans are fulfilled.

The American Legion appreciates the opportunity to provide its views on the President's fiscal year 2000 budget for the Department of Veterans Affairs.

Mr. Chairman, at the outset, the American Legion believes that many areas within the President's proposed budget require improvement. Conversely, we are pleased with the President's recommendations to provide additional resources and staff to met the demands in processing and adjudication of veterans' and dependents' claims in a timely and accurate manner.

As you well know, on October 6, 1998, our national commander, Harold "Butch" Miller, from the Department of Virginia, presented the American Legion's specific budget recommendations for the Department of Veterans Affairs for fiscal year 2000 before a joint session of the Congressional Committee on Veterans' Affairs. Mr. Chairman, there is nothing that has changed to modify those particular recommendations. We are confident that the amount of funding requested by Commander Miller presents a more straightforward budgetary picture of the Department's needs than those presented by the administration.

The American Legion believes that funding for veterans' benefits and services is a bipartisan matter. There is no particular philosophy that should guide VA funding issues other than doing what is fair and what is right. VA programs and services symbolize a sacred trust between the Federal Government and those who have faithfully served in the Armed Forces of this great Nation. The President's fiscal year 2000 budget does not uphold the complete commitment of this Nation to its veterans and dependents.

Mr. Chairman, the Balanced Budget Act of 1997 is creating damaging and severe effects throughout the Veterans Health Administration. For the past 2 years, funding has essentially been frozen at the fiscal year 1997 level. Apart from unsubstantiated third-party insurance reimbursements, Congress has not authorized sufficient funding for the medical care programs and services of the Department. The committee knows that the Veterans Health Administration is facing many critical choices due to funding shortfalls.

The American Legion fully acknowledges that over the past few years it was important to improve internal efficiencies rather than pump more dollars into an old, antiquated system. However, the trend across the Nation today is declining real dollar budgets and increasing workloads. There is little additional margin to decrease internal efficiencies without harming core VHA programs.

For fiscal year 2000, the American Legion recommends a funding increase of \$1.4 billion above the current year level. This is separate from any anticipated third-party reimbursements. Mr. Chairman, this is the minimum amount of funding required to permit

VHA to successfully meet all programs' requirements and to continue providing high-quality health care.

Mr. Chairman, beyond the immediate issue of fiscal year 2000 funding, the American Legion believes the Congress and VHA must explore a range of options to increase annual revenues. The annual appropriation process has historically been the sole source of VHA health care funding. In addition, the option of increasing third-party insurance reimbursements and Medicare subvention are now before the Congress. The American Legion suggests that Congress must meet these issues head-on and develop a mechanism to permanently improve VHA's funding predicament.

The American Legion believes a third option that Congress should adopt is seeking to bring new business into the system, as would be accomplished through the GI bill of health. A GI bill of health demonstration program can easily be incorporated into a Medicare subvention pilot program. The American Legion testified several years ago during the hearings on eligibility reform that the system would implode if VHA's funding mechanisms were not reformed along with eligibility. Mr. Chairman, that is exactly what is occurring today.

Mr. Chairman, one day in the not too distant future, we will wake up and discover that the VHA health care system cannot withstand repeated marginalized budgets. There are indications that this is occurring today within many of the VHA's 22 veterans' integrated service networks. This issue is not so alarming until it occurs in your own back yard, as was attested to today by several members of this committee. The recommendations contained in the GI bill of health will help prevent this inevitable day of reckoning.

As this Nation confronts the subject of saving Medicare for future generations, one only needs to study how the Veterans Health Administration squeezes its dollars. Mr. Chairman, the American Legion also recommends that Congress closely review the President's inadequate fiscal year 2000 funding proposals for medical and prosthetic research, major construction projects, the state extended-care grants program, and the national cemetery system.

The American Legion is generally pleased with the proposed additional resources for the claims adjudication process, and it will take some time before these new resources are fully productive. They will greatly support VBA's road map to excellence. Sadly, however, the first increment of additional FTE and resources for claims adjudication represents a belated recognition that the effort to downsize well-trained personnel in favor of increased computer dependence has failed. This failure led to a deterioration in timeliness and the growing backlog of claims awaiting final disposition. The American Legion supports the efforts underway to improve VBA operations.

These actions validate the adage that there is no substitute to getting the job done the first time.

Mr. Chairman, that concludes my testimony. Thank you.

[The prepared statement of Mr. Williams appears on p. 136.]

The CHAIRMAN. Thank you, gentlemen. We appreciate your waiting and apologize for taking you through the lunch hour here.

Larry, thanks for your comments about the transition team. I think they did an excellent job. We have scheduled hearings. Bob

Dole has agreed to testify. On the staff level, we are already working with the Armed Services Committee or shortly will be working with them. And one thing that may help a little bit, we have in this new Congress 11 members that are both on this committee and on Armed Services, so that is roughly a third of this committee. That may help and we may get their attention over there.

Mr. Bilirakis?

Mr. BILIRAKIS. Mr. Chairman, I just wanted to say to both these gentlemen, I am a member of both your organizations. I am a former non-com, as many of us up here were. But, you know, Mr. Doyle said it. We need your help. And the trouble is—now, you all, you have your legislative digests or whatever you call those pages in your booklets.

Mr. WILLIAMS. Legislative priorities.

Mr. BILIRAKIS. I am a member of the VFW, too, another one of the organizations. But only a very small percentage of veterans out there are members of the service organizations. Twenty percent, I always say, and maybe less, maybe a little more, so there is a good 80, 85 percent out there who you are really doing the job for who are not paying dues and who are not active in any way whatsoever.

But it is critical to get what is needed out to them so they in turn can press their elected representatives. And I would just commend to your attention some way where you can get those lists. Many of them, of course, have veterans' benefits, and so you can get them, I guess, somehow through the VA. But there are also other ways. They could really help us do this job, because we agree with you that things have got to be improved, and we need your help to do it.

Mr. WILLIAMS. I would like to add also that the American Legion, as you are aware, Congressman, have held several town hall meetings around the country, and we have invited veterans who are not members of our organization just to convey what is going on inside the Beltway and that we need their assistance. We put out several publications, alerting them to benefits that they are entitled to, and the fact that if we don't get together as one group, then there is a possibility that this fine benefit package, health care, et cetera, may just one day disappear. So we need them and we agree.

Mr. BILIRAKIS. Well, we certainly do have to work together.

Mr. WILLIAMS. Yes, sir.

Mr. BILIRAKIS. Mr. Shows didn't say so when he talked about his father and his health care, but he is an ex-POW, and I am kind of proud of the fact that we have got a member of our committee, Mr. Chairman, whose Dad sacrificed, as so many others have, as much as he did.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mike.

Any other questions or comments? If not, let me express my appreciation to those of you who stayed through this long, long meeting. I appreciate it very much.

Gentlemen, thank you very much for your hard work.

The meeting stands adjourned.

[Whereupon, at 12:39 p.m., the committee was adjourned.]

## **A P P E N D I X**

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**OPENING STATEMENT  
CHAIRMAN BOB STUMP  
FULL COMMITTEE HEARING ON VA FY '00 BUDGET  
FEBRUARY 11, 1999**

**THE COMMITTEE WILL COME TO ORDER.**

**TODAY WE ARE MEETING TO HEAR TESTIMONY ON THE  
VA'S BUDGET FOR FISCAL YEAR 2000.**

**WE WILL HEAR BOTH FROM THE DEPARTMENT OF  
VETERANS AFFAIRS AND FROM VARIOUS VETERANS  
SERVICE ORGANIZATIONS.**

**I WANT TO BEGIN THE HEARING BY WELCOMING THE  
SECRETARY OF VETERANS AFFAIRS, TOGO D. WEST JR.**

**THIS IS SECRETARY WEST'S SECOND APPEARANCE  
BEFORE THE FULL COMMITTEE.**

**AS YOU KNOW, MR. SECRETARY, EACH YEAR WE VIEW  
THE BUDGET AS A GAUGE OF HOW WELL WE ARE MEETING  
OUR COMMITMENTS TO VETERANS.**

**THE VA BUDGET FOR FISCAL YEAR 2000 APPEARS TO BE  
ADEQUATE FOR BENEFIT PROGRAMS AND CEMETERY  
ADMINISTRATION.**

**HOWEVER, THE ADMINISTRATION'S PROPOSAL TO DENY  
EVEN THE SMALLEST BUDGET INCREASE TO VA HEALTH**

**CARE PROGRAMS IS VERY TROUBLING.**

**MR. SECRETARY, YOUR BUDGET IDENTIFIES HUNDREDS OF MILLIONS OF DOLLARS NEEDED FOR EXISTING FIXED COSTS, NEW ADVANCED TREATMENTS, AND NEW INITIATIVES TO PROVIDE A FULLER CONTINUUM OF CARE TO VETERANS.**

**UNFORTUNATELY, THE ADMINISTRATION HAS NOT INCLUDED ANY NEW FUNDING TO ADDRESS THOSE NEEDS.**

**AS WITH LAST YEAR'S BUDGET, THE VA PREDICTS OVERLY OPTIMISTIC INSURANCE REVENUE FROM NON-SERVICE CONNECTED CARE.**

**BUT MORE SIGNIFICANTLY, THIS YEAR'S BUDGET TRIPLES PROJECTED SAVINGS FROM UNSPECIFIED MANAGEMENT INITIATIVES.**

**WHILE PAST VA HEALTH CARE BUDGETS HAVE ASSUMED SAVINGS OF \$200 – \$300 MILLION, THIS YEAR'S BUDGET ASKS CONGRESS AND VETERANS ALIKE TO RELY UPON VA'S STATED ABILITY TO SAVE AN UNPRECEDENTED \$1.4 BILLION IN FISCAL YEAR 2000.**

**MR. SECRETARY, WE ARE ANXIOUS FOR YOU TO EXPAND ON THIS PART OF THE BUDGET.**

**STATEMENT OF HON. LANE EVANS**  
**FULL COMMITTEE BUDGET HEARING**  
**FEBRUARY 11, 1999**

THANK YOU MR. CHAIRMAN.

I JOIN YOU IN WELCOMING SECRETARY WEST AND OUR OTHER WITNESSES. I AM PLEASED THE SECRETARY IS HERE TO HELP US BETTER UNDERSTAND THE PROPOSED BUDGET.

THIS BUDGET CONTAINS MANY IMPORTANT VETERANS' INITIATIVES THAT I STRONGLY SUPPORT. WHEN THESE INITIATIVES ARE REALIZED, THERE WILL BE REAL IMPROVEMENTS IN VETERANS' BENEFITS AND SERVICES.

UNFORTUNATELY, THIS BUDGET PROVIDES NO MORE DOLLARS OR OTHER RESOURCES FOR THESE INITIATIVES. THIS BUDGET MAY UNDERFUND VETERANS' PROGRAMS NEXT YEAR BY AS MUCH AS TWO AND ONE-HALF BILLION DOLLARS, POSSIBLY MORE.

THIS BUDGET IS LIKE BUILDING A HOUSE OF CARDS. IT IS TRYING TO ADD MORE STORIES BUT WITH NO MORE RESOURCES. THIS MAY WORK FOR A WHILE BUT EVENTUALLY THIS HOUSE OF CARDS WILL FAIL.

HAVING SAID THAT, IT IS IMPORTANT TO EMPHASIZE SOME OF THE COMMENDABLE INITIATIVES INCLUDED IN THIS BUDGET. I HAVE ADVOCATED FOR IMPROVING VETERANS' ACCESS TO NON-VA EMERGENCY CARE. LAST MONTH I INTRODUCED THE "VETERANS ACCESS TO EMERGENCY CARE ACT OF 1999". THE BUDGET TAKES A SMALL STEP IN THE RIGHT DIRECTION ON THIS IMPORANT - LIFE-SAVING, ISSUE.

THE BUDGET ALSO INCREASES ASSISTANCE TO HOMELESS VETERANS, EXPANDS VA TREATMENT FOR VETERANS WITH HEPATITIS C, AND CONTINUES CURRENT EFFORTS TO IMPROVE THE QUALITY AND TIMELINESS OF VETERANS' CLAIMS PROCESSING.

IT ALSO PROPOSES INCREASING VA NON-INSTITUTIONAL LONG-TERM CARE FOR VETERANS, PROVIDING MORE FUNDING FOR THE ESTABLISHMENT OF STATE VETERANS' CEMETERIES AND PROVIDING A COST-OF-LIVING ADJUSTMENT TO VETERANS RECEIVING SERVICE-CONNECTED DISABILITY COMPENSATION.

IT WILL BE UP TO THIS CONGRESS TO SUPPLY THE NEW RESOURCES REQUIRED FOR THIS BUDGET TO BECOME A REAL BLUEPRINT FOR IMPROVING VETERANS' BENEFITS AND SERVICES. I WILL FIGHT FOR THE PROGRAMS AND RESOURCES VETERANS NEED.

THIS BUDGET CAN BE LAID ON THE DOORSTEP OF THE ADMINISTRATION, BUT ONLY FOR SO LONG. IT IS CONGRESS THAT DETERMINES OUR NATIONAL PRIORITIES AND SPENDING. WHILE THE ADMINISTRATION PROPOSES, IT IS THE CONGRESS THAT DISPOSES.

I LOOK FORWARD TO WORKING WITH OTHER MEMBERS WHO SUPPORT OUR VETERANS RECEIVING THE PRIORITY THEY HAVE EARNED.

THANK YOU, MR. CHAIRMAN.

**Statement of Representative Luis Gutierrez  
Hearing on the FY '00 Budget of the Dept. of Veterans Affairs  
February 11, 1999**

Thank you Mr. Chairman. Allow me to also thank the witnesses who have taken the time to be here today. I look forward to hearing from them this morning and appreciate this opportunity to discuss the Administration's proposed budget of the Department of Veterans' Affairs for Fiscal Year 2000.

I believe that America has a responsibility to care for its veterans who have served our country in times of peace and war. Without their service, Americans would not enjoy the freedoms we have today. Unfortunately, we often take these freedoms for granted and fail to think about the sacrifices that were made for us.

We must remember that freedom is not free. Many of our veterans still retain the physical and psychological scars from their service. As a nation, it is our obligation to take care of our proud men and women who served our country. One of the best ways we can do that is to have a Department of Veterans' Affairs that is responsive to the needs of our veterans. And that means having a budget that demonstrates our commitment to them. We need a budget that tells veterans loud and clear, "You are important. You are a priority."

Mr. Chairman, I have worked with this administration on these issues, and I am confident that we can compel the VA to revise and improve their budget before the ink is dry on Fiscal Year 2000 programs. As the ranking Democrat on the House Veterans Affairs Committee, Subcommittee on Health, I have carefully examined President Clinton's Fiscal Year 2000 budget request for the VA medical services. The VA health care budget contains NO MONEY for increased costs of existing programs. The VA health care budget contains NO NEW MONEY to fund administration initiatives. In all probability, the VA health care budget SIGNIFICANTLY UNDERESTIMATES THE COSTS FOR NECESSARY TREATMENTS. The President has recommended a fiscal year 2000 appropriation of \$17.306 billion for veterans care, exactly the same as provided this year.

I have served on the Veterans' Committee since I entered Congress in 1993. I know what's happening at our veterans' hospitals. I hear from veterans in Chicago about the lack of nursing staff, physicians, adequate facilities, the waiting periods for care.

Despite the fact that the VA is already struggling with limited resources, the President's budget calls for the elimination of 8,000 full-time employees from VA health care.

The President's budget plan must be improved to protect the health and benefits of millions of American veterans. Therefore, it is of the utmost importance that this Congress pass a fair and adequate veterans' budget-- a budget that protects the health and benefits compensation veterans have earned and deserve.

I strongly believe that we must honor our commitment to the brave men and women who served in our armed forces by ensuring that adequate funding is provided for the VA. We must create a VA budget that meets veterans' urgent needs today and in the future.

**STATEMENT OF THE HONORABLE MIKE DOYLE (PA-18)****Committee on Veterans' Affairs  
Hearing on the FY 2000 Budget of the Department of Veterans Affairs***February 11, 1999*

I want to thank Chairman Stump for convening today's hearing on the Administration's proposed FY 2000 Budget for the Department of Veterans Affairs and providing for an opportunity to comprehensively and critically examine the pressing issues facing our country's veteran population. I also want to recognize Ranking Member Evans for his efforts in speaking out on these issues as they relate to the budget in a timely and aggressive manner. In addition, I want to welcome Secretary West, as well as the distinguished representatives from the various VSO's who are here to testify before the Committee.

Clearly, everyone here recognizes the great sacrifices that veterans have made, and continue to endure for the overall benefit of our nation. Similarly, we all agree that veterans are entitled to, and deserve to have access to, basic services and benefits. The difficult question that we must address here today - and continue to work on *together* - is how do we translate these platitudes into meaningful and tangible improvements in the everyday lives of our veterans.

While I am supportive of many of the new initiatives included in the Administration's budget, I am deeply concerned about the overall funding levels provided. To the point, the \$43.6 billion requested is simply not sufficient in terms of supporting old programs, let alone supporting the new initiatives. The new initiatives have been projected to cost \$566 million - for which *no* new funding has been provided.

Without question, I am an advocate for structuring the federal budget in a fiscally responsible manner and increasing efficiency in all federal programs and agencies. The Department of Veterans Affairs (DVA) however, has been pushed to the brink in this regard. It is no longer a viable approach to solving the systemic problems that exist to continue to say "do more with less". This directive of "do more with less" in the absence of well thought out direction and oversight has only created more difficult problems. It is time to stop this unproductive approach and find ways that will truly address the situation.

As many of you know, the district I represent has one of the largest veterans populations of any district in the nation. It is not only the largest, but one of the oldest. We are particularly fortunate to have three VA hospitals in the area. Thus, I am particularly troubled by the lack of funding provided for the Health Care Budget for the Department. As a result of various factors, including eligibility reform and dissipating resources, veterans now are saddled with longer waiting periods for medical treatment. Longer waiting periods are only an indicator of the larger and more serious quality of care issues that must not only be examined, but corrected.

I want to reiterate the great need for, and importance of, continuing to work together in securing adequate funding levels that are critical to the overall integrity of the DVA and in particular to the VA medical-care system.

Again, I want to thank all of the witnesses who have come here today to express their response to the Administration's FY 2000 Budget for the Department of Veterans Affairs and to lend the Committee their expertise in matters directly affecting our nation's veterans. It is my hope that today's and subsequent discussions will bear the fruit of a final FY 2000 Budget that *accurately reflects and meets the needs of all veterans.*

**Opening Statement by Representative Howard P. "Buck" McKeon  
House Veterans' Affairs Committee, February 11, 1999  
FY2000 Veteran Affairs Budget Hearing**

Mr. Chairman, I want to thank you for holding this hearing today to discuss this important matter to our nation's veterans. I also would like to thank all the participants for coming today to keep this committee informed of their concerns and beliefs about improving the lives of our veterans.

Unfortunately Mr. Chairman, the Clinton Administration has produced a budget that is woefully inadequate for our military veterans. At a time when the President is determining, if not formalizing, plans to send our men and women into harms way in Kosovo, this Administration has no strategy, long or short, on how to deal with them when they return home and leave their service. This budget is evidence of that.

Specifically, the Administration's request represents the fourth consecutive budget that cuts Veteran funding. At a time when the economy is robust, our budget is in surplus, and our veteran population growing older, I find it appalling that President Clinton would continue to try and take from Veterans to pay for more big government social spending.

This budget represents major cuts in health benefits for our former fighting men and women. It will take away researchers from investigating cause and cure for those unique ailments of our veterans. It will slash veteran staff by about 8,000 employees. It relies on a formula for offset payments that has never been established as credible and has numerous examples of error.

Worse yet, the budget does not address short-term, mid-term, or long-term solutions for the ever growing National Cemetery crisis. Currently, of the 115 National Cemeteries, over 50 percent are either closed for new burials or are only accepting cremation for interment. While three new cemeteries will be opened next year, these do not reflect the growing population growth areas. Furthermore, with the window of 10 years between planing and opening of cemeteries, the administration has no vehicle to address the certain 18 percent death rate increase among veterans over that same time period.

Mr. Chairman, I join both you and Ranking Member Lane Evans in denouncing this poor standard of governance for our veterans. Surely President Clinton, if he wants to send our troops into harms way today, will consider the implications of not having adequate planning for their return tomorrow. I call upon the President and the Department of Veterans' Affairs to revise their budget request and never again disrespect the heroic actions of our veterans with such a poor excuse for funding.

Statement of Rep. Corrine Brown  
VA Full Comttee Meeting 2/11/99

Thank you Mr. Chairman.

I would like to welcome today's panelists to this hearing. I look forward to a new Congress with the hope and intent that this will be an extremely productive year for this committee and for the veterans we serve.

I am honored to have been selected as the Ranking Member on the Subcommittee on Oversight and Investigation. I look forward to meeting with Chairman Terry Everett very soon to plan a mutual agenda.

The VA budget is the lifeblood of services to our veterans. They made the supreme sacrifice for our nation, and the time has come to treat them with the respect and honor they deserve. Unfortunately, this VA budget falls well short of providing the funding needed to honor our commitment to these brave men and women.

I hope the watchword for this Committee will be "How will it help the Veterans?" Not "How much will it cost?"

I want to thank you for joining us today, Secretary West. I look forward to working more closely with you to eliminate the shortfalls in this budget.

THE HONORABLE MICHAEL BILIRAKIS  
COMMITTEE ON VETERANS' AFFAIRS  
FEBRUARY 11, 1999

HEARING THE DEPARTMENT OF VETERANS' AFFAIRS  
FISCAL YEAR 2000 BUDGET

THANK YOU, MR. CHAIRMAN.

I WANT TO COMMEND YOU FOR SCHEDULING THIS TIMELY HEARING ON THE ADMINISTRATION'S FISCAL YEAR 2000 BUDGET REQUEST FOR THE DEPARTMENT OF VETERANS' AFFAIRS. I WOULD ALSO LIKE TO WELCOME SECRETARY WEST AND OUR OTHER WITNESSES TO THE COMMITTEE THIS MORNING.

I AM ANXIOUS TO HEAR SECRETARY WEST'S TESTIMONY REGARDING THE ADMINISTRATION'S OVERALL BUDGET RECOMMENDATIONS FOR THE UPCOMING FISCAL YEAR. AS THE REPRESENTATIVE OF A DISTRICT WITH A LARGE VETERANS POPULATION, I STRONGLY BELIEVE THAT WE MUST DO EVERYTHING WE CAN TO REPAY THE GREAT DEBT THAT WE OWE THE MEN AND WOMEN WHO ANSWERED THE CALL TO DUTY.

FLORIDA HAS ONE OF THE HIGHEST CONCENTRATIONS OF VETERANS WITH SPINAL CORD INJURIES OR DISEASE IN THE COUNTRY. HOWEVER, THE SERVICES AVAILABLE IN FLORIDA FOR THESE VETERANS ARE INADEQUATE. FOR MANY YEARS, I HAVE BEEN WORKING ON A PROJECT TO CONSTRUCT A SPINAL CORD

**INJURY CENTER AT THE VA MEDICAL CENTER IN TAMPA, FLORIDA TO BETTER SERVE THE NEEDS OF THESE VETERANS. I WAS PLEASED TO SEE THAT THE ADMINISTRATION'S BUDGET INCLUDES FUNDING FOR THIS IMPORTANT PROJECT.**

**ALTHOUGH I WAS PLEASED ABOUT THE FUNDING FOR THE SCI CENTER, I HAVE SOME CONCERNS ABOUT THIS BUDGET SUBMISSION. FOR EXAMPLE, THE VA HEALTH CARE BUDGET CONTAINS NO MONEY FOR THE INCREASED COSTS OF EXISTING PROGRAMS. THE BUDGET REQUEST DOES NOT INCLUDE FUNDS TO COVER INFLATION OR ROUTINE PAY INCREASES. IT DOES NOT TAKE INTO ACCOUNT THE INCREASED NUMBER OF VETERANS BEING CARED FOR IN STATE HOMES AND FOR CHAMPVA.**

**THE ADMINISTRATION'S REQUEST ALSO CONTAINS NO NEW MONEY TO FUND THE INITIATIVES PROPOSED IN THE BUDGET SUBMISSION. THE FUNDING FOR THESE PROGRAMS IS OVER \$500 MILLION. WHILE THE SERVICES PROPOSED IN THESE INITIATIVES ARE NEEDED, THE VA'S HEALTH CARE BUDGET IS ALREADY STRAINED TO THE BREAKING POINT. HOW DOES THE VA EXPECT TO PAY FOR THESE INITIATIVES WHEN IT CAN'T EVEN MEET THE CURRENT DEMAND FOR SERVICES?**

I HOPE THAT SECRETARY WEST WILL ALLAY SOME OF MY CONCERNS DURING HIS TESTIMONY TODAY. I AM ALSO ANXIOUS TO HEAR THE RECOMMENDATIONS OF THE AUTHORS OF THE INDEPENDENT BUDGET AS WELL AS THOSE OF OTHER WITNESSES.

AS ALWAYS, MR. CHAIRMAN. I LOOK FORWARD TO WORKING WITH YOU AND THE OTHER MEMBERS OF OUR COMMITTEE TO ENSURE THAT OUR VETERANS RECEIVE THE BENEFITS THEY EARNED THROUGH THEIR SERVICE TO OUR COUNTRY.

THANK YOU, MR. CHAIRMAN.

**STATEMENT OF THE HONORABLE TOGO D. WEST, JR.****SECRETARY OF VETERANS AFFAIRS****FOR PRESENTATION BEFORE THE  
HOUSE COMMITTEE ON VETERANS' AFFAIRS****FEBRUARY 11, 1999****I. Introductory Remarks**

Mr. Chairman, members of the Committee, the President's budget for Fiscal Year 2000 reflects the President's sincere commitment to the needs of our veterans and their families. It acknowledges the nation's responsibility to provide high quality care and services. In short, we believe that the Fiscal Year 2000 budget provides better and more accessible service to more veterans. We are requesting \$43.6 billion in new budget authority for veterans' programs.

**II. Highlights of Department of Veterans Affairs (VA) FY 2000 Budget Submission**

Our budget request builds on VA's previous accomplishments and positions us for the future. Here are some of the highlights of our request.

- **For the Veterans Health Administration (VHA)**

The budget provides \$18.1 billion, including \$749 million in medical collections, to provide medical care to eligible veterans. VA will open 89 new outpatient clinics and treat 54,000 more patients in 2000 than in 1999, a 1.5 percent increase.

We are proposing \$50 million in additional funding to help homeless veterans, including \$40 million in medical care and \$10 million in mandatory transitional housing subsidies. We are asking for a \$136 million increase in VA's efforts to combat Hepatitis C and an increase of \$106 million in VA's long-term care alternative programs.

While not included in the budget, the Administration will continue to seek authorization of a pilot program whereby VA could receive reimbursement from Medicare for covered services provided to certain Medicare-eligible veterans. This program will help us to increase alternative revenues.

The budget includes a legislative proposal to authorize VA to cover the cost of out-of-network emergency care for enrolled veterans with compensable disabilities related to military service. This legislation would ensure that these veterans have access to emergency care when treatment in VA facilities is not an option.

- **For the Veterans Benefits Administration (VBA)**

For benefits processing, the budget provides \$860 million, \$49 million more than the funding level enacted in 1999. This is a six percent increase and will ensure that compensation, pension, education, and housing benefits to veterans will continue to be delivered while we continue the process of reengineering the way we deliver benefits. Four hundred and forty FTE will be added to help us process disability claims more efficiently.

- **For the National Cemetery Administration (NCA)**

The budget requests \$97 million, \$5 million more than the 1999 enacted level, for the operations of the National Cemetery Administration. This increase will provide funding for the activation and first year operations of four new National Cemeteries.

- **In other areas (Construction, the Capital Asset Fund, and Smoking Cessation)**

We are requesting new budget authority of \$296 million for the Department's construction programs. Our request provides funding for four major construction projects and provides resources for minor construction, a proposed new Capital Asset Fund, and grants for State veteran's nursing homes and cemeteries.

The Capital Asset Fund is a proposal that would authorize the establishment of a five-year pilot program allowing VA to sell, transfer, or exchange its excess properties and keep 90 percent of the proceeds. VA would then reinvest those proceeds into non-recurring capital needs to benefit veterans.

A significant portion of the money from the fund would be retained by the local area or network in which the property has been disposed. This proposal would also direct ten percent of the net proceeds from sales to local continuum of care for the homeless through the Department of Housing and Urban Development. That money would include assistance to local homeless veterans. We are asking for authority to spend \$10 million in FY 2000 to fund the administrative start-up costs of the program.

We're also asking for \$56 million to establish smoking cessation programs for veterans who began to smoke during military service. This program will be designed to reach veterans throughout the country by using contractors.

### **III. Improved VA Strategic Planning Processes**

As a Department, we are placing greater focus on the outcome of our actions and policies. As we develop our long-term vision for the Department and our goals, we are placing greater emphasis on understanding the impact our programs have on veterans and their families. We believe this will help us to better link our resources to programs that benefit our veterans.

### **IV. Additional Information**

Mr. Chairman, those are the highlights of our Fiscal Year 2000 budget request. Let me now provide you with some additional details.

- **On VHA's Budget**

In the area of healthcare for veterans, our Fiscal Year 2000 request recognizes the dramatic changes that have occurred in the past four years. In that time, we have changed the organizational structure of the Veterans Health Administration. We have found new ways to help fund our medical programs. We have gotten rid of conflicting and confusing rules on eligibility. And we have changed the culture of VA healthcare.

In addition, we have increased the number of veterans treated, improved the quality of our care, and improved customer satisfaction. At the same time, we have reduced the per-patient cost of providing care.

The goal of our department is to provide world-class quality healthcare to as many veterans as possible. We will continue to insure that taxpayers receive

full value for the funds they entrust to us. Our resources will continue to be shifted from inpatient specialty care to primary care delivered on an outpatient basis.

VA has successfully organized a system of coordinated healthcare delivery focused on continuous quality improvement that is patient-oriented, ambulatory care-based and results driven. We now treat patients in the most appropriate settings for their problems. Veterans have embraced the use of primary care providers and care teams for their health needs.

These strategies will assure the viability of the healthcare system well into the next century. They will also prepare VA to continue to meet the diverse healthcare needs of the veteran population. We believe that the new VA system should serve as a model for future integrated healthcare systems, both public and private.

In 1996, our department committed to the goals of reducing per-patient cost for healthcare by 30 percent, serving 20 percent more veterans, and increasing alternative revenue sources to 10 percent of all Medical Care funding. VA is still committed to meeting these goals, while assuring that quality of care is maintained in our system.

VA is on track towards its long-range goals of 30/20/10. Compared to the 1997 baseline, we project the following results in 2000:

- reduce per-patient cost by 18 percent,
- serve 16 percent more veterans, and
- increase non-appropriated funding to 5.1 percent of the Medical Care budget.

This will be accomplished in large measure by continuing to shift excess acute inpatient resources to expand and enhance outpatient care and other types of care in the most appropriate setting.

Medicare subvention would allow VA to collect funds from Medicare for healthcare services provided to Medicare eligible, higher income veterans without compensable disabilities. Adoption of this demonstration program is VA's top legislative priority.

We urge you to work with us this year to ensure Congress passes a demonstration project as soon as possible.

We will not be able to obtain 10 percent of our funding from alternative revenue sources in the future if Congress does not pass the Medicare subvention pilot legislation. If this pilot proves successful in improving outcomes and lowering costs, our goal would be to open up VA reimbursement throughout the system. I ask for your support of the Administration's proposal in this area.

I have already highlighted some of the major aspects of VHA's \$18.1 billion budget. The \$106 million we requested for additional long-term care will allow us to expand our home and community-based care programs for our older veterans. The \$50 million for homeless programs will allow us to support 1,385 new community-based beds and treat 12,000 more homeless veterans.

VA is also proposing a change in appropriation language. It would provide for two-year spending availability for up to 5 percent of our resources, excluding those funds set aside due to delays in providing medical equipment.

We support this proposal because it promotes more rational spending decisions and recognizes the need for management flexibility during this period of significant change for VA healthcare.

As I mentioned earlier, the Administration is requesting authorization of a new smoking-cessation program for any honorably discharged veteran who began smoking in the military. The program would be delivered by private providers on a per capita basis. Any veterans who began smoking in the military would be eligible for this new program, to the extent resources are available. The Administration will seek authorization of this program in the near future.

Once this program is authorized, the Administration will submit a budget amendment requesting an appropriation of \$56 million for this new activity. It is estimated that between 500,000 and 600,000 veterans would avail themselves of this valuable program over the next five years.

For Medical and Prosthetic Research, a total of \$316 million and 2,838 employees will support more than 2,100 high priority research projects to enhance the quality of healthcare of the veteran population. This level of funding will allow us to maintain the operation of research centers in the areas of Gulf War veterans' illnesses, diabetes, Parkinson's disease, spinal cord injury, cancer, prostate disease, depression, environmental hazards, women's issues, as well as rehabilitation centers and Health Service Research and Development field programs.

In these areas, no other federally supported clinical or research entity can initiate or complete such critical and ambitious research activities on behalf of America's veterans. Our department will continue to increase the amount of non-appropriated research funding we receive from the private and public sectors.

The Balanced Budget Act of 1997, Public Law 105-33, allows VA to retain all collections from third parties, copayments, per diems, and certain torts after June 30, 1997. These collections are deposited in the Medical Care Collections Fund and are available for transfer to the Medical Care appropriation. The funds remain available to VA until they are expended.

For FY 2000, VA estimates that more than \$761 million will be collected through this effort—and revenues will grow to over \$1.2 billion by 2004. To accomplish this growth, we are in the process of changing our billing rates to reasonable charges for inpatient and outpatient procedures; identifying more patients having insurance; and improving our debt collection efforts.

The Medical Administration and Miscellaneous Operating Expenses, or MAMOE, activity is requesting \$61.2 million in appropriations to fund 573 employees who will support VHA operations in Fiscal Year 2000. Transfers of \$415,000 and \$7.1 million in reimbursements will supplement these funds.

This request is somewhat different from past years in that it includes reimbursement authority for activities related to the Facilities Management Service Delivery Office. Facilities Management will begin to receive reimbursement from VHA, VBA and NCA for field-related project management.

This reimbursement will allow VA to use appropriated funds to hire additional staff in the areas of quality management and performance measurement. Capital policy activities will continue to be funded by the appropriation.

- **On VBA's Budget**

For five years, I have traveled throughout this country, first as the Secretary of the Army and later as the Secretary of Veterans Affairs, talking with servicemembers and veterans. I never fail to hear from veterans about issues of veterans benefits. And, every veteran applying for benefits is concerned about the length and quality of the decision-making process. I am a lawyer, and my

profession has a saying, “Justice delayed is Justice denied.” This means that, in effect, for every day a decision is delayed, that benefit is, in fact, denied.

Yet, timeliness is not the only criteria. It is of no use to our veterans for us to process their claims with record speed if we get it wrong. Accuracy is also critical. The number of appeals and remands for additional information take up too much staff time, and, more importantly, too much of our veterans' time.

This budget emphasizes a commitment to restoring the Veterans Benefits Administration's credibility and trust. Through several leadership initiatives, VA seeks to reverse negative perceptions and make the goal of “world class customer service” a reality.

The Veterans Benefits Administration has developed four overall themes that it intends to address. These include:

- restoring VBA credibility and trust;
- achieving dramatic progress in improving performance;
- building knowledge regarding program outcomes; and
- establishing a rational resource acquisition and investment approach.

The *Balanced Scorecard* is VBA's centerpiece for establishing a clear process for setting strategic objectives and priorities and for measuring the progress they have achieved. VBA's FY 2000 budget request is \$860 million and 11,437 full-time equivalent employees or FTE. This represents an increase of \$49 million and 164 FTE above the 1999 level. By combining this increase in the number of employees with positions available due to efficiencies in other areas, VBA will be able to increase its number of benefits adjudicators by 440.

Demographics indicate that many of our experienced employees will be retiring within the next five to eight years. In order to avoid a two to three year skill gap, which will exacerbate our service delivery challenges, we must stabilize the Compensation and Pension workforce for the future by hiring and training additional resources immediately, before the actual losses occur.

Our compensation and pension objectives include working towards the goals of completing rating-related actions in 74 average processing days, completing non-rating actions in 17 average processing days, achieving 96 percent national accuracy rate for core adjudicative rating work, and attaining 90 percent overall satisfaction among veterans with the way claims are handled.

Besides the electronic claims processing pilot project I mentioned earlier, here are some other initiatives we are taking to meet these goals:

- We have developed a multi-year initiative, which requires funding, for four comprehensive training, performance support, and certification systems for service delivery positions. The four systems are for new rating specialists; veterans service representatives; advanced rating specialists; and decision-review officers.
- We are currently developing formal partnership agreements with veterans service organizations, both at the national and local level. The partnership agreements will allow us to train service organization representatives to properly submit fully developed claims and will allow them to access VBA information systems. This will allow VBA employees to devote their time to decision-making, not claims development.

- We are asking for funds to continue an initiative that will provide claims development, disability examinations, and rating decisions for service persons awaiting discharge from active duty. VA plans to have transition teams present at each of the 20 largest military separation points in the U.S. and to support, on a part-time basis, about 30 additional sites. This should allow VA to reach about 80 percent of all DoD separatees.
- Our Systematic Technical Accuracy Review, or STAR, program will improve the accuracy of C&P claims processing by implementing a new national accuracy review program to provide current and diagnostic information about the accuracy of the work being produced at VA regional offices. We have requested funds for additional staffing, the creation of a database, and administrative expenses to aggressively implement this program.
- VBA intends to merge Adjudication and Veterans Services Divisions in all of its regional offices. Through this program, called the "Conversion to Service Center" initiative, veterans will interact directly with the VA employees processing their claims. They will receive more specific information on their claims' status, and they will also know what evidence is needed for decisions and what they can do to expedite action.

Funds requested for the enhancement of education activities include providing for expanding imaging technology. Imaging technology now in use for claims processing in Atlanta and St. Louis will be extended to Muskogee and Buffalo throughout Fiscal Year 2000.

The budget request for the housing program assumes that, if it is cost effective, VA will join other Federal housing loan guaranty programs and eliminate the in-house home-loan property management and disposal activities of foreclosed homes by using discretionary authority current law grants the Department.

VBA will contract for an A-76 study in 1999 to ensure the most cost-effective approach for disposing of foreclosed properties. This study will include a comparative analysis of selling foreclosed properties for cash versus direct VA financing.

Funding has also been included in this budget to provide for financial accounting improvements the housing program needs. When completed, these improvements will enable the Loan Guaranty general ledger system to meet Federal Financial Management Integrity Act requirements. This is necessary in order for VA to achieve an unqualified audit opinion on their annual financial statements.

Administrative expenses to support the insurance program are made available from excess earnings from the National Service Life Insurance, United States Government Life Insurance and Veterans Special Life Insurance programs.

Also included for this program is a new initiative to promote insurance self-service. The insurance program has experienced significant success with its interactive voice response system. This initiative will be the next step in expanding veterans' direct access to their insurance records and benefits.

In this budget, we are requesting \$10 million to expand a current on-going pilot program on electronic claims processing. VBA is working with a consortium of five companies to develop an electronic work environment through imaging and other technologies. We expect to see improvements in customer service, processing timeliness and accuracy as a result. If successful, this demonstration project will pave the way for a significant reengineering of how claims are processed.

VA's benefits programs provide assistance to veterans in recognition of their service to their country and to aid their transition to civilian life. The Administration is requesting \$21.6 billion to support FY 2000 compensation payments to 2.3 million veterans, 300,000 survivors and 633 children of Vietnam veterans who were born with spina bifida, and to support pension payments to 381,000 veterans and 268,000 survivors.

We propose to provide a cost-of-living adjustment, or COLA, based on the change in the Consumer Price Index, to all compensation beneficiaries, including spouses and children receiving dependency and indemnity compensation. The percentage of the COLA is currently estimated at 2.4 percent, which is the same percentage that will be provided, under current law, to veterans pension and Social Security recipients. The increase would be effective December 1, 1999, and would cost an estimated \$293 million during 2000.

If Congress approves, VA will pay full disability benefits to Filipino veterans residing in the United States who currently receive benefits at half the level that U.S. veterans receive. The cost of this legislation is estimated to be \$25 million over five years.

VA also proposes to charge a fee to lenders participating in VA's Home Loan Program. The fee would give VA the authority to charge lenders a fee of \$25 for each VA loan that is guaranteed. The fees would be earmarked for use in developing, maintaining, and enhancing a VA Loan Information System that would interact with the information systems used by lenders.

Also relating to benefits, an appropriation of \$1.5 billion is being requested for the Readjustment Benefits program. The money will provide education opportunities to veterans and eligible dependents and for various special assistance programs for disabled veterans.

Education benefits will be provided for about 450,000 trainees in FY 2000 including 281,000 training under the Montgomery GI Bill. This request includes funds for the annual Consumer Price Index adjustment, which is estimated to be 1.8 percent effective October 1, 1999, for education programs.

- **On NCA's Budget**

In Fiscal Year 1998, approximately 550,000 veterans died—nearly 1,500 a day. The National Cemetery Administration estimates that the annual number of veterans' deaths will peak in the year 2008 before beginning to decrease. NCA is preparing for this increase by building national cemeteries, extending the service life of existing cemeteries, and encouraging states to build state veterans cemeteries.

Our request for the NCA continues to position VA to meet these future requirements. The request includes funding and new employees to address the Fiscal Year 2000 growth in interment workloads at existing cemeteries, including anticipated growth at the new Tahoma National Cemetery. This cemetery will experience the accelerated workload increase typical of a new cemetery, which is far in excess of the annual growth rates of mature cemeteries.

It includes additional funding and FTE to continue the activation of the new Cleveland-area national cemetery, and for the first full year of operations at the new Abraham Lincoln National Cemetery near Chicago, the new Dallas/Ft. Worth National Cemetery, and the new Saratoga National Cemetery near Albany, NY.

It also includes funding to replace some cemetery equipment that has exceeded its useful life, for customer service initiatives, and to cover the increased cost of an integrated data communications project.

#### **V. Additional Funding Requests**

- **For General Administration**

VA is asking for \$206 million in funding for the Office of the Secretary, six Assistant Secretaries and three VA-level staff offices. This request, along with \$4.7 million associated with credit reform funding, will provide a total resource level of \$210.7 million.

When compared to the original Fiscal Year 1999 appropriation, the FY 2000 request is \$7 million higher. The budget authority, along with \$117 million in estimated reimbursements, will provide for an estimated total authority for obligations of \$323 million in FY 2000. FTE will increase by 111 in FY 2000 from the 1999 current estimate of 2,490. This increase occurs primarily in the reimbursable activities.

Here are some of the areas where we will use this increased funding and number of employees.

- **For the Board of Veterans' Appeals**

We are requesting \$41.5 million in funding for the Board of Veterans' Appeals for Fiscal Year 2000. The Board's marked improvement in timeliness, increase in productivity, and reduction of the appeals backlog in Fiscal Years 1995 through 1998 exceeded our most optimistic expectations.

This level of funding will give us the opportunity to continue to improve our timeliness in this area. BVA and VBA have adopted a joint performance indicator that is a system-wide measure of how long it takes to resolve an appeal made by a veteran. In FY 2000, we project that it will take an average of 545 days—45 fewer days than we anticipated it to take in 1999.

- **For the Office of Information and Technology**

This is the first budget request since the reorganization of the Office of Financial Management that resulted in the information management function being moved to the newly created Office of Information and Technology.

VA's newly created Office of Information and Technology is requesting budget authority of \$21.3 million and an average employment of 217 to support VA Information Technology policy and program assistance, the VACO Campus Office Automation Platform and Local Area Network, and other efforts. The Austin Automation Center is separately supported by the Franchise Fund. Budget authority and \$43.1 million in net reimbursements will provide an estimated obligation availability of \$64.4 million in FY 2000.

The department is on schedule in meeting the Y2K challenge. In 1999, we will meet the timeframes for bringing all of our systems into production by March. This will give us nine months to address any remaining issues.

- **For the Office of Human Resources and Administration**

The Office of Human Resources and Administration (HR & A) is requesting \$105.4 million in total obligation authority and an average employment figure of 806. The requested budget authority is \$48.7 million.

Included in this figure is \$450,000 for program oversight of the arming of VA police officers.

The total figure for HR&A reimbursements is \$56.7 million. This includes \$28.3 million and 235 FTE for HR LINK\$ and \$27.7 million and 260 FTE for the Office of Resolution Management (ORM). In FY 2000, the Department is again requesting that the operations of ORM and Office of Employment Discrimination Complaint Adjudication (OEDCA) located in the Office of the Secretary be funded through reimbursement from its customers.

In summary, a total appropriation of \$912.4 million is requested for the General Operating Expenses (GOE), \$706.4 for VBA and \$206 million for General Administration in FY 2000. This funding level, combined with \$158.1 million of administrative costs associated with VA's credit programs, which are funded in the loan program accounts under credit reform provisions; \$10.7 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 \$36.8 million from insurance funds' excess revenues, together with other reimbursable authority, will provide \$1.255 billion to support operations in the GOE account.

- **On the Office of the Inspector General's Budget**

To support the Office of the Inspector General in FY 2000, \$43.2 million and an average employment of 374 FTE are requested. This represents an increase of \$7.2 million and an increase of 12 FTE from the 1999 resource level. The increase in budget authority is primarily due to contracting out of financial audit functions and, increases associated with acquiring additional FTE. Contracting out the financial audit will free up 39 FTE. These actions will enable the OIG to staff new initiatives and focus on several priority audits and investigations.

## **VI. Other Issues**

- **The VA Capital Investment Board**

The Department formally established the VA Capital Investment Board (CIB) in July 1997 and produced the VA's first Capital Plan in 1999. The CIB's membership consists of top management from throughout the Department. The CIB was established primarily to ensure that all significant capital investments are based on sound business principles and also support the VA's strategic and performance goals.

Recognizing the need to enhance capital asset planning for FY 2000, we have initiated a new capital investment planning process to improve the selection methodology for all significant capital assets, including construction, equipment, and information technology, in support of the budget request.

Capital investment proposals that meet specified thresholds (such as major construction projects, equipment, leases and information technology) are scored on how well the project application addresses the 20 sub-attributes of five major criteria.

The five major criteria are: One-VA Customer Service, Return on Taxpayer Investment, High Performing Work Force, Risk, and Comparison to Alternatives. The first three criteria relate to the Department's strategic goals, while the last two address improved business practices.

All significant capital investment proposals that are requested in the FY 2000 budget have been scored and ranked by the board to ensure that they meet the VA's strategic goals and are sound investments.

The Department capital planning process will be continually refined in order to meet the constantly changing needs of the Department.

- **Major and Minor Construction**

I am requesting new budget authority totaling \$60 million for the major construction program. The major construction request includes funding for a surgical suite project at Kansas City, MO; a spinal cord injury and rehabilitation project at Tampa, FL; a patient environment project at Murfreesboro, TN; and a facility rightsizing and gravesite development project at Leavenworth, KS. Additional funds are provided to remove asbestos from Department-owned buildings and to support advanced planning and design activities.

We are also requesting new budget authority totaling \$175 million for VA's minor construction program. The request will be used to make improvements to ambulatory care settings, patient environment, and VA's aging infrastructure. Funds are also requested for nursing home care, clinical improvements, correction of code deficiencies in existing facilities, and the elimination of fire and safety deficiencies.

Funds requested in the minor construction budget would also support VBA construction requirements and NCA gravesite development and improvements to existing National Cemetery Administration roads and buildings.

- **State Extended Care Facilities and State Veterans Cemeteries**

The FY 2000 request of \$40 million for the Grants for the Construction of State Extended Care Facilities will provide funding to assist States to establish new, or renovate existing nursing homes and domiciliaries; and the FY 2000 request of \$11 million for the Grants for the Construction of State Veterans Cemeteries will provide funding to assist States to establish, expand, or improve State veterans cemeteries.

## **VII. Conclusion**

Mr. Chairman, veterans from all periods of service should be satisfied that this budget is a budget that protects their interests and lives up to the nation's commitment to them.

I want to thank the members and staffs for your continued interest in our department. I look forward to continuing to work with you on behalf of our nation's veterans and their families. We owe our veterans the best service we can provide.

**STATEMENT OF  
GORDON H. MANSFIELD, 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 2000**

**FEBRUARY 11, 1999**

Mr. Chairman, Ranking Democratic Member Evans, and members of the Committee, the Paralyzed Veterans of America (PVA) is honored, on behalf of our members and the *Independent Budget*, to present our views on the Administration's Fiscal Year (FY) 2000 budget submission and what we perceive to be the true resource requirements 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 13<sup>th</sup> year of the *Independent Budget*, and on behalf of the co-authors, and all veterans who use and rely upon the VA health care system I will primarily address my remarks on the woefully underestimated resource requirements of this system.

Mr. Chairman, as you stated on the day the President's budget was released, the Administration's FY 2000 budget "ignores the increasing cost of caring for veterans, especially the aging veterans of World War II who depend on VA health care." By once again proposing a straight-lined appropriation, the President is ignoring the true cost of health care for veterans, especially the more-costly care needed by the most vulnerable of our veterans – our older veterans, our poorer veterans, and our veterans in need of specialized services, such as spinal cord dysfunction medicine.

After a number of years of re-organization, can the VA really sustain cuts of \$523 million in acute care, \$51 million in subacute care, \$159 million in psychiatric care, and \$21 million in rehabilitative care, including care for spinal cord dysfunction? This budget ignores the very real cost of medical care inflation, and the increased costs associated with caring for an aging veteran population. Does anyone truly believe that a dollar today will buy a dollar's worth of health care next year? Perhaps only if you are this Administration, and only when it applies to veterans.

In last year's budget submission, the Administration proposed cutting rehabilitative care, including spinal cord injury care by \$34 million. This coupled with the proposed \$21 million cut in this year's proposal would seem to fly in the face of Congressional intent, expressed clearly in statute and reaffirmed last year, to maintain capacity in specialized services. How can capacity be maintained with fewer staff and fewer beds and fewer dollars?

We greatly appreciate the actions taken by this Committee last year in requiring VA to maintain its capacity to provide specialized services, including spinal cord dysfunction, blind rehabilitation, and amputee programs medicine. As the committee has realized, these are core VA programs vital to the mission of the system. And yet, because of their high cost, they are the most vulnerable to local management decisions for downsizing when budgets are as tight as they are

today. The FY 2000 budget submission, because of its no growth appropriation request, places these programs in even greater danger.

Because of a lack of adequate data provided by VA, Paralyzed Veterans of America and other VSOs have provided inventories of these programs, detailing staffing, beds and resources, existing and required, to see that capacity is maintained. We propose that the Committee ask VA to improve their reporting mechanisms so that not only the specialized services can be tracked in an accurate way, but to provide a full inventory list of facilities, programs and services that can be tracked down to the individual hospital level to see how budgets and management decision are potentially eroding the provision of health care to veterans.

The only increase in medical care envisioned by the Administration for next year lies in its estimate that third-party collections will increase by \$151 million. We have voiced our concerns over this gimmicky funding scheme in the past, and we must reiterate them again today. The collection estimates proffered by this Administration have never come to fruition. Can we really expect this scheme to produce an additional \$151 million? How much more money can be wrung out of insurance companies when already there are reports of billing irregularities that seem endemic throughout the collection effort?

At the same time the Administration has proposed flat-lining VA medical care funding it has also produced a list of new initiatives. These improvements to VA health care are appropriate and long over due. Unfortunately, however, in asking VA to perform these services, the budget does not provide the dollars to pay for them.

The Administration asks for a \$250 million program to expand treatment for Hepatitis C related illnesses in the veteran population. The budget calls for \$50 million improvement in programs for homeless veterans. The budget calls for

\$106 million for expanded long term care programs in home and community based services. The budget calls for \$244 million dollars in needed emergency care services. These services are needed, but there are no new dollars to pay for them. To pay for the emergency care services, alone, the budget calls on VA to reduce 1,500 health care staff. All the funding for these new initiatives must come from existing services and a budget already strained to the breaking point. In all, the Administration expects to achieve \$1.4 billion in what it calls "management efficiencies and savings." The *Independent Budget* does not believe that these "efficiencies" are possible in a system already in turmoil from the effects of prior "efficiencies. VA is consistently being asked to do more with less. Under this budget proposal it is being asked to do more and more and more, with less and less and less.

This year, the *Independent Budget* recommends that Congress appropriate \$20.289 billion for VA medical care for FY 2000. This figure represents a core appropriation of \$19.734 with a more realistic third-party collection estimate of \$555 million added back as appropriated dollars. The Administration's requested appropriation is fully \$2.983 billion lower than the amount estimated by the *Independent Budget*, and is even \$2.428 billion lower than the core-appropriation without third-party collections "added back."

With the financing scheme embarked upon in FY 1998, dollars collected from third-parties were essentially "subtracted" from appropriated dollars. This short-changing of veterans must end. The *Independent Budget* position on this is clear – third-party collections must not be substituted for appropriated dollars, but rather should be used as an alternative funding stream to begin to repair damage done by chronic under-funding, to shore up problems encountered by VA reorganization, and to begin to address the long-term care needs of an increasingly elderly population of veterans. We ask that you assist us in

restoring these cuts in appropriated dollars and work with us to use these collections to insure that the health care received by veterans is of the highest quality.

The *Independent Budget* co-authors applaud the work of Congress last session to increase VA research to \$316 million. This year, we see that the Administration has proposed this same amount. We also note that while VA research is accorded flat funding, the President has proposed a 2 percent increase in funding for the National Institutes of Health (NIH) and a 7 percent increase in funding for the National Science Foundation. The *Independent Budget* recommends a VA research appropriation of \$375 million for FY 2000. We ask that you remember VA research in any bipartisan congressional attempt to dramatically increase research funding.

The Administration has requested an appropriation of \$61.2 million for Medical Administration and Miscellaneous Operating Expenses (MAMOE), a decrease of \$1.8 million over last year. The *Independent Budget* recommends \$69 million. As health care quality issues become increasingly important, now is not the time to decrease staffing levels needed to monitor, report, and maintain quality. There must be an increased commitment to ensure that veterans receive the quality health care they have earned.

This year, once again, we must work toward achieving Medicare subvention for the VA. The *Independent Budget* co-authors believe that this is an important piece of the puzzle in achieving alternative funding streams. But we also believe that if achieved, these funding streams must not be used in lieu of appropriated dollars. We all worked together toward the goal that the VA could retain third-party collections, envisioning that these funds would be used to supplement appropriated dollars and to begin to address funding and innovation deficiencies in the VA. The reality has been – VA health care was flat-lined and these dollars were used to fix VA appropriations at an unrealistic level. We must work to ensure that this does not happen with Medicare subvention – real protections

must be built into whichever subvention plan moves forward. Finally, although we fully support a fee-for-service approach, we remain skeptical concerning the efficacy of a managed care approach in Medicare subvention, particularly for veterans with serious disabilities in need of ready access to specialized health care services. The needs of these veterans must be protected. Also, any managed care component of Medicare subvention must ensure that no higher-priority veteran is displaced and that the needs of disabled veterans are fully realized, and fully protected, in any managed care format.

We also note that once again, in its budget submission, the Administration is proposing, in order to enable "the Government to more accurately measure the true cost of our national defense" to:

(1) move veterans-related discretionary accounts into the Defense function; (2) fund veterans entitlements on an accrual basis in DOD's budget and fund discretionary veterans programs in the Defense function; (3) fund veterans entitlements on an accrual basis in DOD's budget and display veterans spending in related functions (e.g., Education); or (4) fund veterans entitlements on an accrual basis in DOD's budget and continue to reflect veterans spending in its current function. Budget of the United States Government, Fiscal Year 2000, page 172.

The *Independent Budget* co-authors remain adamantly opposed to this concept.

The health care and benefits earned by veterans are indeed an ongoing cost of our national defense. But the needs of veterans are very different than the needs of our active duty military.

We recognize that this Committee does not appropriate dollars, but you do authorize them. The authorization process must recognize the real resource requirements of the VA. We look to you, and your expertise in veterans' issues, to help us carry this message forward, to your colleagues on the budget and appropriations committees and to the public. This year, more so than ever, we need your help.

We ask for your assistance to ensure that the VA receives the funding it needs so that veterans who rely upon the VA for their health care needs are accorded adequate, quality health care. We ask that you work with us to make certain that others in Congress realize the true resource needs of the system and that they

do not rely solely on the pie-in-the-sky assumptions contained within the Administration's FY 2000 request. We ask you to reaffirm our Nation's covenant with veterans and to remain faithful to generations of promises. The health, the well being, and the lives of veterans are at stake.

On behalf of the co-authors of the *Independent Budget*, I thank you for this opportunity to testify. I will be happy to answer any questions you might have.

**STATEMENT OF  
DAVID W. GORMAN  
EXECUTIVE DIRECTOR, WASHINGTON HEADQUARTERS  
OF THE  
DISABLED AMERICAN VETERANS  
BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES HOUSE OF REPRESENTATIVES  
FEBRUARY 11, 1999**

Mr. Chairman and Members of the Committee:

I am pleased to appear before you to present the views of the more than one million members of the Disabled American Veterans (DAV) and its Women's Auxiliary on the President's fiscal year (FY) 2000 proposed budget for the Department of Veterans Affairs (VA) and related issues of importance to America's veterans.

As part of a collaborative effort to ensure that the needs of America's veterans are adequately addressed, DAV, AMVETS, Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars of the United States (VFW) each year present the *Independent Budget (IB)* to assess the state of veterans' programs and their real resource needs. The *IB* includes our collective views on policy questions, programmatic issues, and resource requirements.

Because we are not motivated or constrained by the politics of the Federal budget process, our analyses are more objective and can be more candid than the assessments presented by VA officials. Because our goals are purely related to what is best for veterans and thus what is best for their programs, and because we are not concerned with political exigencies of the moment, we focus on long-term efficiency and effectiveness rather than short-term, budget-driven goals inherent in the Administration's approach. We therefore believe our recommendations more accurately reflect the resources necessary to enable VA to provide an acceptable level of benefits and services for our Nation's more than 25 million veterans and their dependents and survivors.

Consistent with the division of responsibility between the *IB's* four co-authors, I will focus on DAV's areas of primary responsibility in the formulation of the *IB* for FY 2000. Those areas are Benefit Programs, General Operating Expenses, and the United States Court of Veterans Appeals. We appreciate the courtesy this Committee has extended to us by allowing us to present our views in this format.

Of the Administration's requested \$43.6 billion in budget authority for VA, \$24.4 billion would be for the benefit programs. Within that, \$21.867 billion is for compensation and pensions and related benefits funded under that appropriation. The President's proposal requests \$1.469 billion for readjustment benefits, which include vocational rehabilitation, education benefits, and special housing and automobile grants for disabled veterans. Budget authority of \$439 million is requested for housing programs.

For General Operating Expenses, the Administration's budget would provide \$1.255 billion. Of this, \$932.4 million would fund the operations of the Veterans Benefits Administration (VBA), and \$323 million would be for General Administration functions.

This budget includes a proposed cost-of-living adjustment (COLA) for veterans' disability compensation and survivors' dependency and indemnity compensation. This would be effective December 1, 1999, and based on the rise in the cost of living as shown by the Consumer Price Index. The *IB* supports this benefit adjustment, of course. Because compensation is paid to make up for lost earning power, it is necessary to adjust compensation to offset the rise in the cost of living and keep pace with inflation.

The Administration again this year included in its budget the proposal to make permanent the Omnibus Budget Reconciliation Act (OBRA) provision that requires compensation increases

be rounded down to the nearest dollar. This temporary deficit reduction measure is due to expire in 2003. We strongly oppose this proposal. Compensation rates are certainly modest. With rounding down several years, disabled veterans have already lost ground to inflation. Permanent rounding down of the compensation increase will eventually result in a substantial erosion of the value of the benefit. Only under the most extreme circumstances should Congress reduce benefits to America's disabled veterans. In a situation of budget surpluses, this proposal is entirely unwarranted and inappropriate. Indeed, we find it extremely offensive for the Administration to include this unjustified proposal in its budget year after year. We urge the Committee to adamantly reject it, as well as the proposals to make several other of the OBRA deficit reduction provisions permanent.

In addition, the Administration has proposed legislation to authorize the payment of full disability benefits to Filipino veterans residing in the United States.

The *IB* includes several other recommendations for improving or preserving the integrity of benefits funded under the compensation and pension appropriation. These include:

- maintain the integrity of VA's *Schedule for Rating Disabilities* by rejecting any suggestions to intrude into the current methodology of its formulation
- establish more equitable rules for service connection of hearing loss and tinnitus
- change the law to authorize temporary increases in compensation to be effective on the date of the hospitalization or medical care that results in temporary total disability
- change the law to permit career military veterans to receive disability compensation and military retired pay without offset
- change the law to remove the offset between military nondisability separation, severance, or readjustment pay and disability compensation
- change the law to include in the statutory presumption of service connection on the basis of radiation exposure lung cancer, bone cancer, skin cancer, colon cancer, posterior subcapsular cataracts, nonmalignant thyroid nodular disease, ovarian cancer, parathyroid adenoma, tumors of the brain and central nervous system, and rectal cancer
- repeal the prohibition on service connection for smoking-related disabilities
- change the law to permit veterans to recover taxes withheld on disability severance pay or exempt retired pay beyond the current 3-year period
- reject any proposal to means test compensation or DIC, or proposals to study the prospects of means testing these benefits
- conduct a VA study to determine if reinstatement of the prior age-65 presumption of total disability for pension purposes would result in savings
- change the law to restore the reimbursement for a headstone or marker acquired privately in lieu of furnishing a Government headstone or marker
- change the law to permit the payment of fees under the Equal Access to Justice Act to nonattorneys who represent eligible VA claimants before the Court of Veterans Appeals in cases in which the Government's position was not substantially justified

We hope that you will give serious consideration to these recommendations.

The *IB* makes the following recommendations for improving the readjustment benefits:

- change the law to permit refund of Montgomery GI Bill contributions when the individual becomes ineligible for the benefit by reason of a "general" discharge or a

discharge "under honorable conditions"

- extend the authority for participation in unpaid work experience to jobs in the private sector
- change the law to provide an increase in the educational allowance under the survivors' and dependents' educational assistance program and to provide for automatic annual adjustments in the future
- change the law to adjust the amount of the special housing and adaptation grants provided for seriously disabled veterans and provide for automatic annual adjustments indexed to the rise in the cost of living
- change the law to adjust the amount of the allowance for specially equipped automobiles for seriously disabled veterans and provide for automatic annual adjustments to keep pace with the rise in the cost of living

We ask that you refer to the *IB* for more detail on these recommendations.

The *IB* also recommends a change in law to remove the 2-year limit on payments to entitled survivors from amounts that were owed, but had not been paid, to the beneficiary at the time of the beneficiary's death.

For the past several years, the *IB* has recommended a substantial increase in personnel to process compensation and pension claims. The Administration's budget includes authority for increased staffing to process compensation and pension claims. A total of 440 additional full-time employees (FTE) would be devoted to claims processing. The budget also proposes expenditures of \$30 million for information technology to support reengineered business processes in benefits administration. We applaud the Administration's finally recognizing the urgent need for additional personnel and resources to overcome the adverse effects of years of inadequate staffing. Once VA began to accurately and honestly measure the accuracy and quality of its claims processing and decisionmaking, it learned of serious deficiencies. VA also recognized, and now fully acknowledges, that the inevitable effect of insufficient staffing is a vicious cycle of declining quality and increasing backlogs. Too few people to keep abreast of the workload results in immediate backlogs, but also increases the pressure to produce quantity at the expense of quality. That, in the long term, is naturally counterproductive and diminishes efficiency because substantial portions of the cases must be reworked to correct errors. Regrettably, these simple facts and our warnings were casually brushed aside, without appropriate action by VA or Congress, until the situation deteriorated into a crisis situation. VA will need these additional FTE, additional resources, and the support of Congress to overcome what has been allowed to become nearly insurmountable backlogs and systemic deficiencies.

Of the proposed 440 additional FTE for claims processing, all but 164 would be reallocated from within other areas of VBA. The 276 FTE reallocation would shift 120 FTE from support functions, 115 from loan guaranty, 22 from insurance services, and 19 from education services. We understand that reallocation of maximum staffing levels between these VBA services will not be totally accomplished by simple redistribution of FTE authority on paper. It will require some physical reassignment of personnel from the downsized services to claims adjudication. We have some concern that employees who had the basic educational and other qualifications and training for those positions, may not have the necessary basic qualifications or be well suited for positions as adjudicators. Claims adjudication requires understanding of widely varied and esoteric legal principles and rules. Many of these positions also require an ability to understand and apply principles of anatomy, physiology, psychology, pathology, and the often complex physical and mental processes of disease causation and effect.

While we also applaud the Administration's planned investment in information technology, we question whether the President's budget devotes enough funding to this effort. We suggest that this Committee look behind the budget recommendations to determine VBA's real information technology needs. We suspect that the budget request falls far short of what is really needed for an organization as large, diverse, and geographically dispersed as VBA.

We know, for example, that loan guaranty service desperately needs the technology to allow it to communicate regularly with lenders who already rely on this technology for data transmission. To fund development of a VA Loan Information System, the Administration's budget proposes to charge lenders a fee on loans guaranteed. Under the proposal, Congress would enact legislation to authorize VA to collect from the lender a \$25 fee for the guaranteed loan. Lenders would be prohibited from passing the costs on to veterans. The program would have a 4-year sunset. VA expects to collect up to \$15 million over a 4-year period.

While this has an associated risk that lenders will devise creative ways to indirectly pass this cost to the borrower, the \$25 amount does not impose a substantial burden on lenders, who have a lucrative business in VA loans and who receive valuable protection from loss through VA's guaranty of loans. In the absence of an appropriation for this purpose, a small lenders' fee appears to be a reasonable means of providing funds for this essential initiative.

Although prompt development and disposition of disability claims for separating servicemembers is an important goal in VBA's Business Process Reengineering Plan (BPR), the President's budget would provide only \$1 million to support VA's pre-discharge examination and rating project. The project is designed to routinely provide these services on site to servicemembers who do not separate near VA regional offices. VA has estimated that it will cost \$10 million to develop the operations infrastructure for this program at separation sites in the continental United States and abroad. The DAV already participates in the transition assistance program and stands ready to expand that participation to aid VA in providing on-site claims services at more locations.

We believe one of the most counterproductive obstacles to efficient and fair claims processing today is one created through a misinterpretation of law by the United States Court of Veterans Appeals. Congress designed VA's benefits delivery system to be informal and helpful so a veteran entitled to compensation for disabilities incurred in the service of the Nation, for example, would not be met by a passive, indifferent, resistant, or contentious bureaucracy, or have to expend part of his or her modest disability benefits to pay a lawyer just to get what the veteran was rightfully due. VA and its predecessor veterans agencies have carried out that policy toward veterans by assuming the obligation to assist veterans in filing and prosecuting their claims, identifying and gathering pertinent evidence, and making it VA's duty to apply all relevant law and regulations so that the veteran received every benefit supported in law.

A premise for the requirement that VA fully assist the veteran in obtaining the evidence necessary to substantiate the claim was that the veteran—often sick and physically or mentally disabled—lacked the understanding and resources to deal with the regimented bureaucracy or the institutions from which records must be obtained. The spirit of assistance, as well as efficiency, demanded that VA negotiate these processes for the veteran. This duty to assist the veteran or family members, has been the cornerstone of the benevolent system of benefits Congress established for this Nation's veterans.

Another unique aspect of the VA benefits system is its liberal burden of proof. Unlike adversarial litigation, no opposing interest is involved in VA claims. Therefore, where courts dispose of civil conflicts by deciding in favor of the party whose evidence is of greater weight, VA grants the benefit sought where the evidence supporting the grant is at least as strong as any evidence against the claim. Nonetheless, because the process is nonadversarial, there may be no evidence in opposition, and the veteran is still required to submit enough documentation to "justify a belief in a fair and impartial mind that the claim is well grounded." That has been the burden of proof for VA claimants since at least 1924.

When judicial review legislation was debated in Congress, many experts and other witnesses feared that the courts would corrupt this informal, helpful process by imposing the formalities of adversarial litigation upon VA. Another widely held concern was that VA abandon its informal and pro-veteran stance in reaction to judicial review. Congress sought to prevent the courts or VA from changing the existing character of the administrative claims and appeals procedures. One of the things Congress did to preserve the existing system was the inclusion of the burden of proof and the duty to assist in a statute, so these beneficial provisions

could not be abandoned. In subsection (a) of section 5107, title 38, United States Code, Congress codified VA's burden of proof. In subsection (b), Congress codified the benefit of the doubt provision for resolving conflicts in the evidence. These two elements of section 5107 correspond to its heading, "Burden of proof; benefit of the doubt." Following the stated "burden of submitting evidence sufficient to justify a belief by a fair and impartial individual that the claim is well grounded," Congress also included in section 5107(a), a sentence providing that VA shall assist the claimant in developing the facts pertinent to the claim.

Despite clearly stated congressional intent and sincere efforts to prevent it, the courts have not remained mindful of the will of Congress. One of the most notable ways in which the courts have imposed change upon the VA process, is the perversion of the well-grounded claim principle. The Court of Veterans Appeals turned the principle that the Government has the duty to assist the veteran in establishing a well-grounded claim on its head. The Court construed section 5107(a) as requiring claimants to provide, without VA assistance, evidence sufficient to establish that the claim is well grounded before VA has any duty to assist such claimant. Naturally, if claimants had the ability to obtain all the preliminary evidence required under the Court's rulings, they would not need the assistance. The Court's interpretation defeats the very purpose of the duty to assist; the Court requires the claimant to do, without assistance, the very thing for which the assistance was intended.

Before the Court began making its mistaken decisions, VA never applied the well-grounded claim requirement as a precondition to the duty to assist. VA made millions of claims decisions before the advent of judicial review. We are confident that, absent an isolated aberration, VA would be unable to produce a single case in which it refused assistance or summarily disposed of the claim because it was not well grounded. Now, claims are routinely denied on that misplaced procedural formality, contrary to the intent of Congress. The *IB* discusses this issue in detail and includes a recommendation that Congress promptly enact legislation to override the courts' erroneous case law on this point. We have an abundance of administrative materials, old legal opinions, and legislative history that prove without question the Court of Veterans Appeals is mistaken in its interpretation of section 5107. We will be providing this to the Committee in the near future.

The *IB* also includes recommendations for legislation to override other new requirements imposed upon the administrative process by the courts contrary to law and congressional intent. The Court of Veterans Appeals and the Court of Appeals for the Federal Circuit have rejected challenges to their holdings on these points, and legislation is badly needed to restore beneficial aspects of the administrative process that Congress intended to preserve.

Regrettably, the courts are not the only extraneous entities that seek to impose their own views upon a unique system that many do not understand and others do not appreciate. VA's difficulties have prompted outside reviews from several sources recently. Some of the recommendations of those sources are incongruent with VA's mission and strategic plan, as included in its budget. Although we find beneficial recommendations in the January 14, 1999, report of the Commission on Servicemembers and Veterans Transition Assistance, other recommendations are ill-advised, some of which merit our mentioning here.

The Transition Commission seems to have lost sight of the fact that the people of this Nation believe veterans deserve a Government agency familiar with and devoted to veterans' special needs. For example, the Commission made many recommendations to combine VA and Department of Defense (DOD) health care funding, management, and delivery under one system. Obviously, veterans would not be well served by DOD because their needs would be secondary to weapons systems and institutional priorities of the defense establishment. If the recommendation envisions VA providing DOD's health care services, we note the VA's health care delivery system is already suffering from years of inadequate resources and has difficulty just meeting the needs of veterans.

For similar reasons, the Commission loses credibility by recommending that VA and DOD's disability compensation systems be combined into a single system. To place the veterans' system under DOD would not only be objectionable for the reasons that veterans would likely be poorly served by the military establishment, it would also mean that VA's core element, and thus VA, would be disbanded. On the other hand, as testimony on the VA budget and

oversight have revealed for the past several years, VA hardly has the ability to take on additional responsibilities when it cannot properly dispose of veterans' claims within a reasonable time. The Transition Commission report recommends that Congress revisit the recommendations of the Veterans' Claims Adjudication Commission. That raises serious concerns. We have previously provided this Committee with our views about the invalidity of the recommendations of the Veterans' Claims Adjudication Commission. The object of several of those recommendations was to reduce veterans' rights and were previously considered by this Committee without action.

The Commission also made the disturbing recommendation that the costs of treating service-connected disabilities be shifted to the private sector. Throughout our Nation's history, the costs of national defense have been the responsibility of the Federal Government. We cannot now as a matter of Government convenience merely abandon what is clearly a Government obligation. This would represent a departure from our core national values and is an insult to those who bear the risks and burdens of our national defense.

Finally, we seriously question the wisdom, and fairness, changing the law to take away the wartime status of military service after February 28, 1993. Our men and women in the military services have been engaged in recurring armed conflict since that time. They have been involved in recent bombing campaigns and have come under threat in the "no-fly" zones on a daily basis. The Transition Commission argues "[a]ll other periods of war in the Nation's history have been assigned termination dates." That argument incredibly fails to recognize that this war cannot have an ending date until it ends. The Commission argues: "[t]he cease-fire in the Persian Gulf War took effect on February 28, 1991, although there was fighting through March 2, 1991. However, neither Congress nor the President has terminated this period of war for benefits purposes."

We strongly oppose these and other recommendations that have as their sole purpose the reduction or elimination of benefits and services to our Nation's veterans and the dismantling of the benefits delivery system dedicated to meeting their needs.

This concludes DAV's testimony on the FY 2000 VA budget and related matters. We hope our analyses of the issues and VA's funding needs will be helpful to you. We appreciate the opportunity to present our views, and we thank this Committee for its continuing support for this Nation's veterans.



**DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS**

The Disabled American Veterans (DAV) does not currently receive any money from any federal grant or contract.

During fiscal year (FY) 1995, DAV received \$55,252.56 from Court of Veterans Appeals appropriated funds provided to the Legal Service Corporation for services provided by DAV to the Veterans Consortium Pro Bono Program. In FY 1996, DAV received \$8,448.12 for services provided to the Consortium. Since June 1996, DAV has provided its services to the Consortium at no cost to the Consortium.



DISABLED AMERICAN VETERANS

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# FACT SHEET

## BIOGRAPHICAL INFORMATION

### **DAVID W. GORMAN**

Executive Director, Washington Headquarters  
Disabled American Veterans

David W. Gorman, who lost both legs in Vietnam combat, was appointed Executive Director of the Disabled American Veterans (DAV) Washington Headquarters in 1995. Working at the million-member organization's National Service and Legislative Headquarters in Washington, D.C., his responsibilities include oversight of the DAV National Service, Legislative, Employment and Voluntary Service Programs. He is the organization's principal spokesperson before Congress, the White House and the U.S. Department of Veterans Affairs (VA).

Mr. Gorman enjoys a reputation as one of the nation's foremost experts on the VA's massive nationwide medical system. Due his comprehensive understanding of the VA's inner workings, he has been asked to sit on numerous VA and Congressionally chartered advisory committees, as well many ad hoc groups, seeking ways to better serve America's veterans.

After attending Cape Cod Community College, Mr. Gorman entered the U.S. Army in 1969, serving with the 173<sup>rd</sup> Airborne Brigade, the famed "Sky Soldiers" of the Vietnam War. During a campaign to secure an area in Central Vietnam where United States forces had suffered extremely high casualties, he stepped on a land mine, leaving him with wounds that required amputation of both 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 Chapter 12 in Rockville, Md.

Mr. Gorman, became a professional National Service Officer in the DAV's Boston office in 1971, rising to the post of supervisor of the organization's Providence, R.I., office the following year. In 1975, he was assigned to the DAV National Appeals Staff, which represents veterans in claims before the VA Board of Veterans Appeals (BVA) in Washington, D.C. BVA is the highest level of appeal in the VA claims processing system. He was later 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.

**STATEMENT OF**

**Veronica A'zera  
AMVETS Legislative Director**

**For the  
House Veterans Affairs Committee**

**Fiscal Year 2000 Independent Budget**

**Thursday, February 11, 1999  
334 Cannon House Office Building**

Mr. Chairman, I am Veronica A'zera, national legislative director for AMVETS. We appreciate the opportunity to join with our distinguished colleagues from the Independent Budget to provide testimony to the House Veterans Affairs Committee on the Department of Veterans Affairs (VA) budget for fiscal year 2000. Neither AMVETS nor myself has been the recipient of any federal grants or contracts during FY99 or the previous two years. As you may know, AMVETS' portion of the Independent Budget is the National Cemetery Administration section. We have been a partner on this project with Disabled American Veterans, Paralyzed Veterans of America and the Veterans of Foreign Wars for 13 years.

The passage of the Veterans Programs Enhancement Act of 1998 (Public Law 105-368) redesignated the National Cemetery System (NCS) as the National Cemetery Administration (NCA), which elevated it to the same organizational status within Department of Veterans Affairs as the Veterans Health Administration and the Veterans Benefits Administration. It also redesignated the director of the NCS as the under secretary of memorial affairs. VA has provided the highest standards of compassionate service to each veteran and family member eligible for interment in the system's 115 cemeteries.

Expansion of VA cemeteries over the next 10 years is critical to meeting the burial demands that will be placed on the system. NCA projects that interments will peak at approximately 107,000 in 2008. It has, however, no strategic plan in place beyond the year 2000. IBVSOs recommend NCA establish a longer and successive planning period to develop strategies for obtaining funds, acquiring land, and assessing veterans' burial preferences so that the system is responsive to the needs and demands of veterans and their families.

The demand for burial space comes at a time when space is at a premium. Of the 115 national cemeteries, 22 are closed to new burials and 36 are open to only cremated remains. Although three new cemeteries will open this year in Texas, New York and Illinois, there are no plans to address the burial needs of major population centers such as Atlanta, Miami and Sacramento. To date, VA has built or initiated construction of new cemeteries in only six of the 10 areas most in need, as identified in the congressionally mandated study of 1987.

The IB partners would like to acknowledge the ability of the dedicated staff who continue to perform the burial mission of VA, despite budgetary shortfalls, inadequate staff, aging equipment, and the increasing workload of new cemetery activations, development of gravesites, and land acquisitions. With the emphasis on a smaller and more efficient government workforce, the staffing needs of NCA have become more critical as the interment rate has increased. Cemetery operations include interment and grounds maintenance, both of which are labor-intensive activities that can be augmented, but not supplanted, by machinery. Although we fully support efforts to make government more efficient, NCA's unique maintenance needs can only be met through adequate staffing.

In 1978, Public Law 95-476 authorized VA to administer the State Cemetery Grants Program, under which states receive financial assistance to provide burial space for veterans and eligible dependents. State veterans' cemeteries are operated and permanently maintained by the states. Recently passed legislation allows states to receive 100% funding from VA to establish a state veterans cemetery. The new fully funded grant program should encourage states to establish cemeteries to meet the demands of the aging veteran population and the rising interment rate. The expanded grant program will also create new funding demands of the program. The IBVSOs recommend an increased funding level to ensure that all approved state cemetery grant applications will be funded.

Downsizing of the military, with its increased operational and readiness demands, has made it very difficult for the active duty forces to provide details at many national cemeteries. To the disappointment of growing numbers of family members, which I am sure you have heard from, veterans are laid to rest in national cemeteries without military honors. Resources must be committed to ensure that military honors are provided for all veteran requests.

Statistics on refusal of requests for funeral honors vary, depending on who is reporting them. According to a Department of Defense (DOD) poll of the military departments, between June and September 1998 only 1.4% honor requests were denied. However, VA reports that just at the national cemeteries alone, 57% of veteran interments did not receive military honors. The National Funeral Directors Association reported that in private cemeteries, 22% of the families that requested honors were denied.

In answer to this growing problem, Congress inserted language into the DOD Authorization Act for FY 1999 to take steps to correct the problem. Some of the significant provisions include:

- By December 31, 1998, the secretaries of defense and veterans affairs shall hold a conference to determine means of improving and increasing availability of funeral honors for veterans. (The conference was held at the National Guard Association Headquarters on November 17, 1998; VSO's participated).
- The secretary of defense shall report on the conference to Congress no later than March 31, 1999, including information on modifications to DOD policy adopted and recommended changes in legislation.
- DOD shall provide an honor guard detail for the funeral of any veteran after December 31, 1999. The detail shall consist of not less than three persons and shall include the capability to play "Taps."
- Unless DOD recommends an acceptable alternative, the current law will take affect after December 31, 1999.

The IBVSOs support the provisions in the current DOD Authorization Act, and we are awaiting DOD's report.

In summary, the addition of new cemeteries, coupled with the increased interment rate of the aging veteran population, has intensified the NCA's budgetary problems. In order to address all these funding issues, our recommendation is that Congress fund the NCA account at \$106 million for FY 2000. This amount is \$9 million more than the Clinton/Gore Administration budget proposal. It accounts for the higher costs of administrative expenses due to increased programmatic workload, general inflation, and wage increases.

In conclusion, long-range planning and adequate funding are crucial to addressing veterans' burial needs during the peak years and beyond. Shortfalls mean reduced services to veterans, cemetery neglect and disrespect to the memory and honor due to our Nation's servicemen and women.

Mr. Chairman, I will be happy to address any questions you or the committee members may have.

STATEMENT OF  
KENNETH A. STEADMAN  
EXECUTIVE DIRECTOR  
VETERANS OF FOREIGN WARS OF THE UNITED STATES

Before the

COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

THE DEPARTMENT OF VETERANS AFFAIRS BUDGET FOR FISCAL YEAR 2000

WASHINGTON, D. C.

FEBRUARY 11, 1999

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Once again, the VFW is proud to be the co-author of the veterans' Independent Budget. As in the past, our contribution lies in the construction portion. But, as an organization of two million, the Veterans of Foreign Wars obviously is concerned with all aspects of the VA's budget. With that, I feel compelled to first speak about our grave concerns with this proposed budget.

The Administration's proposed budget for the Department of Veterans Affairs is devastating to our nation's veterans. This proposed budget will seriously undermine VA's ability to provide quality, timely, accessible health care for veterans.

The VFW hears daily complaints of increased waiting times for veterans to see a specialty provider, such as an Orthopedic Doctor or a Dermatologist. This is happening through out the country. More egregious, however, is the one-year wait for hip replacement surgery in Ann Arbor, the one-year wait for dentures in Maine, and the one-year wait for a dermatology appointment in New Orleans. These are only a few examples, unfortunately, of a nation-wide epidemic. An epidemic of increased waiting times and delays in getting appointments which, in these examples, can only be interpreted as a denial of care. And it WILL get worse this year and next year because of this proposed budget.

For a fourth year in a row, the health care appropriations is flat lined at just over \$17 billion. This provides for absolutely no increase to cover new programs or inflation. Inflation alone will account for nearly \$1 billion. The Administration's budget is worse than a flat line budget -- it's a "negative growth" budget that threatens the health and well being of veterans.

This proposed budget also does not provide any real increase in personnel desperately needed for important projects needed to correct quality problems in the processing of veteran's claims. This funding proposal is an unrealistic and unfair budget that will not meet the needs of America's veterans. It is unfair in that, in the presence of the largest budget surplus in recent history, while other federal agencies will have double-digit increases, veterans are being asked to once again sacrifice with what is essentially a "negative growth budget."

Let me now address the VFW's primary responsibility on the Independent budget, the VA Construction funding.

The VA Construction budget consists of Major Construction, Minor Construction, and Grants for Construction of State Extended Care Facilities, Grants for States Veteran Cemeteries, and the Parking Garage Revolving Fund. The VA Construction program must face the serious challenge of modernizing and replacing major patient care facilities as well as repairing rapidly aging infrastructure.

The ongoing transformation of the VA health care system from an inpatient hospital system to a system of outpatient community based clinics has taxed the system's aging and antiquated infrastructure. In the twelve previous editions of the Independent Budget, we have strongly advocated budget increases to ensure that patient care, safety, and privacy needs are met. The construction needs have consistently exceeded the authorized construction budget. This has created a growing backlog in projects that are needed to meet critical patient care needs and safety requirements. This practice is totally unacceptable and must be stopped.

We believe that VA's construction program must emphasize expanding primary care access, making facilities more modern and attractive, and increasing long-term care capacity in non-institutional and institutional settings. Not only does this make the VA more efficient, but it also raises the quality of life for veterans. Veterans deserve nothing less than what is available in the private sector, both medically and by utilizing modern and up to date facilities. Too often, however, the quality of life that is afforded veterans who utilize the VA health care system is compromised by inadequate funding, overworked staff, and decaying physical plants.

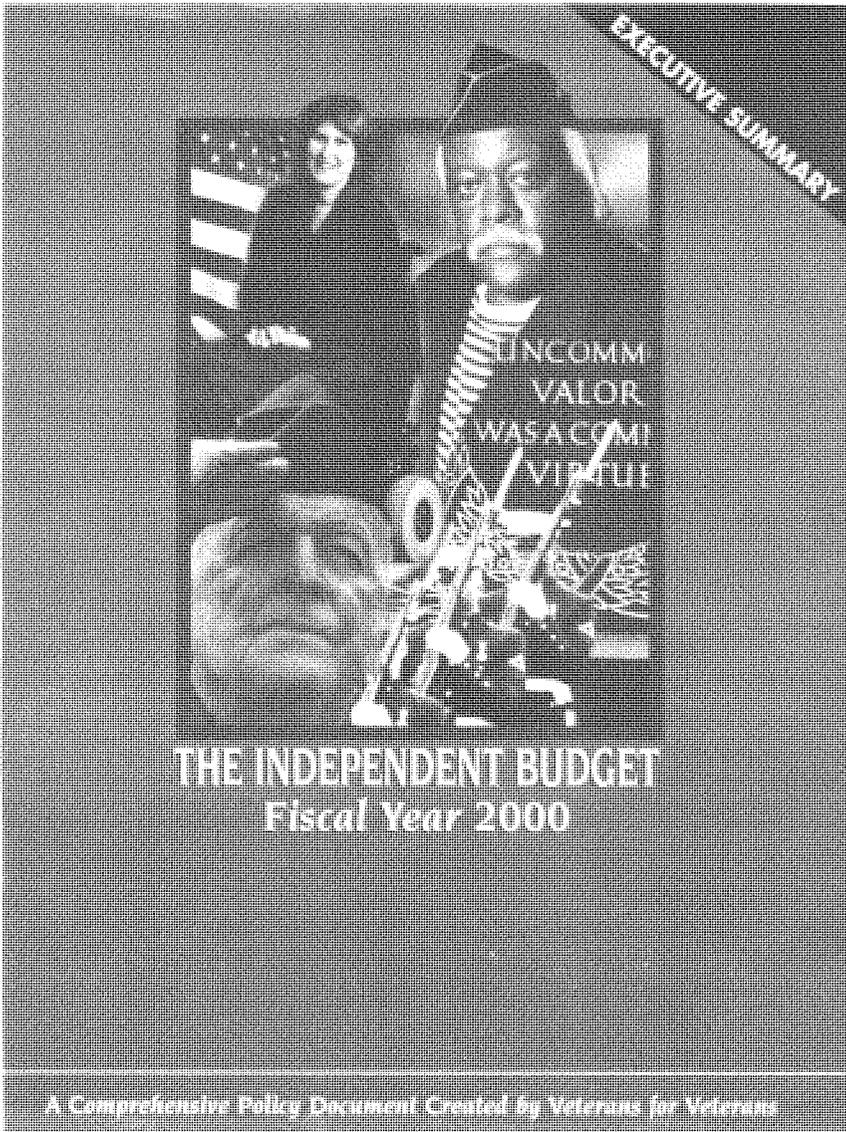
The need for additional outpatient and extended care facilities and infrastructure improvements are now the most important construction needs in the VA health care system. Unfortunately, many renovation projects are threatened because costs will exceed the Minor Construction project ceiling of \$4 million. Therefore, we recommend that the Minor Construction cost ceiling be adjusted annually, using an inflation adjusted matrix, so funding shortfalls due solely to inflation of any costs do not continue to occur with each passing year.

An independent study by Price Waterhouse concluded that over 42% of all Veterans Health Administration facilities are at least 50 years old. The study concluded that Major and Minor Construction accounts were significantly under funded and that the VA has not been able to make a significant investment in its aging properties. This has created a backlog of maintenance and repair projects. Inadequate construction funding will make it difficult for VA to entice paying patients into aging and inefficient structures.

We recommend Major Construction funding at \$176 million and Minor Construction funding at \$185 million.

In conclusion, this "epidemic" must stop. We must turn this flat-lined, negative-growth budget into something that the VFW, the Independent Budget, YOUR veterans, and you can agree will be beneficial for veterans. Nothing else will do.

This concludes my statement, Mr. Chairman, and I will be happy to respond to questions you may have.



EXECUTIVE SUMMARY

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**THE INDEPENDENT BUDGET**  
*Fiscal Year 2000*

A Comprehensive Policy Document Created by Veterans for Veterans

**Department of Veterans Affairs Budget Summary**  
**Discretionary Programs Funding**  
(Dollars in Thousands)

	FY 1999 Appropriations	FY 2000 Independent Budget Recommended Appropriation	FY 2000 Presidential Recommended Appropriation	President / IB % Difference	President - IB Abs Difference (Thousands)
<b>Veterans Health Administration</b>					
Medical Care	\$ 17,206,000	\$ 20,289,000 <sup>1</sup>	\$ 17,306,000	(14.70)	(2,983,000)
Medical Care Collections Fund	\$ 258,000	\$ 533,000	\$ 749,000	34.85	491,000
Total Available for Medical Care	\$ 17,464,000	\$ 20,844,000	\$ 18,055,000	(13.39)	(2,789,000)
Medical and Prosthetic Research	\$ 316,000	\$ 375,000	\$ 316,000	(15.73)	(59,000)
Medical Administration and Miscellaneous Operating Expenses	\$ 43,000	\$ 69,000	\$ 61,000	(11.59)	(8,000)
Subtotal, Veterans Health Administration	\$ 17,863,000	\$ 20,733,000	\$ 17,863,000	(14.71)	(3,050,000)
<b>Veterans Benefits Administration</b>					
Education Loan Program Account	\$ 1	\$ 1	\$ 1	-	-
Vocational Rehabilitation Program Account	\$ 55	\$ 56	\$ 57	1.79	1
Subtotal, Veterans Benefits Administration	\$ 56	\$ 57	\$ 58	1.75	1
<b>Departmental Administration</b>					
Veterans Benefits Administration (VBA)	\$ 656,000	\$ 740,000	\$ 706,000	(4.59)	(34,000)
General Administration	\$ 199,000	\$ 283,000	\$ 386,000	1.48	3,000
General Operating Expenses Subtotal (GOE)	\$ 833,000	\$ 943,000	\$ 912,000	(3.29)	(31,000)
Veterans Housing Benefit Program Fund Program Account	\$ 139,000	\$ 162,000	\$ 157,000	(3.09)	(5,000)
Native American Veterans Housing Loan Program Account	\$ 500	\$ 500	\$ 500	-	-
Education Loan Program Account	\$ 200	\$ 200	\$ 200	-	-
Vocational Rehabilitation Program Account	\$ 400	\$ 400	\$ 400	-	-
Total, Veterans Benefits Administration	\$ 816,000	\$ 903,000	\$ 864,000	(4.32)	(39,000)
<b>Miscellaneous Administration (Credit Reform)</b>					
Veterans Housing Benefit Program Fund Program Account	\$ 5,000	\$ 5,000	\$ 5,000	-	-
Native American Veterans Housing Loan Program Account	\$ 17	\$ 17	\$ 17	-	-
Subtotal, Miscellaneous Administration (Credit Reform)	\$ 5,000	\$ 5,000	\$ 5,000	-	-
National Cemetery System	\$ 92,000	\$ 106,000	\$ 97,000	(8.49)	(9,000)
Office of the Inspector General	\$ 36,000	\$ 38,000	\$ 43,000	13.15	5,000
Subtotal, Departmental Administration and Miscellaneous Programs	\$ 983,000	\$ 1,087,000	\$ 1,052,000	(3.22)	(35,000)
<b>Construction Programs</b>					
Construction, Major Projects	\$ 142,000	\$ 176,000	\$ 60,000	(65.91)	(116,000)
Construction, Minor Projects	\$ 175,000	\$ 183,000	\$ 173,000	(5.41)	(10,000)
Grants for Construction of State Extended Care Facilities	\$ 90,000	\$ 94,000	\$ 40,000	(52.38)	(44,000)
Grants for Construction of State Veterans Cemeteries	\$ 10,000	\$ 11,000	\$ 11,000	-	-
Total, Construction Programs	\$ 417,000	\$ 464,000	\$ 284,000	(37.29)	(130,000)
<b>Appropriation Offset</b>					
Medical Care Collections Fund	\$ (258,000)	\$ -	\$ (749,000)	-	(749,000)
Total, Discretionary Programs	\$ 19,250,000	\$ 22,444,000	\$ 19,184,000	(14.53)	(3,260,000)

<sup>1</sup> MC is not offset by MOCF in the IB recommended appropriation for FY 1999 or FY 2000.

## Prologue

This is the 13th *Independent Budget*—the most authoritative analysis of budgetary information on programs administered by the Department of Veterans Affairs (VA). The *Independent Budget* is developed by four major veterans service organizations—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars of the United States—and is the catalyst for legislative, budgetary, and policy initiatives within the veteran and allied advocacy communities.

As the Administration and Congress develop budgets and policies for the new millennium, we urge them to look up from the balance sheets and into the faces of the men and women who risked their lives to defend our Country. We ask them to consider the human consequences of inadequate budgets and benefit denials for those who answered the call to military service. Veterans ask only that promises made long ago be fulfilled. Those promises take on a new urgency in this era dominated by resource constraints, which have replaced the national sense of duty.

The values that led veterans to offer their lives in service to the greater good seem to have little currency in budget negotiations. These values—honor, loyalty, and sacrifice for the common good—must be weighed in the balance as we allot our Nation's wealth.



**Cecil R. Aultman**  
National Commander  
AMVETS



**Andrew A. Kistler**  
National Commander  
Disabled American Veterans



**Homer S. Townsend, Jr.**  
National President  
Paralyzed Veterans of America



**Thomas A. Pouillot**  
Commander-in-Chief  
Veterans of Foreign Wars  
of the United States

***Acknowledgments***

We would like to thank the staff from the four *Independent Budget* veterans service organizations, especially Jim Jewell, VFW, and Richard Wannemacher, DAV, and Steering Committee members John Carswell (FY 2000 Chair), PVA, Veronica Azera, AMVETS, Joe Violante, DAV, and Fred Juarbe, VFW, for their insightful guidance on and review of the document. We would like to especially thank Anthony L. Baskerville, DAV, Diane Prescott, PVA, Rick Surratt, DAV, and Jo Ann Webb, PVA, for their writing contributions; William A. Baughman, PVA, for his analytical support; James Angelo, PVA, for his production assistance; Patricia Scully, PVA, for her editorial assistance; Susan England, PVA, and Nina Schwartz, PVA, for their graphic design, and Lien Au, PVA, and Carol Baird, PVA, for their administrative support. Thanks to Diane Prescott and Jo Ann Webb for managing the overall production of the document. We would also like to thank the many others from the veterans community who contributed to the development of this document.

*FY 2000 Independent Budget Endorsers*

Air Force Sergeants Association	Legion of Valor of the U.S.A., Inc.
Alliance for Aging Research	Mankind Research Foundation, Inc.
American Association of Dental Schools	Marine Corps League, Inc. *
American Association of Spinal Cord Injury Nurses	The Military Chaplains Association
American Association of Spinal Cord Injury Psychologists and Social Workers	The Military Justice Clinic, Inc. *
American Chiropractic Association *	Military Order of the Purple Heart of the USA, Inc.
American Ex-Prisoners of War	National Amputation Foundation, Inc.
American Geriatrics Society *	National Association for Uniformed Services
American Gold Star Mothers, Inc. *	National Association of County Veterans Service Officers
American Optometric Association	National Association of Military Widows
American Paraplegia Society	National Association of Veterans' Research and Education Foundations
American Physiological Society	National Coalition for Homeless Veterans
American Podiatric Medical Association	National Consumers League *
American Psychiatric Association	National Hispanic Council on Aging
American Society of Nephrology	National Mental Health Association *
Arthritis Foundation	National Multiple Sclerosis Society
Association for Assessment and Accreditation of Laboratory Animal Care International	National Organization for Rare Disorders *
Association for Health Services Research	Navy League of the U.S. *
Association of American Medical Colleges	Non Commissioned Officers Association of the United States of America
Association of Professors of Medicine	Nurses Organization of Veterans Affairs
Association of Program Directors in Internal Medicine	Research! America *
Association of Schools of Public Health	Reserve Officers Association of the United States
Association of Subspecialty Professors	The Retired Officers Association
Association of the U.S. Army	Society for Neuroscience
Blinded Veterans Association	Society of Military Widows
Brotherhood Rally of All Veterans Organization	United States Coast Guard Chief Petty Officers Association
Catholic War Veterans, USA, Inc.	Veterans of the Vietnam War, Inc.
Diabetes Action Research and Education Foundation	Vietnam Era Veterans Association
Disabled Sports USA	Vietnam Veterans of America, Inc.
The Enlisted Association of the National Guard of the United States	
Jewish War Veterans of the U.S.A.	* <i>New Endorser</i>

## Guiding Principles

- Veterans should not have to wait for benefits to which they are entitled.
- Veterans should be sure that high-quality medical care will always be available to them.
- Disabled veterans with special needs should be sure that specialized care will remain the focus of the Department of Veterans Affairs (VA) medical-care system.
- Veterans should be guaranteed access to the full continuum of health-care services, including long-term care.
- New entitlements and expansions of existing entitlements should be exempt from the pay-go provisions in the Budget Enforcement Act.
- Veterans should have national cemeteries with available gravesites in every state.
- VA's mission to support the military medical system in time of war or national emergency is essential to the Nation's security.
- VA's mission to conduct medical and prosthetics research in areas of veterans' special needs is critical to the integrity of the veterans' health-care system and to the advancement of American medicine.
- VA's mission to support health professional education is vital to the health of all Americans.

## Summary of Recommendations

For the 13th year, four veterans service organizations—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars—along with 54 endorsers, have joined together to present budget and policy recommendations for the Department of Veterans Affairs in the *Independent Budget*. Since we first published the *Independent Budget*, we have become increasingly alarmed by the detrimental effects of chronic underfunding on services for our Nation's 25 million veterans. Inadequate funding has caused serious deterioration in the Department's ability to provide high quality health care to veterans and to effectively administer compensation and pension benefits. The effects are evident in treatment delays, backlogs in the procurement of prosthetic devices and medical equipment, and the inability of VA to process benefits claims and respond to the burial demands of the National Cemetery Administration.

As we enter the new millennium, it is clear that VA faces a financial crisis. The Balanced Budget Agreement of 1997 has flat-lined funding for the Department at a time when the health-care needs of aging veterans have never been greater. The financial strain on the VA system can no longer be relieved through token budget increases or further attempts at restructuring within the Veterans Health and Benefits Administrations. Without additional funding, it will be impossible for VA to undertake such vital initiatives as hepatitis C screening and treatment and the provision of emergency services. We call on Congress and the Administration to fully fund VA to ensure the provision of the full range of services to all veterans, including those able to defray the costs of care, who want to use the veterans health-care system.

Our budget recommendations are based on national health-care estimates from the Veterans Health Administration and non-governmental utilization data. Historical funding patterns of VA programs have been used to project FY 2000 budget needs, incorporating population demographics and policy directives. Table 1 includes budget recommendations for all VA program areas.

## SUMMARY OF RECOMMENDATIONS

**DEPARTMENT OF VETERANS AFFAIRS BUDGET SUMMARY  
 DISCRETIONARY PROGRAM FUNDING (Dollars in Thousands)**

	FY 1999 Appropriations	FY 2000 Independent Budget Recommended Appropriation	FY 2000 Administration Request
<b>Veterans Health Administration</b>			
Medical Care	\$17,306,000	\$20,289,000 <sup>1</sup>	\$17,306,000
Medical Care Collections Fund	\$ 558,000	\$235,000	\$749,000
Total Available for Medical Care	\$17,864,000	\$20,844,000	\$18,055,000
Medical and Prosthetic Research	\$316,000	\$375,000	\$316,000
Medical Administration and Miscellaneous Operating Expenses	\$63,000	\$69,000	\$61,000
<b>SUBTOTAL, VETERANS HEALTH ADMINISTRATION</b>	<b>\$17,685,000</b>	<b>\$20,733,000</b>	<b>\$17,638,000</b>
<b>Veterans Benefits Administration</b>			
Education Loan Program Account	\$1	\$1	\$1
Vocational Rehabilitation Program Account	\$55	\$56	\$57
<b>SUBTOTAL, VETERANS BENEFITS ADMINISTRATION</b>	<b>\$56</b>	<b>\$57</b>	<b>\$58</b>
<b>Departmental Administration</b>			
Veterans Benefits Administration (VBA)	\$456,000	\$740,000	\$708,000
General Administration	\$199,000	\$203,000	\$206,000
<b>GENERAL OPERATING EXPENSES SUBTOTAL (GOE)</b>	<b>\$ 855,000</b>	<b>\$943,000</b>	<b>\$912,000</b>
Veterans Housing Benefit Program Fund Program Account	\$159,000	\$162,000	\$157,000
Native American Veterans Housing Loan Program Account	\$500	\$500	\$500
Education Loan Program Account	\$200	\$200	\$200
Vocational Rehabilitation Program Account	\$400	\$400	\$400
<b>TOTAL, VETERANS BENEFITS ADMINISTRATION</b>	<b>\$ 816,000</b>	<b>\$903,000</b>	<b>\$864,000</b>
<b>Miscellaneous Administration (Credit Reform)</b>			
Veterans Housing Benefit Program Fund Program Account	\$5,000	\$5,000	\$5,000
Native American Veterans Housing Loan Program Account	\$17	\$17	\$17
<b>SUBTOTAL, MISCELLANEOUS ADMINISTRATION (CREDIT REFORM)</b>	<b>\$5,000</b>	<b>\$5,000</b>	<b>\$5,000</b>
National Cemetery Administration	\$92,000	\$106,000	\$97,000
Office of the Inspector General	\$36,000	\$38,000	\$43,000
<b>SUBTOTAL, DEPT. ADMIN. AND MISC. PROGRAMS</b>	<b>\$ 983,000</b>	<b>\$1,087,000</b>	<b>\$1,052,000</b>
<b>Construction Programs</b>			
Construction, Major Projects	\$ 142,000	\$176,000	\$60,000
Construction, Minor Projects	\$ 175,000	\$185,000	\$175,000
Grants for Construction of State Extended Care Facilities	\$90,000	\$84,000	\$40,000
Grants for Construction of State Veterans Cemeteries	\$10,000	\$11,000	\$11,000
<b>TOTAL, CONSTRUCTION PROGRAMS</b>	<b>\$417,000</b>	<b>\$456,000</b>	<b>\$286,000</b>
<b>Appropriation Offset</b>			
Medical Care Collections Fund	\$(558,000)	\$0	\$(749,000)
<b>TOTAL, DISCRETIONARY PROGRAMS</b>	<b>\$19,250,000</b>	<b>\$22,444,000</b>	<b>\$19,184,000</b>

<sup>1</sup>MC is not offset by MCCF in the IB recommended appropriation for FY 2000

### Critical Issues

In November 1998, the *Independent Budget* veterans service organizations (IBVSOs) released the *Critical Issues Report* on the fiscal year 2000 Department of Veterans Affairs budget. The *Report* was prepared for a meeting with the Office of Management and Budget (OMB) and presented recommendations on critical issues for consideration as the Administration develops its FY 2000 budget proposal. The recommendations are as follows:

- **A medical care budget of \$20.3 billion in FY 2000.** VHA needs adequate funding to ensure the provision of accessible and high quality services to veterans. Chronic underfunding of the VA health system has resulted in lower quality services, treatment delays, and the reduction and elimination of services for veterans. Included in this amount are \$700 million for hepatitis C screening and \$550 million for emergency care services. Congress and the Administration should provide sufficient funding to ensure that all veterans who want to use the veterans health-care system are enrolled and that they have access to the full continuum of services.
- **Additional resources to ensure the provision of high quality services for veterans with specialized needs.** Specialized services in VHA are deteriorating as VHA administrators, faced with budget shortfalls, reorganize and cut staff and high-cost services. These services are the hallmark of VA and must be preserved to ensure the integrity of the VA health system.
- **Collections from third-party payers must supplement, not substitute for, medical care appropriations.** It is the moral obligation of the federal government to ensure that our Nation's veterans have access to the high quality health care they earned through military service. Forcing VA to rely on uncertain medical care cost recoveries not only neglects this moral obligation, but also puts VHA programs and the veterans they serve at risk.
- **Adequate funding to ensure greater access to long-term care services.** To meet health needs of veterans as they age, the VA budget must include sufficient resources to ensure that veterans enrolled in VHA have access to the full continuum of long-term care services.
- **A medical and prosthetic research budget of \$375 million.** Additional funding for medical and prosthetic research is necessary to further enhance VA's research programs, particularly in its 18 research priority areas.
- **Additional staffing and funding to enable high quality and timely administration of compensation and pension claims.** Without additional resources, the Veterans Benefits Administration will continue to face substantial backlogs in the processing of claims. VA's inability to process benefits claims with quality and within a reasonable time period has been and continues to be one of its most serious and persistent problems. It is unconscionable that substantial numbers of veterans die before the proper resolution of their claims.
- **A \$49 million budget for Medical Administration and Miscellaneous Operating Expenses (MAMOE).** Inadequate MAMOE staffing levels have jeopardized VHA's ability to effectively monitor and ensure high quality services. Decentralization, reorganizations, budget cuts, and efforts to reduce spending heighten the need to correct the deficiencies within VHA's quality monitoring and assurance program.
- **A \$106 million budget for the National Cemetery Administration and the addition of 80 full-time employee equivalents.** Funding and staffing resources are needed to operate and maintain VA's 115 national cemeteries and meet the increasing workload demands that have resulted from the higher interment rate of the aging veteran population.

While the *Critical Issues Report* presented our broad recommendations, the more detailed and comprehensive recommendations on the following pages are equally vital to the provision of high quality services to veterans.

## *Recommendations to Congress*

### BENEFIT PROGRAMS

#### COMPENSATION AND PENSIONS

##### *Compensation*

- Enact a COLA for all compensation benefits sufficient to offset the rise in the cost of living.
- Do not intrude into the discretion exercised by the Secretary of Veterans Affairs in adopting or revising the *Schedule for Rating Disabilities*; reject the suggestion to undertake an economic validation with a view toward tampering with the rating schedule.
- Enact a presumption of service connection for combat veterans suffering from tinnitus or hearing loss of a type typically related to noise exposure or acoustic trauma, to apply when the record does not affirmatively prove such condition or conditions are unrelated to service.
- Amend the law to authorize increased compensation on the basis of a temporary total rating for hospitalization or convalescence to be effective, for payment purposes, on the date of admission to the hospital or the date of treatment, surgery, or other circumstances necessitating convalescence.
- Repeal the inequitable requirement that veterans' military retired pay based on longevity be offset by an amount equal to their disability compensation.
- Enact legislation to remove the requirement that military nondisability separation, severance, or readjustment pay be offset against VA disability compensation.
- Enact legislation to include in the statutory presumption for service connection of radiation-related disabilities lung cancer, bone cancer, skin cancer, colon cancer, posterior subcapsular cataracts, nonmalignant thyroid nodular disease, ovarian cancer, parathyroid adenoma, tumors of the brain and central nervous system, and rectal cancer.
- Repeal the prohibition on service connection for smoking-related disabilities.
- Amend the law to provide for an exception to the 3-year limitation on amendment of tax

returns in the case of erroneous taxation of disability severance pay or in the case of retroactive exemption of more than 3 years, change the law to discontinue the withholding of taxes from disability severance pay.

- Reject any proposal to means test compensation or DIC, or proposals to study the prospects of means testing these benefits.

##### *Burial Benefits*

- Amend 38 U.S.C. § 2306 to reinstate former subsection (d), which provided for reimbursement of the cost of acquiring a headstone or marker privately, in lieu of furnishing a Government headstone or marker.

##### *Miscellaneous Assistance*

- Amend the EAJA statute to permit payment of EAJA fees to unsupervised nonattorneys who represent appellants before CVA.

### READJUSTMENT BENEFITS

#### *Montgomery GI Bill*

- Change the law to permit refund of an individual's MGIB contributions when his or her discharge was characterized as "general" or "under honorable conditions" because of minor infractions or inefficiency.

#### *Survivors' and Dependents' Educational Assistance*

- Increase the educational allowance for this year under Survivors' and Dependents' Educational Assistance program and change the law to provide for automatic annual adjustments in the future.

#### *Vocational Rehabilitation*

- Extend the authority for unpaid work experience to any private sector and not-for-profit sector employers who are willing to develop such unpaid work experience opportunities consistent with the veterans training program.

- **Housing Grants**  
Increase the specially adapted housing grants and provide for future automatic annual adjustments indexed to the rise in the cost of living.

- **Automobile Grants And Adaptive Equipment**  
Increase the automobile allowance to 80% of the average cost of a new automobile and provide for automatic annual adjustments in the future.

**OTHER SUGGESTED  
BENEFIT IMPROVEMENTS**

- Remove the 2-year limitation on payment of accrued benefits

**GENERAL OPERATING EXPENSES**

**VETERANS BENEFITS  
ADMINISTRATION**

- Reestablish the correct meaning and intent of the "well-grounded claim" requirement in 38 U.S.C. § 5107. Enact legislation to override the erroneous interpretation and effect given this provision by courts.

**C&P Service**

**Inadequate Staffing**

- Include sufficient funding in VAs appropriations to increase FTE in C&P by 400.

**Resources to Develop Computerized  
Training for New Business Process**

- Include \$5 million in the GOE appropriation for development of programs to train C&P personnel in redesigned work functions and responsibilities.

**Expansion of Separation Site Services**

- Appropriate \$14 million to cover the costs of establishing VA pre-discharge claims processing services at military separation sites.

**Loan Guarantee Service**

- Enact legislation authorizing a temporary lenders' fee of \$25 per loan as a means to allow Loan Guaranty Service to develop

essential new information technology for data exchange with lenders.

**GENERAL ADMINISTRATION ISSUES**

**Board of Veterans' Appeal**

- Absent timely action by VA, intervene to ensure that the counterproductive problem of the unlawful provision in 38 C.F.R. § 19.5 exempting BVA from VA manuals, circulars, and other Department directives is corrected.

**NATIONAL CEMETERY  
ADMINISTRATION**

**National Cemetery Administration**

- Fund NCA at a level of \$106 million to support the addition of 80 full-time employee equivalents.
- Provide adequate funding to DOD to allow DOD to provide military honors to all families who request them.
- Provide \$10 million to the state grant programs to ensure that all approved state cemetery grant applications will be funded.

**Arlington National Cemetery**

- Add \$5 million to the budget for Arlington National Cemetery to ensure critical grounds maintenance needs are addressed. The cemetery should add additional administrative and wage grade personnel to oversee expanded contracting and operational projects to ensure that the cemetery is maintained to shrine-like standards.
- Require that contract agreements be developed by individuals with specific contracting expertise. An appropriate level of contract specialists should be added to the Arlington staff.
- Direct the Department of the Army to review the superintendent's position and consider elevation of the position to the Senior Executive Service.

## SUMMARY OF RECOMMENDATIONS

## UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS VA ADMINISTRATIVE PROCEDURES IN JUDICIAL REVIEW

- Enact legislation to provide that procedures prescribed by title 38, United States Code, and regulations of the Secretary of Veterans Affairs in accordance with that title shall be exclusive for purposes of VA and BVAs claims and appellate proceedings to preclude courts from imposing additional procedures upon the VA system.

### SCOPE OF REVIEW AND JURISDICTION OF THE COURT

#### Scope of Review

- Amend section 7261 of title 38, United States Code, to provide that the Court will hold unlawful and set aside any adverse finding of material fact which is not reasonably supported by a preponderance of the evidence.

#### Jurisdiction of the Court

- Amend the law to prohibit the Court of Appeals for Veterans Claims from allowing the Secretary of Veterans Affairs to determine the issues the Court will decide in connection with a veteran's appeal.

## MEDICAL PROGRAMS

### Medical Care

#### Financing Issues

- Base the VA medical care budget on the principle that third-party collections are to supplement—not substitute for—appropriations.
- Provide appropriations to fully cover the costs of the full range of medical care, including emergency services, for all enrolled veterans.
- Offset shortfalls in MCCR by guaranteed supplemental appropriations.
- Ensure that third party payments are only collected for the treatment of nonservice-connected conditions.
- Give VA the authority to privatize its MCCR collection efforts.
- Amend the law to allow VA to make outpatient copayments comparable with those in the private sector.

- Require VHA to report collection rates for services provided to nonveterans to assure that the costs of all care provided to anyone other than enrolled veterans are fully covered by collections.
- Pass Medicare subvention legislation that permits veterans the option of choosing VA health care. This legislation must ensure that Medicare subvention dollars are a supplement to an adequate VA appropriation.

#### Quality Issues

- Pass legislation requiring VA to report to Congress on the outcomes and effectiveness of internal and external review processes as well as on patient satisfaction with these processes.
- Fund MAMOE to ensure that VHA National Headquarters has adequate staffing to carry out centrally directed quality assurance functions.
- Carry out comprehensive oversight of VA's quality assurance programs in order to evaluate the scope of and changes to the current effort and the status of compliance with key public laws. If this oversight demonstrates that legislation is necessary to support a quality assurance system for detecting problems and providing remedial action, Congress should enact appropriate laws.

#### Eligibility Reform Issues

- Revise the law (38 U.S.C. § 1710) to remove the "within appropriations" limitation.
- Guarantee that all Priority 1 through 7 veterans who apply for enrollment in the VA health-care system be enrolled and able to receive all necessary health-care services.
- Support the Secretary's decision to enroll Priority 7 veterans.
- Provide VHA with adequate resources to ensure the provision of high quality care to veterans with specialized needs.
- Maintain rigorous oversight over VHA to ensure compliance with Public Law 104-262.
- Authorize and fund VA to provide emergency services for all enrolled veterans.

**Specialized Services Issues****Spinal Cord Injury Medicine**

- Fund incentive pay increases for SCI physicians to attract and retain physicians in the specialty of SCI medicine.
- Fund pay increases for SCI chiefs.

**Prosthetics and Sensory Aids**

- Increase appropriations to meet prosthetics needs so that other programs will not be compromised by funding shortfalls in prosthetics.

**Homelessness**

- Prohibit community providers from denying or delaying services to veterans and specifically address homeless veterans in all legislation designed to assist homeless individuals.
- Specifically address veterans in legislation for workforce development or employment.
- Fully fund the Homeless Veterans Reintegration Program with an appropriation of at least \$50 million through 2004.
- Fully fund both the grants and per diem aspects of the Homeless Providers Grant and Per Diem Program.
- Create a structured means of ensuring collaboration among federally funded efforts, to ensure that more effective services are delivered to veterans. Creation of a White House Veterans Federal Coordinating Committee, co-chaired by the Domestic Policy Advisor and the Secretary of Veterans Affairs and reporting directly to the Vice President, would be a positive step toward improving collaboration.

**Blind Rehabilitation**

- Engage in vigorous oversight to ensure that VHA complies with the provision of the Eligibility Reform Act of 1996 requiring VHA to maintain capacity to provide specialized services to disabled veterans.

**Women Veterans Services**

- Permanently authorize the Sexual Trauma Act.

**Gulf War Illness**

- Maintain prudent oversight to ensure that both VA and NAS adhere to the time limits imposed upon them so that they effectively

and efficiently address the continuing health-care needs of these worthy veterans.

**Long-Term Care Issues**

- Designate long-term care as a specialized service. Direct VHA to maintain its capacity to provide long-term care and to expand noninstitutional long-term care programs.
- Recognize VA's leadership role in the emerging field of geriatric medicine and direct VA to work aggressively with other government and nongovernment entities that are concerned with caring for an aging population so as to enable VA to share its expertise in geriatric medicine.

**Nursing Home Care**

- Pass legislation to require VA to provide nursing home care, along with access to all other institutional and noninstitutional long-term care services, as part of its benefits package for enrolled veterans.

**State Veterans' Homes**

- Provide funding to VA to meet its per diem support commitment of one-third of the average national cost of care in state veterans homes.
- Fund the expansion of the state veterans home program as a cost-effective means to meet veterans' long-term care needs.

**Assisted Living Adult Day Health Care (ADHC)**

- Make ADHC a permanent program and expand its authority so that it can become an integral part of the benefits package for all enrolled veterans.

**Assisted Living**

- Give VA the authority to finance assisted living under U.S.C. 38, Section 1730.
- Amend VA's leasing authority to permit open-ended leases that could be renewed indefinitely as long as the services provided continue to fulfill the terms of the original agreement.

**Respite Care**

- Amend U.S.C. 38, Section 1720B, to authorize VA to provide respite care in non-VA settings.

## SUMMARY OF RECOMMENDATIONS

**Workforce Issues****Staff Shortages**

- Provide adequate funds to ensure appropriate levels of staffing at VHA facilities.
- Request the Office of Inspector General or the General Accounting Office to conduct a study of clinical staffing levels at VHA facilities.

**Administrative Issues****Hepatitis C**

- Provide adequate funding to VHA to screen veterans at risk for hepatitis C and treat those diagnosed with the disease.

**VA Medical And Prosthetic Research**

- Fund the VA Medical and Prosthetics Research appropriation at \$375 million. Place VA on the same funding trajectory as NIH to ensure parity.
- Direct GAO to study the issue of physician-investigators, their clinical demands, and the impact on VA's research program.

**Medical Administration and Miscellaneous Operating Expenses (MAMOE)**

- Provide adequate funding to the MAMOE account to support VHA National Headquarters' role of quality management, policy guidance, and information collection, analysis, and dissemination.

**CONSTRUCTION PROGRAMS**

- Ensure adequate funding for the Major Construction program in order to address high priority projects.
- Adequately fund the Minor Construction in order to address VHA's aging infrastructure.
- Increase construction budgets to allow consolidations, realignments, and other actions that are necessary to implement VA's changing national health-care strategy.
- Adjust the minor construction project cost ceiling annually, using an inflation-adjusted matrix, so funding shortfalls due to inflation of costs do not continue.

- Make the Enhanced-Use leases program permanent.
- Extend the term limitations, currently at 20 years or 35 years in cases of leases involving new construction or substantial rehabilitation, to 55 years.
- Change the minor construction appropriation language to allow the use of minor construction funds for Enhanced-Use leasing projects.

**VETERANS' EMPLOYMENT AND TRAINING**

- Mandate the eligibility of all disabled veterans on a priority basis for all federally funded employment and training programs.
- Amend section 1142(a) of title 10, United States Code, to authorize an extended time frame for providing individual transition services.
- Amend section 7722 of title 38, United States Code, to mandate that the Secretary of Veterans Affairs provide outreach services to members of the Armed Forces as part of VA's transition program.
- Amend section 7723 of title 38, United States Code, to require that the Secretary of Veterans Affairs establish and maintain transition assistance offices on U.S. military installations outside of the United States.
- Fund NVTI at an adequate level to ensure training is continued in an ever-changing environment.
- Consider an alternative means of delivering employment services for veterans through a competitive bidding process.
- Fund DVOP and LVER programs at the statutorily mandated levels.
- Begin the process, through the House or Senate Veterans' Affairs Committee, of reevaluation and reconfiguration of the delivery of employment and training services to veterans.
- Enact legislation requiring the President to establish an independent Veterans' Employment Network.

## *Recommendations to the Department of Veterans Affairs*

### **BENEFIT PROGRAMS**

#### **COMPENSATION AND PENSIONS**

##### ***Pensions***

- Conduct a study to determine if the removal of the presumption of permanent and total disability for pension purposes at age 65 results in savings or whether costs of VA examinations and record development outweigh potential savings

### **GENERAL OPERATING EXPENSES**

#### **GENERAL ADMINISTRATION ISSUES**

##### ***Board of Veterans' Appeals***

- Amend 38 C.F.R. § 19.5 to remove its unlawful provision exempting BVA from VA manuals, circulars, and other Department directives.
- Direct the Chairman of the Board of Veterans' Appeals to discontinue Board members' consultation with VA General Counsel staff on cases in which BVA's decisions have been appealed to the courts.

### **NATIONAL CEMETERY ADMINISTRATION**

#### ***National Cemetery Administration Issues***

- Establish a longer planning period and successive planning periods to develop strategies for obtaining funds, acquiring land, and assessing veterans' burial preferences to make the system responsive to the needs and demands of veterans and their families.

### **MEDICAL PROGRAMS**

#### ***Medical Care***

##### ***Financing Issues***

- Monitor copayment collection efforts to ensure that VA officials are complying with its procedures.
- Improve billing accuracy and ensure that debt amounts are accurate.
- Give veterans sufficient notice before offsetting compensation and pension checks because of overdue copayments. Establish

policies that allow debts to be collected without causing undue hardship to the veteran during the period of repayment.

- Ensure that veterans are given preference over nonveterans in all treatment settings.
- Improve financial accounting systems to more effectively track its revenues and expenses.
- Guarantee Priority 1 through 6 veterans full access to VA services before implementing Medicare subvention.

##### ***Quality Issues***

- Develop internal and external review processes for clinical decisions.
- Include a mechanism for expedited review of urgent care in the VA appeals process.
- Educate veterans about the internal and external review processes for clinical decisions.
- Require that patient advocates inform veterans about representatives from veterans service organizations who can serve as their advocates.
- Improve its health-care information technology systems to facilitate improved monitoring of health outcomes.
- Develop information disclosure standards for VISNs.
- Require VISNs to provide veterans with information on VA providers' level of education and board certification status and VA facilities' experience with performing specific procedures as well as their licensure, certification, and accreditation status.
- Use compliance with information requirements as a component of VISN directors' annual performance evaluations.
- Develop a "report card" for VA users that judges VA facilities on a variety of quality and consumer satisfaction measures.

##### ***Eligibility Reform Issues***

- VHA headquarters must ensure compliance with Public Law 104-262 from its networks.
- Improve information systems to accurately

## SUMMARY OF RECOMMENDATIONS

track the collection and management of data on the specialized service capacity.

- Require VISNs to submit written proposals regarding the consolidation or closure of programs for veterans. Proposals must address how the VISN will shift resources to ensure that alternative treatment modalities are provided.

### **Specialized Services Issues**

#### **Care for the Seriously Mentally Ill**

- Maintain sufficient capacity both in inpatient and outpatient settings for veterans with addictive disorders who require treatment and alternative aftercare programs, as mandated by Public Law 104-262.
- Put the money saved from eliminating long-term care beds into other care options for seriously mentally ill veterans, such as Intensive Psychiatric Community Care programs.
- Implement a tracking system to assess the effects of discharging seriously mentally ill veterans from inpatient and long-term care beds into the community.
- Provide better case management and long-term follow-up for seriously mentally ill veterans.
- Establish annual goals to ensure that veterans with serious mental illness who are unemployed be assessed and referred for work-based rehabilitation.
- Direct networks to encourage consumer involvement in mental health care and to establish Mental Health Consumer Councils.
- Require VISNs to submit written proposals regarding the consolidation or closure of programs for veterans with serious mental illness. Proposals must address how the VISNs will provide alternative mental health services.

#### **Spinal Cord Injury Medicine**

- Provide an additional 3 full-time employee equivalents (FTEEs) for the Strategic Health Group for Spinal Cord Injury and Other Spinal Cord Disorders to develop education and training programs.
- Explore the possibility of using military physicians for periods of temporary duty in VA SCI Services.

- Explore the use of graduates and trainees from the Uniformed Services University of the Health Sciences.

- Recruit physicians from related fields in internal medicine and provide them with SCI training.

#### **Posttraumatic Stress Disorder (PTSD)**

- Increase national oversight of specialized programs, including PTSD programs.
- Approve all changes or closures of specialized programs, including PTSD programs. Closures of inpatient programs should be contingent upon the availability of adequate community support services.
- Provide safe, clean, sober housing for veterans in PTSD and substance abuse treatment programs.
- Require that each VISN have at least one specialized inpatient or residential PTSD program.

#### **Prosthetics and Sensory Aids**

- Nationally centralize and protect funding for prosthetics and sensory aids.
- Add at least three FTEEs to the Strategic Healthcare Group for Prosthetics and Sensory Aids at VHA National Headquarters.
- Allow VA Clinicians to prescribe prosthetic devices and sensory aids on the basis of medical need, not cost.
- Ensure that prosthetics and sensory aids departments are fully staffed by appropriately trained teams and directors.
- Ensure that sufficient training funds are reserved for sponsoring prosthetics training conferences for appropriate technical and clinical personnel.
- Require all VISNs to adopt the VISN 3 model for organizing prosthetics services, as recommended by the Prosthetic Program Reinvention Project Workgroup.

#### **Homelessness**

- Fully fund both the grants and per diem aspects of the Homeless Providers Grant and Per Diem Program.
- Make managers accountable through performance evaluations for access to and effectiveness of services for very low income and homeless veterans.

- Review all treatment programs to ensure that the focus is on obtaining and sustaining employment, including VHA's work therapy programs.
- **Community-Based Outpatient Clinics (CBOCs)**
  - Ensure that CBOCs are staffed by clinically appropriate health providers who can meet the special health-care needs of veterans wherever the specialized services workload justifies specialized resources.
  - Develop clinically specified referral protocols to guide patient management in cases where patients' conditions call for expertise or equipment not available in the clinic.
- **Blind Rehabilitation**
  - Include VIST and BROS programs in any definition of capacity with reference to the P.L. 104-262 mandate regarding specialized services for severely disabled veterans.
  - Base VHA decisions regarding lengths of inpatient stays in blind rehabilitation facilities on individual veterans' needs, not on costs.
  - Increase capacity to provide residential blind rehabilitation.
  - Devote sufficient resources to establish more BROS positions so that veterans receive needed services in a timely manner.
- **Women Veterans**
  - Require that CBOCs that serve women veterans have a female nurse practitioner on staff.
  - Require that all VHA facilities have women veteran coordinators.
  - Ensure that staff at all VA facilities receive training and are sensitized to the unique health care needs and privacy issues of women veterans.
  - Provide gender-appropriate treatment and facilities.
- **Addictive Disorders**
  - Maintain capacity to serve veterans with addictive disorders, as mandated by Public Law 104-262.
  - Ensure that treatment for addictive disorders is available to veterans in each VAMC location and that it is coordinated with treatment for PTSD and other neuropsychiatric conditions.
- Ensure that each veteran is assigned a care manager.
- Ensure that eligible veterans have full access to the entire continuum of services that responds to their needs for medical care, counseling, housing, vocational training, and income support.
- Collaborate with other Federal and State agencies and community groups to ensure that veterans receiving outpatient care or partial hospitalization have access to safe, clean, sober transitional housing while in VA care. This issue must be officially recognized as one of quality of care.
- **Gulf War Illness**
  - Foster and maintain a close working relationship with NAS to determine what hazardous toxins Gulf War veterans may have been exposed to and what illness may be associated with such exposure.
  - Ensure that physicians and other healthcare professionals treating Gulf War veterans understand the health issues pertaining to Gulf War veterans. Ensure that health-care providers have a uniform system of examining and treating symptoms, complaints, and diagnosed illnesses associated with and common in Gulf War veterans.
- **Traumatic Brain Injury (TBI) Care**
  - Ensure that all VISNs provide adequate TBI care.
  - Include TBI performance standards within VISN management's performance requirements.
- **Long-Term Care Issues**
  - Designate long-term care as a specialized service. Maintain the capacity to provide long-term care and to expand noninstitutional long-term care programs.
  - Provide the full continuum of long-term care services, including case management, to ensure that veterans in need of long-term care receive the optimal mix of services in a coordinated, integrated fashion.
  - Direct 16% of its budget to long-term care initiatives, an increase of 3% over previous years' expenditures.

## SUMMARY OF RECOMMENDATIONS

**Nursing Home Care**

- Increase capacity to provide services in VA nursing homes, State veterans homes, and community nursing homes.
- Do not eliminate nursing home beds

**Community Nursing Homes**

- Ensure that nursing home stays are long enough to meet veterans' health needs and to allow for planning for veterans' long-term placement in the appropriate care setting
- Discharge planners must work with the patient and family to develop a care plan prior to placement in a nursing home. This plan should include a functional assessment to determine if nursing home placement is appropriate. All alternatives to nursing home care, including home care and assisted living, should be considered.

**Home- and Community-Based Care**

- Direct a greater proportion of its long-term care budget to noninstitutional home and community-based programs.
- Expand home- and community-based programs by increasing capacity in existing programs and by developing new programs, such as assisted living.

**Assisted Living**

- Aggressively pursue development of assisted living capacity within VA and through private sector partnerships.
- Use minor construction funds to convert existing buildings to assisted living facilities.
- Use the Enhanced-Use leasing authority to create assisted living capacity to care for veterans and their spouses.

**Workforce Issues****Staff Shortages**

- Staff facilities with adequate numbers of trained clinicians to meet the workload demand and deliver care that is appropriate for its unique veteran populations.
- Track outcomes and monitor care to ensure the provision of high-quality services.
- Develop mechanisms to ensure the most efficient distribution of clinical staff in VA facilities.
- Ensure that pay scales are competitive with

those in the private sector to attract and retain clinicians.

- Develop mechanisms to increase the amount of patient contact hours per shift by reducing or eliminating unnecessary paperwork, logistical errands, and patient transport.
- Track and tabulate the number of patient interaction hours as a means of ensuring high quality.

**VA Volunteer Service**

- Designate a staff person with volunteer staff experience to be responsible for recruiting volunteers, developing volunteer assignments, and maintaining a program that formally recognizes volunteers for their contributions.
- Develop volunteer activities in outpatient settings and encourage local volunteers to participate.
- Factor VAVS volunteer support into the planning and activation of each CBOC.
- Include VAVS volunteer productivity data in VHA facility productivity measurement systems and facility management performance standards to create incentives for facilities and managers to use VAVS volunteers.
- VISN directors should include a plan of action for the use of volunteer support in any documentation of the approval package for CBOCs that is forwarded to the Under Secretary for Health.

**Administrative Issues****Hepatitis C**

- Develop a measurable and comprehensive process to identify, treat, and educate all veterans who may be at risk for hepatitis C.
- Notify veterans who are at risk for hepatitis C and inform them of their right to receive free screening tests for the disease.
- Monitor VA facilities to ensure that veterans at risk for hepatitis C are being screened for the disease.
- Be part of any Federal effort to identify individuals who may be at risk and to provide comprehensive treatment for those diagnosed with the disease.

**National Formulary**

- Revise and expand the national formulary.
- Implement a true national formulary based on clinical needs.
- Ensure that each VISN and VA medical center fully complies with the national formulary policies regarding formulary and off-formulary items.
- Effectively communicate to physicians and veterans that they have access to off-formulary medicines and supplies.

**Medical And Prosthetic Research**

- Convene a task force to address problem areas with patient work load and time demands on physician-investigators.

**MAMOE**

- VHA National Headquarters must maintain hands-on oversight to protect and fulfill congressional mandates to monitor and maintain the capacity of specialized programs.
- VHA headquarters must enhance efforts to establish performance measures, as well as standards for timely access, quality, and cost-effectiveness.

**CONSTRUCTION**

- Network directors must have the authority and flexibility to alter their priorities for major construction projects based on changing needs without fear of losing construction dollars.
- Network directors must annually adjust their 5-year construction plans to account for changes in medical missions, VERA, and eligibility reform.

- VHA National Headquarters staff should review, coordinate, and approve VISN construction projects.
- Develop an objective mechanism to evaluate construction needs in order to determine construction priorities and evaluate facility assets.
- Establish additional community-based clinics to reach veterans who would otherwise travel long distances to obtain health care. This arrangement will help ensure that eligible veterans have equal access to quality health care throughout the Nation.
- Continue to be primarily a care provider, not a payer. The system must not lose its identity in the proliferation of service contracts.
- Ensure that leased facilities meet all Federal standards for accessibility.
- Require all Enhanced-Use projects to comply with its mission and benefit veterans by improving access to care or the quality of patient care services provided.

## SUMMARY OF RECOMMENDATIONS

*Recommendations to the Department of Defense***VETERANS' EMPLOYMENT AND TRAINING**

- Merge DTAP with TAP.
- Make pre-separation counseling optional for members being separated prior to completion

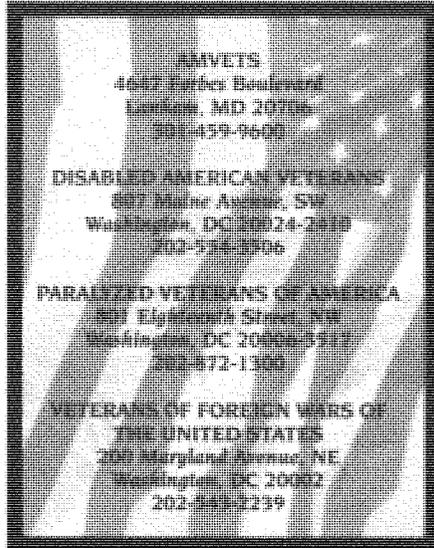
of their first 180 days of active duty, unless separation is due to a service-connected disability

- Provide an Internet-accessible automated, interactive transition assistance platform aboard ships, as well as in remote and isolated areas.

*Recommendations to the Department of Labor***VETERANS' EMPLOYMENT AND TRAINING**

- Review the current structure and process for the delivery of employment services to veterans and emphasize and reward states for successful outcomes instead of process.
- VETS must develop meaningful performance standards and withhold future monies from states not meeting these standards.

- Implement pilot programs to reward states, and individual employees, that are most effective in assisting veterans, particularly those with barriers to employment, find work.
- VETS should review, as part of the state's performance, its record of career enhancement efforts and outcomes for DVOPs and LVERs and make it a part of the overall compliance measures.





**Non Commissioned Officers Association of the United States of America**

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**STATEMENT OF  
LARRY D. RHEA  
DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS**

**BEFORE THE  
COMMITTEE ON VETERANS AFFAIRS  
U.S. HOUSE OF REPRESENTATIVES  
ON THE  
FISCAL YEAR 2000 BUDGET  
FOR THE  
DEPARTMENT OF VETERANS AFFAIRS  
FEBRUARY 11, 1999**

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 1999. 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.

### MORE OF THE SAME

Mr. Chairman, NCOA has been invited before this Committee each year to testify on the Clinton Administration's various budget proposals for the Department of Veterans Affairs. While the subject today is the Fiscal Year 2000 Budget proposal, NCOA could very easily dust off our testimony for previous years, submit it to you today, and it would be just as relevant as when it was originally presented. During each of those previous years Mr. Chairman, NCOA indicated to the Committee the troubling trends and path that this Administration has chartered for the Nation's warriors. While there are some positive aspects in the FY00 VA Budget, the proposal being discussed today continues the troublesome path started at the onset of this Administration.

In short Mr. Chairman and Distinguished Members, the President's FY00 Budget for Veterans is more of the same. It is a hype piece, filled with now tiresome promises to do more but conditions VA's doing more with less and less, while placing unrealistic reliance on outside funding streams. There reaches a point Mr. Chairman when the only thing you can accomplish with less is less. VA is at that point.

The Distinguished ranking member of this Committee, The Honorable Lane Evans described the funding for veterans' programs in the proposed budget as "totally inadequate." The Distinguished Chairman described the proposal as a "slap in the face" to the Nation's veterans. Chairman Stump and Mr. Evans, neither of you will get any disagreement from this Association as to your characterization of what the President has proposed. In fact, we are inclined to believe your comments were tempered rather kindly. What the Administration has presented in the budget for veterans ignores reality and defies common sense. Less is less and, and to repeat what the Association stated earlier, the VA has been at the point for some time now when less can only lead to less accomplished.

NCOA believes veterans have earned and deserve better than what this budget offers. The Association sincerely hopes that the Distinguished Members of this Committee will fight for the additional resources that veteran's programs and benefits require.

### **SPECIFICS SUPPORTED**

NCOA is grateful for and supports the following provisions of the FY00 budget for VA:

- The cost-of-living adjustment (COLA) to all compensation beneficiaries
- The \$316 million (a \$7 million increase) in medical and prosthetic research funding
- The requested \$869 million (\$49 million, a 6% increase) for administration to ensure delivery of benefits, that includes plans for an additional 164 new FTE
- The activation money for the National Cemeteries in Chicago, IL, Dallas, TX, Saratoga, NY, and Cleveland, OH
- The \$10 million requested to continue development of the Electronic Claims Processing pilot system
- The initiative to authorize VA to cover the cost of out-of-network emergency care for enrolled veterans with compensable service-connected disabilities

### **SPECIFIC CONCERNS**

**Medical Care** – NCOA shares the view of the Distinguished Chairman and Ranking Member of this Committee that the health care portion of VA's FY00 Budget is the area of greatest concern. The proposed budget ignores inflation in health care delivery costs, overstates potential savings, and third-party collections are again unrealistically over projected. As this budget is structured, NCOA seriously doubts that VA can achieved its stated goals and institute stated new initiatives without a reduction in the level of service to some current veteran users. For example, the cost, approaching \$1 billion, to treat the new threat of hepatitis C has not been sufficiently addressed by the Administration.

Last year NCOA stated its belief that the Veterans Health Administration was moving in the right direction, with one exception. That one exception then, and it remains today, is the unrealistic reliance on outside funding and those estimates then being used to reduce health care appropriations. Added to this concern Mr. Chairman, is VA's assertion that it can now wring more than \$1.4 billion in savings through management reforms to achieve greater efficiencies. If VA's past performance in these areas is any indicator at all, then the underlying assumptions, upon which much of the health care budget is based, are risky at best and potentially catastrophic.

National Veterans Cemeteries - As stated earlier, NCOA is appreciative for the funding requested to activate and put into operation four new National Veterans Cemeteries. The Association is compelled however to remind the Committee that when these four cemeteries are fully operational, the National Cemetery System still will have sufficient capacity to meet the burial needs of WWII veterans desiring burial in a National Veterans Cemetery. NCOA remains concerned that VA has not articulated any plan for expansion of the NCS. The Association continues to believe the National Cemetery System needs a properly funded plan that will accommodate future requirements: a plan that includes new cemeteries in the National Cemetery System complimented by the State Veterans Cemetery Grant Program.

The Association is also grateful that the budget requests \$269,000 to replace cemetery equipment that has exceeded its life expectancy and usefulness. This small amount though does little to reduce the backlog of cemetery equipment in need of replacement, a backlog that VA now estimates at nearly 58 million. As this Association has been advocating for many years Mr. Chairman, this is an area of the budget that needs and deserves the Committee's attention. The problem of equipment replacement will not disappear and each year that passes only compounds the problem in future years. If VA wants to achieve their stated goal, which is a cemetery appearance rating of 100%, then immediate attention is needed. The budget request of \$269,000 is appreciated but we all have to recognize that it barely hints at the size of the problem. NCOA strongly recommends that this backlog be retired with a lump sum appropriation this year.

**Education Benefits** - NCOA is sincerely grateful for the improvements enacted last year in the veterans' education benefit, particularly for the increase of 20% in the basic entitlement. Even with those improvements Mr. Chairman, NCOA knows of no one who would contend that the benefit is adequate. The Final Report of the Commission on Servicemembers and Veterans Transition Assistance addressed the education benefit in detail. An initiative on this issue is already underway in the Senate. The Secretary of Defense and the Chiefs of the Military Services have testified as to the need for enhancement of the education benefit to allow the military services to achieve recruiting and retention requirements. The benefit has steadily lost its value as a recruiting and retention incentive. Among college bound youth, military service is viewed not as a stepping stone to higher education but rather as a stumbling block. As a transition benefit, fewer than 40% of program participants use the benefit.

The above having been stated Mr. Chairman underscores the reason that NCOA is again supremely disappointed with the President's budget - nothing was proposed for additional enhancement of this important and critical veteran benefit. New non-veteran education spending is again proposed in FY00 by the Administration. The veterans' education benefit was completely ignored by the Administration in the previous two years even though more than \$126 billion in combined increases and tax incentives for non-veteran education was approved.

NCOA senses a growing recognition that fundamental and dramatic changes in the veteran education benefit are overdue. The Association sincerely hopes that this Committee will seize the momentum that now exists to address this benefit in a fundamental and sweeping manner. If the veteran education benefit is to ever be restored to its pre-eminent position as the flagship of federal education programs, Congress will have to lead the way. NCOA urges you to do so.

**VA Home Loan Program** - The FY00 budget seeks again, as was the case last year, to charge a \$25 fee for each VA home loan that is guaranteed. That amount by itself Mr. Chairman is not significant but NCOA is adamantly opposed to the Administration's

proposal. It represents another chipping away at a benefit that this Association will not support. Over the years, the home loan program has steadily lost its value and another fee does nothing to increase the value of this program for veterans. For many years now, NCOA has asked Congress to repeal the down-payment requirements and loan origination fees that have steadily decreased the value and appeal of the home loan guaranty program. NCOA is pleased that the Final Report of the Commission on Servicemembers and Veterans Transition Assistance has recommended the elimination of the two-percent funding fee. Whatever the action this Committee may take on the Commission recommendation, NCOA asks that you reject emphatically the \$25 fee proposed in the President's budget.

### Transition Commission

Two years ago, this Committee joined with the Senate Committee in establishing a rare Congressional Commission to examine veterans benefits. In the Association's opinion, that Commission has presented Congress a roadmap to repair many VA programs together with an opportunity to enact these changes in a surplus budget environment.

Last year, veterans lost nearly \$20 billion in budget cuts, and have lost that much again over the previous ten years. It would take the restoration of only a small amount of these cuts over the next few years to enact the tremendous improvements proposed by your own Commission.

NCOA urges you to work with the Budget and Armed Services Committees to establish a funding plan, beginning this year, to provide for a newly enhanced GI Bill, an affordable program of medical benefits for veterans and their families, a substantially revised employment program for veterans, and, dozens of other new and revised program initiatives contained within the Commission Report.

In Addition to establishing a funding plan, the Association recommends the establishment of a timeline for change. The Commission has done its job but must now rely on your leadership to assure that their efforts were not in vain.

**Conclusion**

**In conclusion, NCOA requests that this Committee advocate funding for veteran's benefits and programs above the level proposed by the Administration's budget. Veterans programs and benefits should not be linked to any additional fees, conditioning increases to outside sources, or on savings projections that will unlikely be achieved. In the mix of a \$1.7 trillion federal budget, a budget that contains close to 100 new initiatives, NCOA believes that veterans deserve more certainty than offered by this budget.**

**Thank you.**



**Non Commissioned Officers Association of the United States of America**

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**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.

**STATEMENT OF CARROLL WILLIAMS, DIRECTOR  
NATIONAL VETERANS AFFAIRS AND  
REHABILITATION COMMISSION  
THE AMERICAN LEGION  
BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES HOUSE OF REPRESENTATIVES  
ON  
THE DEPARTMENT OF VETERANS AFFAIRS BUDGET  
FISCAL YEAR 2000**

**FEBRUARY 11, 1999**

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 (FY) 2000.

Overall, the President's FY 2000 proposal includes a budget authority of \$43.6 billion for Department of Veterans Affairs discretionary and entitlement programs. The proposal reflects an increase of approximately \$200 million in budget authority over FY 1999. On October 6, 1998, National Commander Harold L. "Butch" Miller appeared before a Joint Session of the Congressional Committees on Veterans' Affairs to present The American Legion's FY 2000 budget recommendations. The President's FY 2000 budget request provides for certain programs and functions as follows:

**FISCAL YEAR 2000  
DEPARTMENT OF VETERANS AFFAIRS BUDGET PROPOSAL**

	<u>Proposed FY 2000</u>	<u>American Legion Recommendation</u>
Medical Care (includes MCCF receipts)	\$18.1 billion	\$19.5 billion
Medical Research	\$ 316 million	\$ 335 million
Construction		
Major	\$ 60 million	\$ 200 million
Minor	\$ 175 million	\$ 200 million
State Veterans' Homes		
Grants Program	\$ 40 million	\$ 100 million
National Cemetery Admin.	\$ 97 million	\$ 105 million
Veterans Benefits (GOE)	\$ 706 million	\$ 877 million

**MEDICAL CARE**

Mr. Chairman, the Administration's FY 2000 budget request for the Veterans Health Administration (VHA) will further damage an already fragile health care system. The proposal will allow the system to stumble along, hoping for future long-term "fixes". The American Legion is extremely disappointed with the degree of fiscal austerity imposed by the Clinton Administration on VHA. Elsewhere in the Administration's FY 2000 budget, there is sufficient evidence of a far more progressive fiscal policy toward certain non-veteran federal programs. However, the fiscal policy devoted to veterans health care is extremely stagnant, if not regressive.

Once again, the Administration relies on unnamed management efficiencies and a full-time employee (FTE) reduction of nearly 7,000 positions to meet the expanding needs of VHA. The budget proposal also increases reliance on an inconsistent and unreliable Medical Care Cost Fund (MCCF) to generate sufficient recoveries to compensate for relatively no growth in federal appropriations.

The American Legion is supportive of VHA's goals of reducing per-patient cost for health care services. However, the FY 2000 budget proposal will weaken direct patient care in too many areas in order to partially strengthen other programs. VHA proposes to increase funding for treatment of hepatitis C patients, provide additional funding for long-term care, expand emergency care for service-disabled veterans enrolled in VHA, increase by 54,000 the number of veterans treated, open 89 new outpatient clinics, provide additional funding for homelessness initiatives, and meet increasing medical care inflation and pay raises with no real increase in appropriations.

What is most likely to happen due to the expanded initiatives and a no growth budget is continued reductions in direct patient care. All the applicable patient care data and statistics can subsequently be furnished to justify current policies.

Mr. Chairman, The American Legion believes the FY 2000 budget proposal for VHA represents a serious breach of faith with America's veterans. In an era of budgetary surpluses in the billions of dollars, where are the resources and plans to permanently strengthen VHA? In recent years, Congress has claimed veterans' benefits in an effort to reduce the federal deficit. Now that there is a balanced budget, no one is even considering restoring any of the growing list of denied benefits. Congress can do better in FY 2000 than the Administration proposes. Appropriate funding support of VHA programs and services must be provided until such time that a long-term strategy develops to safeguard the veterans' health care system.

Mr. Chairman, to acquire a realistic picture of the current conditions within VHA, one must meet and listen to the staff that actually provides the direct care and services to the nation's veterans. There is an immense disconnect when listening to the managers and administrators and direct care staff describe the state of VHA. It is like speaking to two totally distinct health care systems rather than one. The American Legion encourages the distinguished members of this Committee to interact with the staffs of local VHA facilities to learn about the every day working conditions. Ask the nursing staff and technicians about the quality of health care provided to veterans. The American Legion is not implying that conditions within VHA are beyond repair. What we are saying is that when conditions indicate that problems are building, Congress must try to make corrections sooner, not later. Not dealing with VHA's budgetary problems head-on can result in too many unintended consequences that ultimately makes the problems harder to resolve. We must be proactive rather than reactive to the health care needs of America's veterans and their families.

Mr. Chairman, four years ago VHA took a hard look at changes that need to be made throughout the system. That review resulted in the Veterans Integrated Service Network (VISN) reorganization and its enhanced efficiencies, eligibility reform, the implementation of the Veterans Equitable Resource Allocation (VERA) model, greater sharing authority, improved access to primary care, retention of MCCF reimbursements and other reforms. VHA is currently in the last phase of its reform efforts and the budgetary dilemma is still not resolved. In spite of all the recently required reforms, VHA continues to fall behind in essential funding. Congress must examine other measures to strengthen VHA programs and services and move permanently away from the year-to-year survival mode the system is currently treading.

Recently, Members of Congress and the Governors of several northeastern states sent a letter to President Clinton describing untenable conditions at their respective VHA facilities. The letter asked President Clinton to support increased funding for the northeastern facilities. Obviously, this action is in response to the impact of VERA. However, as we review the conditions of the entire VHA, there are many parallels throughout the nation. Even VISNs that receive increased funding under VERA must continue to reduce staff size and create other efficiencies to adjust to the effects of increased costs. While VERA is a useful management tool, it can only distribute the budget that Congress provides.

There are many examples of reduced programs and services throughout VHA. The net effect is that the system cannot adjust and respond to all exigencies, while operating under the strict Balanced Budget Act funding caps.

**The American Legion proposes an increase in direct appropriations of \$1.4 billion for VHA in FY 2000. This amount will raise VHA funding to \$19.5 billion (including MCCF reimbursements) to provide expanded clinical initiatives, provide for medical inflation and employee cost-of-living increases, and provide needed care for aging veterans. To do anything less is unconscionable.**

### THE GI BILL OF HEALTH

The American health care industry is much different today than at the end of World War II. Nevertheless, issues of primary importance to The American Legion regarding VA medical care are not much different, almost 55 years after the end of that era.

The highest issues of concern to The American Legion regarding the current and future VA health care system are:

- Funding;
- Quality of care;
- Access to care; and
- Special care programs.

Mr. Chairman, in the early 1980s serious funding constraints began to negatively affect the delivery of VA care. In 1986, Congress instituted a means test and third-party reimbursement program to help stem the tide of funding shortfalls. At the beginning of the 1990s, eligibility restrictions impeded the delivery of cost-effective quality care; archaic management structures slowed system progress; and funding constraints became more acute, in spite of several one billion dollar increases to the VHA's budget under then Secretary Jesse Brown.

Despite an urgent need to address many internal issues, most efforts to reform and modernize VHA were put on hold in early 1993, when the Clinton Administration launched its efforts to reform the nation's health care system. The Administration's 'Health Security Act' proposed sweeping changes not only for private health care, but also for government health care. VHA's need to modernize would have greatly benefited under the 'Health Security Act.' Veterans Service Organizations provided constructive input into the preparation of the President's proposal. Although the "Health Security Act" did not become law, it became the vehicle for many of the changes that have occurred in managed care since that time.

After the 'Health Security Act' collapsed in 1994, The American Legion developed its own legislative proposal for the revitalization of the VHA. Many of the recommendations of the 'Health Security Act' were considered and included in the proposal. This effort culminated in the **GI Bill of Health**. Although VHA was lukewarm to the proposal at first, today VA recognizes a need to develop other non-appropriated sources of income.

Under Secretary of Health Dr. Ken Kizer will tell you that VHA today is in Phase 3 of its restructuring plan. Phase 1 began soon after his appointment in October 1994. Phase I included studying the existing system, and preparing a detailed reorganization plan. The result of that effort was the 22 VISN concept and the effort to decentralize VA health care. The first phase lasted through early 1996 when all VISNs became operational.

Phase 2 began with the passage and implementation of the "Veterans Health Care Eligibility Reform Act of 1996." This phase resulted in the most evolutionary changes ever undertaken within VHA -- the transition from hospital-based care to primary care. That is where VHA is today -- Phase 3, or fine-tuning VHA's strategic reform initiative.

The American Legion supports many of VA's efforts to improve the delivery of veterans health care. The increased emphasis on outpatient care is the right decision. Until recently, VA's own resource distribution system favored hospital-based care. After experimenting with several resource distribution models, funding within VHA complements primary health care initiatives. There are, however, some valid concerns about the adequacy of VERA with regard to specialty care services and other inpatient procedures. No matter how the funding pie is divided, if the pie is not large enough to start, every VISN is affected.

Obvious improvements have been made regarding the delivery of VA health care over the past four years. However, The American Legion believes that VHA's efforts to modernize its health care system have proceeded far past an appropriate level. The American Legion believes it is time to develop a long-range strategic plan and design the next phase of VHA's modernization effort.

It's an old axiom that *unless you know where you're going you surely will not know how to get there*. Currently, for budgetary reasons, VHA conducts its strategic planning in five-year increments. However, the budget is always in a state of uncertainty. The best plans can therefore easily be disrupted by unforeseen events. It would be advantageous today to develop a long-range planning horizon (15 to 20 years), devoid of budgetary specifics. Once accomplished, a conception can be selected from among several models, deciding on where to take the system and to simultaneously develop particulars on how to get there.

The American Legion concedes that over the past several years it was important to fix VHA's internal problems rather than pump more dollars into an old, broken system. However, after much needed reform, VHA's fundamental funding problems are not yet resolved. The "Balanced Budget Act of 1997" has placed VHA in a budgetary box. There is no more room to save and redirect dollars, short of continuing to pinch one program for another. It is time to develop a premium support system to supplement taxpayer dollars to strengthen and maintain VHA for the long-term.

The **GI Bill of Health** would direct VA to offer certain veterans, on a premium basis, a "standardized core benefit package", at least equivalent to the enrollment benefit package offered to higher priority veterans. This health benefit package would be offered to those veterans who choose to enroll in a VA preferred provider health plan. The package could also be offered to eligible dependents on a premium basis. Beyond the core package, VA or private insurance companies could offer additional benefits, each with its own configuration of co-payments and deductibles. Premium-supported packages would offer an additional range of benefits to eligible veterans and provide VHA with a means to pay for that care.

Certain proposals in the **GI Bill of Health** have already been implemented. These are streamlining eligibility, developing a patient enrollment system, retention of third-party reimbursement, contracting outpatient services into the local community, and greater cooperation with DOD health care and with the private health care sector. Proposals to still be reached include Medicare subvention, development of a VHA - preferred provider health plan, and providing greater access to eligible dependents of veterans through third-party insurance.

America needs a health care system that is easy to understand -- a system that addresses the needs of veterans, especially military retirees who are losing access to medical services through base closings and realignments. The vision for the future must be long-term rather than year-to-year. The American Legion is hopeful that the 106th Congress will address these concerns and continue to rebuild the VA health care system for current and future generations.

The **GI Bill of Health** is a blueprint for preparing VHA to meet the health care needs of America's veterans and their eligible dependents in the 21st Century. Under the proposal:

- all veterans and their dependents would have access to the VA health care system;
- all priority veterans would receive health care treatment at no cost;
- all other veterans and dependents would pay for care;
- retains, expands access, and strengthens VA specialized treatment programs;
- VA would offer defined health benefit packages on a premium basis to all eligible veterans and dependents;
- VA would bill, collect, and retain all appropriate third-party reimbursements, co-payments, deductibles, and premiums -- where applicable;
- VA would create a health plan network consisting of public and private providers;
- VA would open access to more health care facilities within local communities through sharing agreements and contracts with public health care providers.

The **GI Bill of Health** recognizes that there is only so much that can be accomplished to strengthen and preserve VA health care through an exclusive reliance on federal appropriations. Simply meeting medical care inflation, pharmaceutical cost increases and employee cost-of-living increases on a yearly basis requires upwards of \$800 million in new budget authority. Add to that the cost of new medical initiatives and other unanticipated expenses, and year-to-year cost increases are not sustainable.

In the short-term additional direct appropriations will help support VHA's funding challenges. Over the long-term, the **GI Bill of Health** is VHA's best hope for meeting its funding requirements.

#### **MEDICARE SUBVENTION**

The American Legion supports Medicare subvention for the treatment of nonservice-connected conditions of Medicare-eligible veterans within the VA health care system. Medicare-eligible veterans should be able to select VA as their primary health care provider under Medicare+Choice. Medicare-eligible veterans being treated for nonservice-connected conditions are currently billed by VA. VA cannot bill Medicare. Therefore, VA subsidizes Medicare. A veteran is financially penalized for going to VA rather than a private health care provider for the treatment of nonservice-connected conditions. VA can provide quality health care to Medicare-eligible veterans at a reduced rate, because of its infrastructure, economy of scale, and purchasing power.

#### **MEDICAL AND PROSTHETIC RESEARCH**

For FY 2000, the President proposes funding Medical and Prosthetic Research activities at \$316 million, resulting in a decrease of 98 full-time employees (FTE). The funding level is the same as the amount appropriated during FY 1999, and is expected to support the same number of research projects (2,104).

The American Legion appreciates that there is no reduction proposed for research funding in FY 2000. The FY 1999 research budget contained the first significant increase in research activities in many years (+\$44 million). However, the FY 2000 proposal cannot sustain the same buying power. Medical and Prosthetic Research must receive additional funding to offset increased costs. Reducing staffing levels by 98 FTE is not the proper way to adjust for inadequate funding.

An additional \$10.5 million is needed simply to meet current service requirements. Additionally, to allow for modest program expansion, particularly in the Quality Enhancement Research Initiative (QUERI), increased funding is mandatory. The QUERI is directly relevant to the prominent illnesses and diseases that affects veterans.

**In order to provide program consistency within the Medical and Prosthetic Research Service, to allow for inflationary adjustments, and to support QUERI, The American Legion recommends funding VA medical and prosthetic research at \$335 million for FY 2000.**

#### **MEDICAL CONSTRUCTION AND INFRASTRUCTURE SUPPORT**

##### **Major Construction**

The President's FY 2000 major construction proposal provides for budget authority of \$60 million. Approved projects include:

- Kansas City VAMC -- Surgical Suite (estimated cost -- \$13 million)
- Tampa VAMC -- Spinal Cord Injury and Rehabilitation Facility (FY 2000 funding request -- \$17.5 million)
- Murfreesboro VAMC -- Psychiatric Patient Privacy (estimated cost -- \$12.7 million)
- Leavenworth, KS -- National Cemetery Gravesite Development -- \$11.9 million

- Veterans Benefits Administration -- Various Stations -- \$1 million
- Design Funds and Asbestos Abatement -- \$5 million

The American Legion is extremely disappointed with the proposed FY 2000 major construction budget. There are still several unfunded major priority projects from FY 1999. These include seismic corrections and nursing home infrastructure support at VAMC Palo Alto, CA; outpatient clinical additions at VAMCs Washington, DC, and Dallas, TX; and ward renovations at VAMC West Haven, CT. In addition other major priority needs include a clinical addition and outpatient improvements project at VAMCs Milwaukee, WI, and Atlanta, GA; ambulatory care addition at VAMC Hines, IL; and infrastructure improvement projects at VAMCs Buffalo, NY; Fargo, ND and Portland, OR (Vancouver Division).

The American Legion believes current major construction requirements throughout VHA total nearly \$200 million. Simply because VHA's emphasis has shifted to primary care is no reason to neglect other capital assets. VA must develop a well-founded annual major priority construction listing so that Congress can make the necessary adjustments to the projects approved by the Office of Management and Budget.

**The American Legion recommends major construction funding of \$200 million for FY 2000.**

#### Minor Construction

The minor projects construction appropriation provides for constructing, altering, extending, and improving any VA facility, including planning, architectural and engineering services, and site acquisition, where the estimated cost of a project is less than \$4 million.

The President requests new budget authority of \$175 million for the FY 2000, Minor Projects appropriation. This request includes:

#### Medical Care

Inpatient care and support -- \$49.7 million  
 Outpatient care and support -- \$48.2 million  
 Infrastructure and physical plant -- \$30.1 million  
 Other -- \$22.6 million

Regional Office Program -- \$2.5 million

National Cemetery Administration -- \$18.9 million

Other Projects -- \$3 million

**The American Legion recommends \$200 million for FY 2000 Minor Projects.**

#### GRANTS FOR CONSTRUCTION OF STATE EXTENDED CARE FACILITIES

State Veterans' Homes are relied upon to absorb a greater share of the needs of an aging veterans population. Many VA facilities are reducing long-term care beds and the VA does not plan to build many more nursing beds. Due to the current trend within VHA to de-emphasize institutional long-term care, the State Veterans' Home Program becomes more vital to meeting the needs of aging veterans.

On the basis of the funds available in FY 1999 and the FY 2000 request, a total of 42 priority one projects with an estimated cost of \$104.8 million will remain unfunded at the end of FY 2000. In addition, the estimated backlog does not take into account the applications that will be received between August 1998 and August 1999 for prioritization on the FY 2001 priority list.

It is important to note that VA is currently contracted to conduct a management study aimed at re-designing VA's methodology for prioritizing State Veterans' Homes capital investment decisions. The study will actively incorporate the participation and involvement of all State Veterans' Homes, the National Association of State Veterans' Homes and other stakeholders. The resulting list of options and recommendations for changes to the current methodology used to award VA construction grants will be forwarded to Congress in March 1999.

In today's budget climate, having adequate funding for all VA programs and services is difficult. However, The American Legion has every confidence that Congress will provide sufficient funds for the vital efforts of State Veterans' Homes.

**The American Legion recommends \$100 million for the State Veterans' Home Extended Care Construction Grant program for FY 2000.**

#### NATIONAL CEMETERY ADMINISTRATION

The \$97 million requested for the National Cemetery Administration (NCA) for FY 2000, is not sufficient for existing and planned requirements.

The NCA experienced substantial new growth over the past several years and plans on activating four new national cemeteries over the next year. The FY 2000 budget request is increased nearly \$5 million over the current year level and provides an increase of 37 FTE. This may seem adequate to some. However, the current year budget of \$92 million is underfunded by nearly \$3 million. Given that assessment, an increase of \$5 million does not provide appropriate resources for existing or planned workload requirements, cost-of-living increases, equipment and other operational expenses.

The current funding shortfall is primarily related to maintenance requirements. Each year, NCA acreage increases through cemetery expansion projects, increased workloads, and new cemetery development. This increases equipment costs, direct staff and contract costs, and all maintenance costs. These costs are never adequately covered. Thus, NCA's budget is now estimated to be underfunded by approximately \$3 million. Additional funding above the President's request for FY 2000 would be devoted primarily to NCA maintenance requirements.

For the first time ever, interments in national cemeteries are projected to exceed 80,000 during FY 2000. Each year for the next decade, more and more aging World War II veterans and their eligible dependents will choose to be buried in a national cemetery. The nation must be properly prepared to serve those who gave so much. No amount of money can ever repay their sacrifices. It will continue to cost more to adequately fund the National Cemetery Administration over the next decade. To allow the system to sustain shortfalls now will not enable the NCA to justly serve the future burial needs of the veteran population.

**The American Legion recommends that Congress provide the National Cemetery Administration \$105 million for FY 2000.**

#### VETERANS TRANSITION ASSISTANCE COMMISSION

The American Legion is currently reviewing the report of the Congressional Commission on Servicemembers and Veterans Transition Commission. The Commission undertook a difficult and wide-ranging review of various benefit programs available to servicemembers and veterans.

The American Legion is grateful for the efforts and the contributions of the Commission. We look forward to presenting our analysis of the Commission's report to this Committee and the appropriate Subcommittees in the near future.

#### VETERANS BENEFITS ADMINISTRATION

Mr. Chairman, for FY 2000, the proposed appropriation for all mandatory benefit programs, including compensation, pension, burial, education, vocational rehabilitation and

training, insurance, and housing, totals \$23.5 billion. This represents a decrease of \$469 million over the FY 1999 level and reflects a net decrease in benefit payments, primarily in the compensation and pension programs and veterans housing. It also reflects several legislative proposals including a 2.4 percent cost-of-living adjustment (COLA) in monthly disability compensation and DIC benefits, increased benefits for certain Filipino veterans, and a number of budget savings initiatives.

While we are generally supportive of the Administration's requests, we have a number of concerns about the adequacy of the funding in several areas and some of the underlying budget assumptions and projections.

#### **GENERAL OPERATING EXPENSES**

The Veterans Benefits Administration (VBA) is requesting budget authority for an increase of 440 FTE in staffing for claims processing and adjudication functions. This will bring overall staffing in VBA to 11,437 FTE, with 7,236 FTE allocated to the Compensation and Pension (C&P) program and related activities. The proposed increase in personnel is a recognition that C&P must have additional decision-makers to handle the projected volume of claims and appeals in FY 2000, to achieve the goals and objectives set forth in VBA's strategic plan, "Roadmap to Excellence." The proposed increase is also part of improved succession planning which calls for recruiting and training new personnel to replace the large number of highly experienced workers who will be retiring in the very near future. In conjunction with the additional staffing resources is funding for a broad spectrum of continuing and new initiatives intended to improve the efficiency, quality, and timeliness of actions on benefit claims and appeals. The budget submittal provides detailed discussion of the funding requests for the performance and program improvement initiatives for each of its business lines -- Compensation and Pension, Educational Assistance, Vocational Rehabilitation and Counseling, Housing Program, and Insurance.

Mr. Chairman, at last year's hearing on VA's budget, The American Legion expressed the view that VBA appeared to be serious in its commitment to addressing many of its core problems. VBA committed to correcting many long-standing concerns and complaints by veterans, veterans service organizations, and many Members of Congress about poor quality decision-making, excessive processing times, and the waste of critically scarce resources. Since then, VBA has continued to develop and implement many components of its strategic plan which include soliciting input from its stakeholders. These efforts, if successful, will result in substantially improved service to veterans and other claimants, the modernization of its computer systems, further development and refinement of its strategic plans, goals and outcome measures, and making daily operations more efficient, timely, and cost-effective.

The American Legion is generally supportive of the overall proposed level of funding for the Veterans Benefits Administration for FY 2000. There is a continued emphasis on an integrated planning and management approach to solving some of the most stubborn operational and service-related problems. VBA recognizes the need to provide more detailed explanation and justification for its proposed funding, including measurement data on outcomes and service improvements. The budget describes the many initiatives which, we agree, should enable VBA to better measure the performance of its main business line programs and the progress made toward its stated goals and objectives. The proposed funding should also enable VBA to provide higher quality, more timely service to veterans and others who seek information on VA benefits and services.

#### **C&P CLAIMS PROCESSING**

Mandatory benefit payments to disabled veterans and their survivors are projected to be approximately \$22 billion in FY 2000. This will be a net increase of about \$450 million over current year estimated expenditures. In both the compensation and pension programs, despite some decrease in actual caseload, overall average benefit payments will be higher. Increases in the number and percentage of service connected disabilities, substantial retroactive awards in many older cases, and cost of living adjustments have contributed to the projected increase.

In recent years, one of the most frequent complaints expressed by veterans, stakeholders, and Members of Congress, is the amount of time it takes the regional office to complete action on a claim and pay the benefits due. This complaint has been echoed by others, such as the Veterans Claims Adjudication Commission, the National Academy of Public Administration, and most recently, the Servicemembers and Veterans Transition Assistance Commission. Many factors directly and indirectly affect the amount of time it takes to process a benefit claim and provide the applicant a fair and proper decision. The reduction of claims processing time is among the key goals of VBA's Business Process Reengineering (BPR) effort. The stated long-range objective is to complete rating-related action in an average of 74 days and to have nonrating-related action completed in an average of 17 days; achieve a 96 percent accuracy rate for core adjudication work; and attain 90 percent overall satisfaction with the handling of all claims. However, current workload data indicates a continued increase in the processing times for all types of claims, appeals and remands, and the level of the backlog of pending claims. Thus, The American Legion is skeptical of VBA's ability to achieve the service and performance improvements promised for FY 2000.

Internal VBA efforts to better assess and evaluate the impact of changes in the way it does business and how this affects "customer satisfaction," under its balanced scorecard approach, are to continue. The budget submittal includes a discussion of various strategies and initiatives designed to provide greater satisfaction and service, along with data on some of the results achieved during FY 1998 and FY 1999. It acknowledges that the increased emphasis on quality, rather than production as the main priority, is slowing the processing of claims. This effort, along with a slight decline in the projected backlog of pending claims in FY 1999 and FY 2000, will ultimately result in better service. It also acknowledges that major improvements in the timeliness of claims processing will be difficult to achieve, even with additional staffing.

The increased legal and medical complexity of benefit claims will continue to have a significant impact on timeliness. Precedent decisions of the Court of Appeals for Veterans Claims have a significant impact on regional office workloads. The volume of special claims, such as Gulf War Illness, ionizing radiation, and post-traumatic stress disorder, are very complex and time-consuming. Reorganization initiatives will continue to be developed and refined, and more attention is to be focused on developing accurate, comprehensive work management data and how to accomplish this without detracting from work that needs to be done. There is also an acknowledgment that VBA will soon be facing the retirement of a significant number of its highly trained decision-makers and appropriate plans must be made for this transition. The requested 440 additional FTE are a key part of VBA's overall succession plan.

The American Legion believes there are a number of noteworthy initiatives that are expected to have a favorable impact on VBA operations and the level and quality of direct service C&P provided to veterans and their families. There will be more and better types of training for employees in order to improve the quality of claims processing. Work will also continue on improvements in information technology and the implementation of new data systems to support of the adjudication function, and increase the amount of information available about a claim in response to an inquiry. There will be enhanced telecommunication and internet access to VA, based on tests currently underway. Regional offices have also begun to out-base personnel at VA medical centers and locations within the community. As part of this program, VBA personnel are located at a number of military facilities to process claims prior to an individual's discharge from service. The recently completed Decision Review Officer pilot study is under evaluation and a decision to implement it nationwide will be made later this year. This initiative is also intended to reduce the overall number of appeals and remands.

Mr. Chairman, VBA service improvement goals for the C&P Service for FY 2000 are very ambitious. The budget request outlines a broad range of plans and initiatives by which it hopes to achieve its goals. We agree there is a critical need for VBA to substantially improve the timeliness and quality of service provided to veterans and dependents. VBA must also develop and implement more reliable and accurate workload and program performance data to support and justify future budgets. During this general transition phase, VBA must have the necessary legislative and budgetary support. However, *VBA must also begin to demonstrate real progress toward the specific goals it has set for itself, in the very near future.*

### BOARD OF VETERANS APPEALS

For FY 2000, attorney staffing at the Board of Veterans Appeals (BVA or the Board) will be reduced from 244 FTE to 233 FTE. These attorneys provide support to the 62 Board Members in the process of deciding appeals of regional office decisions denying veterans' benefits.

BVA's objectives and performance measures for FY 2000 continue to emphasize the need to provide quality service to veterans and other appellants in an efficient and timely manner. The Board is to be commended for the progress it has made in substantially reducing the average time to render a decision, once a case has been submitted to the Board. The average is now 120 days. This is the result of a number of factors, including legislative changes providing Administrative Law Judge status and pay for Board Members, additional support staffing, administrative reorganization, and a new quality assurance program.

While BVA is, by statute, a separate legal and operational entity apart from the Veterans Benefits Administration, it is nonetheless an integral part of the claims adjudication process and its activities are directly affected by the quality of regional office decision-making. As such, BVA is one of VBA's most important stakeholders, since they have a vested interest in the successful outcome of VBA's performance and customer satisfaction plans and initiatives. In recognition of this relationship and interdependency, VBA and the Board initiated a coordinated effort to more accurately report the amount of time taken to resolve an appeal and to take coordinated action to improve the quality of regional office decision-making and reduce the number of appeals and remands. Appeals resolution time is the overall measure of the amount of time elapsed from the initiation of an appeal to some eventual final action by the regional office or the Board. The Board and VBA must evaluate the effect of quality improvement initiatives for future planning and budgetary purposes. At the end of the first quarter of FY 1999, the total elapsed processing time for all appeals was 968 days. This was down slightly from 1027 days at the end of FY 1998. *If remands are factored into the appeals resolution time, we do not see how the goal of 590 days in FY 1999 and 545 days in FY 2000 can be achieved.*

The Board's workload, timeliness, and performance are directly and indirectly affected by a variety of factors external to VA. Principal among these are the precedent decisions issued by the U.S. Court of Appeals for Veterans Claims (the Court), that overturn not only the decision of the BVA in a particular case, but the underlying legal interpretation of the law or regulation relied upon by the regional office and the Board in denying the claim. Such decisions by the Court have necessitated that VBA and BVA implement frequent and often fundamental changes in the way benefit claims are adjudicated and appeals decided. Judicial review has not only helped ensure that veterans receive full due process, but it is forcing VBA and BVA to devote additional resources separately and jointly to improving the quality of decisions on benefit claims and appeals. The American Legion supports these cooperative efforts.

The enactment of new legislation by the 105th Congress will directly affect the Board's workload in FY 2000. Public Law 105-111 authorized the review of prior BVA decisions, based on a claim of clear and unmistakable error (CUE). There are currently about 1,700 CUE claims at the Board awaiting action. The budget projects an average of 2,000 such claims to be filed with the Board annually. However, the impact of such claims on the Board's workload cannot as yet be determined.

### VOCATIONAL REHABILITATION AND COUNSELING

The fundamental mission of the Vocational Rehabilitation and Counseling (VR&C) program is to assist service-disabled veterans to become employable and to obtain and maintain suitable employment. It also assists those who are seriously disabled in achieving maximum independence in daily living.

Mr. Chairman, the VR&C program has been the subject of major concern over the last ten years. There are real questions about whether it has the resources, management, and leadership necessary to adequately meet the training and employment needs of service-connected disabled veterans. The program has come under some very strong criticism from veteran-participants, stakeholders, GAO, Members of Congress, and others, at previous oversight and budget hearings.

After reviewing the FY 2000 proposal for the Vocational Rehabilitation and Counseling Service (VR&C), we remain deeply concerned by the apparent lack of responsiveness to the long-standing problems affecting the timeliness of service, case management, and employment assistance. We do not believe the requested funding level is adequate. Nor will it allow VR&C to carry out its mission as Congress intended or fulfill its proposed service improvement goals.

As proposed, staffing in FY 2000 will remain at 677 FTE with no future projected increases to handle an estimated 51,000 VR&C participants annually. The proposed budget includes six strategic objectives. However, information concerning current performance levels is lacking and there is little in the way of substantive data in support of the stated goals.

It is indicated that lost productivity, associated with the significant number of staff retirements expected over the next five years, will be compensated for by training existing staff and hiring highly trained replacements. VR&C also plans to continue relying heavily on the use of outside contractors for counseling, testing, and employment services. Efforts to build partnerships with other Federal agencies and outside organizations will continue.

Mr. Chairman, Public Law 104-275 took away a very important opportunity for many service disabled veterans to obtain needed assistance through the VR&C program. This legislation was a budget-driven initiative intended to obviate the U.S. Court of Veterans Appeals precedent decision in Davenport v. Brown. The American Legion continues to believe the restriction that Congress imposed on eligibility for the program was very unfair and should be repealed. It penalizes many service disabled veterans who would otherwise have been able to benefit from needed education and employment assistance, denying them the opportunity to not only better themselves, but provide a better life for their families. The American Legion believes this law should be changed to reinstate entitlement to vocational rehabilitation training for those veterans with a service connected disability, so that VR&C can fully assist veterans who are disabled as a result of military service.

#### SUMMARY

The American Legion has for many years maintained that funding for veterans benefits and services is unquestionably a bipartisan issue. There are some who hold a view that less government is the best government. Likewise, there are others who hold that the programs and services provided by VA represent a sacred trust between the Federal government and those who have faithfully served in the Armed Forces. The President's FY 2000 budget request for the Department of Veterans Affairs represents the "less is best" philosophy in numerous areas.

The Balanced Budget Act of 1997 is creating damaging effects throughout the Veterans Health Administration. For the past two years, funding has been frozen at the FY 1997 level. Apart from insubstantial third-party reimbursements, Congress has not provided adequate funding for the medical programs and services of the Department.

Funding for VA medical care is dangerously low. The Department has not met its third-party reimbursement projections since enactment of the Balanced Budget Act. For FY 2000, the Administration once again presents unrealistic third-party reimbursement projections. The results of insufficient funding over the past several years will have its greatest impact during FY 2000. The Administration proposes to reduce full-time employment by nearly 7,000 positions in order to adjust to insufficient funding.

Many VA medical centers are having to face critical choices. Do they eliminate hospital beds and other critical services or simply close their doors? They can either downsize and become smaller, or simply go out of business. Many facilities have closed or are planning to close inpatient services due to a low inpatient census. In many cases a low census is not a reflection of patient demand, but rather of administrative actions. Instead of seeking to bring in new business, as would be accomplished through the GI Bill of Health, VA is making many irreversible decisions to downsize programs and services.

For FY 2000, the Administration proposes \$17.3 billion in budget authority. This level is unchanged from current year services. In order to compensate for cost-of-living increases, medical inflation, new activations, and other clinical requirements, the Administration projects FY

2000 MCCF recoveries of approximately \$750 million. This is a projected increase of \$124 million above FY 1999.

For FY 1998, MCCF recoveries totaled \$560 million, with a cost obligation of \$102 million. Under the best of circumstances, it is highly doubtful that MCCF collections will net \$750 million during FY 2000. Without a direct increase in federal appropriations for VHA programs and services in FY 2000, VHA will be forced to accelerate the recent downsizing and consolidation trends.

The American Legion acknowledges that over the past few years it was important to improve VHA's internal efficiencies rather than pump more dollars into an old system. However, there is no further room to improve internal efficiencies without **damaging** the core programs. It even appears that Members of Congress who are responsible for VHA oversight have come to the same conclusion. It is time to develop a premium support system to supplement taxpayer dollars to strengthen and maintain VHA.

Congress can no longer merely react to VHA's funding problems. During the hearings on eligibility reform a few years ago, The American Legion testified that the system would collapse upon itself if the funding mechanisms were not reformed along with eligibility. That is exactly what is occurring today.

The American Legion once again recommends that Congress closely examine the **GI Bill of Health**, and commit to pilot testing the proposal. A limited **GI Bill of Health** demonstration program can easily be incorporated into a Medicare subvention pilot program. At a minimum, Congress must develop alternative approaches to ensure that veterans' and servicemembers have access to VA medical care, paid for by either federal appropriations or through other revenue sources.

The American Legion recommends that Congress also closely review the President's inadequate FY 2000 funding proposals for medical and prosthetic research, major construction, the state extended care grants program, and the National Cemetery Administration.

The American Legion is generally pleased with the proposed additional resources for the claims adjudication process. It will take time before these new resources are fully productive. However, they will greatly support VBA's "Roadmap to Excellence." Sadly, however, the first increment of additional FTE and resources for claims adjudication represent a belated recognition that the effort to downsize well trained personnel in lieu of increased computer dependence failed. This has led to a deterioration in timeliness and the growing backlog of claims awaiting action. The American Legion supports the efforts underway to improve VBA operations. There is no substitute to getting the decision right the first time, however.

Mr. Chairman, that completes our statement.

**STATEMENT OF  
 JACQUELINE GARRICK, ACSW, CSW, CTS  
 DEPUTY DIRECTOR FOR HEALTH CARE  
 NATIONAL VETERANS AFFAIRS AND  
 REHABILITATION COMMISSION  
 THE AMERICAN LEGION  
 BEFORE THE  
 SUBCOMMITTEE ON HEALTH  
 COMMITTEE ON VETERANS' AFFAIRS  
 UNITED STATES HOUSE OF REPRESENTATIVES  
 ON  
 THE VETERANS HEALTH ADMINISTRATION BUDGET  
 FISCAL YEAR 2000**

**FEBRUARY 24, 1999**

Mr. Chairman and Members of the Committee, The American Legion appreciates the opportunity to continue the discussion of the President's budget request for FY 2000 concerning funding for the Veterans Health Administration (VHA). The American Legion submitted its testimony on the Department of Veterans Affairs FY 2000 Budget before the full Committee hearing on February 12, 1999. Today, this testimony will focus on VHA's precarious funding situation and, potential solutions to existing and projected budgetary problems.

The President's FY 2000 proposal recommends only \$18.1 billion for VHA. This budget request dramatically represents the adverse effect the Balanced Budget Agreement of 1997 is having on VHA's ability to provide quality health care to this Nation's veterans. The American Legion continues to witness the negative impact on service delivery throughout all 22 Veterans Integrated Service Networks (VISNs) across the country.

Nationally there is genuine concern for VHA's ability to meet the growing health care demands in the immediate future. Network directors have spoken earnestly about their VISN's ability to provide care in FY 2000 and beyond under the current budget constraints. The American Legion continues to hear of the realistic possibility of shortfalls that would force network directors to choose between quality of care or termination of programs or services.

Mr. Chairman, the Administration's FY 2000 budget request for the VHA could very well do further damage to an already fragile health care system. The American Legion is extremely disappointed with the degree of fiscal austerity imposed by the Administration on VHA. Elsewhere in the Administration's FY 2000 budget, there is sufficient evidence of a far more progressive fiscal policy toward certain non-veteran federal programs. However, the fiscal attention devoted to veteran's health care is extremely regressive.

The Administration continues to rely on unnamed management efficiencies and a full-time employee (FTE) reductions (nearly 7,000 positions) to meet the expanding budgetary needs of VHA. The budget proposal also increases reliance on a currently inconsistent and unreliable Medical Care Collections Fund (MCCF) to generate sufficient recoveries to offset discretionary appropriations.

Yet, VHA continues to recognize its need for increased expanded services:

- Treatment of hepatitis C patients,
- Long-term care,
- Emergency services for veterans enrolled in VHA,
- Treatment of 54,000 additional veterans,
- Opening of 89 new outpatient clinics,

- New homelessness initiatives,
- Medical care inflation, and
- Pay raises.

The President's recommendations would not allow VHA to meet these objectives. If VHA continues on this "crash course," it will be forced to continue reductions in direct patient care. The American Legion believes the FY 2000 budget proposal for VHA represents a serious breach of faith with America's veterans. In an era of budgetary surpluses (in the billions of dollars), where are the additional resources and long-range plans to permanently strengthen VHA? In recent years, Congress turned to elimination of certain veterans' benefits in an effort to reduce the federal deficit. Now that there is a balanced budget, who is even considering restoring those benefits? Congress can do better in FY 2000 than the Administration proposes. Appropriate funding support for VHA programs and services must be provided. A long-term strategy must also be developed to safeguard the veterans' health care system, a true national resource that benefits all Americans.

Mr. Chairman, to acquire a realistic picture of the current conditions within VHA, listen to the staff who actually provide direct care and services to veterans. There is an immense disconnect between the views of administrators and direct care providers when they describe the state of VHA. It is like speaking to two totally distinct health care systems rather than one. The American Legion encourages the distinguished members of this Subcommittee to interact with the staffs of local VHA facilities to learn about the every day working conditions. Ask the nursing staff and technicians about the demands and stresses place on them in order to deliver quality health care to veterans. If it were not for the dedicated and compassionate employees at VA facilities, veterans would already be suffering greatly because of the constraints of the budget. Although VHA employees are the final gatekeepers for patient safety and quality care, they should never have to stand alone in this mission. Every American should demand excellent health care in VHA.

The American Legion is not saying that conditions within VHA are beyond repair. When conditions indicate that problems are building, Congress must try to make corrections sooner, not later. Not dealing with VHA's budgetary problems head-on can result in too many unintended and regrettable consequences that ultimately makes the problems harder to resolve. We must be proactive rather than reactive to the health care needs of America's veterans and their families.

Mr. Chairman, four years ago VHA took a hard look at changes that needed to be made throughout the system. That review resulted in the reorganization into VISNs, enhanced efficiencies, eligibility reform, the implementation of the Veterans Equitable Resource Allocation (VERA) model, greater sharing authority, improved access to primary care, retention of MCCF reimbursements, and other reforms. VHA is currently in the last phase of its reform efforts, yet the budgetary dilemma is still not resolved. In spite of all the recently required reforms, VHA continues to fall behind in essential funding. Congress must examine other measures to strengthen VHA programs and services, but more importantly, it must address and resolve its budgetary dilemma.

The focus of the funding problem has been on VERA, as demonstrated by the actions of several stakeholder groups. Recently, Members of Congress and the Governors of several northeastern states sent a letter to President Clinton describing untenable conditions at their respective VHA facilities. The letter asked President Clinton to support increased funding for the northeastern facilities. Obviously, this was a response to the adverse budgetary impact of VERA in that region of the country. However, as we review the conditions of the entire VHA, there are many parallels throughout the Nation. Even those VISNs that receive increased funding under VERA must continue to reduce staff size and create other efficiencies to adjust to the effects of increased costs. While VERA is a useful management tool, it can only distribute the limited budget that Congress provides.

There are many examples of reduced programs and services throughout VHA. The net effect is that the system cannot adjust and respond to all exigencies, while operating under the strict Balanced Budget Act funding caps.

**The American Legion proposes an increase in discretionary appropriations of \$1.4 billion for VHA in FY 2000.** This amount will raise VHA funding to \$19.5 billion (including MCCF reimbursements) to provide expanded clinical initiatives, provide for medical inflation and employee cost-of-living increases, and provide needed care for aging veterans. To do anything less is unconscionable.

Mr. Chairman, there is a long history to VHA's current budget predicament. After several consecutive \$1 billion increases in medical care funding in the early 1990s, the Balanced Budget Act of 1997 has essentially eradicated earlier budgetary gains. In constant dollars, VHA funding is no better off today than ten years ago. Awareness exists that the current and proposed FY 2000 VHA budgets are seriously over-extended. What is seriously lacking are constructive recommendations that concentrate on workable solutions rather than rehashing the problems. The American Legion sees a long-term solution within the GI Bill of Health.

### THE GI BILL OF HEALTH

The American health care industry is much different today than at the end of World War II. Nevertheless, issues of primary importance to The American Legion regarding VA medical care are not much different.

The most significant issues of concern to The American Legion regarding the current and future VA health care system include:

- Funding;
- Quality of care;
- Access to care; and
- Special care programs.

Mr. Chairman, in the early 1980s serious funding constraints began to negatively affect the delivery of VA care. In 1986, Congress instituted a means test and third-party reimbursement program to help stem the tide of funding shortfalls. At the beginning of the 1990s, eligibility restrictions impeded the delivery of cost-effective quality care; archaic management structures slowed system progress; and funding constraints became more acute, in spite of several \$1 billion increases to the VHA's budget under former Secretary Jesse Brown.

Despite an urgent need to address many internal issues, most efforts to reform and modernize VHA were put on hold in early 1993, when the Clinton Administration launched its efforts to reform the nation's health care system. The Administration's "Health Security Act" proposed sweeping changes not only for private health care, but also for government health care. VHA's need to modernize would have greatly benefited under the "Health Care Security Act." All of the major veterans service organizations provided the Administration with constructive input during the preparation of the health care proposal. Although the "Health Care Security Act" did not become law, it became the vehicle for the many changes that have occurred in managed care since that time.

After the "Health Care Security Act" collapsed in 1994, The American Legion developed its own legislative proposal for the revitalization of the VHA. Many of the recommendations of the "Health Care Security Act" were considered and included in the proposal. This effort culminated in the *GI Bill of Health*.

The *GI Bill of Health* is a blueprint for preparing VHA to meet the health care needs of America's veterans and their eligible dependents in the 21st Century. Under the proposal:

- all veterans and their dependents would have access to the VA health care system;
- all priority veterans would receive health care treatment at no cost;
- all other veterans and dependents would pay for care;
- retains, expands access, and strengthens VA specialized treatment programs;
- VA would offer defined health benefit packages on a premium basis to all eligible veterans and dependents;
- VA would bill, collect, and retain all appropriate third-party reimbursements, co-payments, deductibles, and premiums – where applicable;
- VA would create a health plan network consisting of public and private providers;
- VA would open access to more health care facilities within local communities through sharing agreements and contracts with public health care providers.

The American Legion predicts the *GI Bill of Health* will follow a similar course as health care reform has followed in the private sector. In the years since the "Health Care Security Act" failed, incremental reform continues to creep into the health care industry. VHA has also experienced incremental changes, such as the Veterans Eligibility Reform Act of 1996 and new authorities gained under the Balanced Budget Agreement of 1997.

Inherent in these reforms are several key components of the *GI Bill of Health*. Certain proposals in the *GI Bill of Health* have already been implemented. The *GI Bill of Health* components already enacted:

- the streamlining of eligibility,
- capitation (VERA),
- enrollment,
- extension of care to all veterans (priority groups 1 through 7),
- retention of third-party reimbursement,
- contracting outpatient services into the local community,
- greater cooperation with DOD, and
- a defined benefits package plan for enrollees.

As a result of these actions, there are only two key components of the *GI Bill of Health* that still need to be enacted:

- for VHA to gain the authority to treat veterans' dependents, and
- the creation of a premium based plan.

The enactment of the *GI Bill of Health* would direct VA to offer certain veterans, on a premium basis, a "standardized" core benefit package, at least equivalent to the enrollment benefit package offered to higher priority veterans. This health benefit package would be offered to those veterans who choose to enroll in a VA preferred provider health plan. The package could also be offered to eligible dependents on a premium basis. Beyond the core package, VA or private insurance companies could offer additional benefits, each with its own configuration of co-payments and deductibles. Premium-supported packages would offer an additional range of benefits to eligible veterans and provide VHA with a means to pay for that care.

The *GI Bill of Health* recognizes that there is only so much that can be accomplished to strengthen and preserve VA health care through an exclusive reliance on federal appropriations. Simply meeting medical care inflation, pharmaceutical cost increases and employee cost-of-living increases on a yearly basis requires upwards of \$800 million in new budget authority. Add to that the cost of new medical initiatives and other unanticipated expenses, and year-to-year cost increases are not sustainable.

In the short-term, additional discretionary appropriations will help support VHA's funding challenges. Over the long-term, the *GI Bill of Health* is VHA's best hope for meeting its funding requirements.

The *GI Bill of Health* proposes to integrate VA health care with the Nation's private medical providers and provide access to greater numbers of veterans, and certain dependents, using private health insurance. The *GI Bill of Health* also supports VHA's efforts to enact system wide Medicare subvention. These concepts are certainly worth the time and effort for the Subcommittee and the full Committee to explore.

#### GI BILL OF HEALTH TEST PILOT

Mr. Chairman, The American Legion followed up on your recommendation in the 105th Congress and now proposes that the next component of the *GI Bill of Health* that should be considered is expanding access to VHA services to veterans' dependents under the CHAMPVA provisions of Title 38, USC, 1713.

The cry of the VA has long been the quotation from Abraham Lincoln, "*To care for him who shall have borne the battle, and for his widow and his orphan.*" We say that, but when those spouses and children are sick, we leave them out on the street. The deplorable way the families of sick Gulf War veterans were treated only serves to exemplify this point. When these family members initially sought help from the VA for health care because of the hazards of war, they were turned away. As a Nation, we provide health care for military families while the service member is on active duty or upon retirement. The Veterans Benefits Administration (VBA) provides some benefits to family members, but VHA turns a blind eye to the health care needs of a veteran's family. We leave veterans, who choose to use VA, with little means of providing access to quality health care for their family members. We discriminate against veterans who are married and may have children.

The Department of Health and Human Services and Congress realizes that the Nation's children are too precious to leave uninsured. Working together they created the Children's Health Insurance Program (CHIP). The *GI Bill of Health* would allow VA to provide services under this program for children of veterans.

Many female veterans believe that if there were more women treated at VA, then health care delivery for them would improve as well. It only makes sense that programs that benefit female veterans would improve, if more women had access to VA. For instance, VA would have a greater incentive to increase mammography and OB/GYN services.

We also know that women would use the VA, not just because they have told The American Legion, but because they have also told VA. In a study conducted by the VA in San Francisco, CA, researchers found that "83% of spouses reported that they would choose to receive their medical care at VA if allowed to do so." This research group concluded, "Spouses of male veterans represented a sizable group that could be incorporated into the VA system, especially given their strong desire to do so." These are also the partners VA depends on to care for veterans at home. It is in the vested interest of VA to ensure these caregivers are healthy and well supported, if VA intends to shift its focal point of care to outpatient and keep disabled veterans home as long as possible. Females also tend to be younger and healthier than their male counterparts, and are usually the health care decision-makers in a family. This is a cohort that VA needs to capture, if it is to survive.

Currently, in the private sector, managed care succeeds because the organizations avoid adverse selection by maintaining a younger, healthier enrollee pool that offsets the costs for the more medically needy patients. Managed care organizations profit as their risk pools grow. In VA, this profit could be reinvested back into the health care delivery system, since there is no expensive CEO or stockholders to pay. VA needs this influx of "healthy dollars" to increase its buying power. Providing care to veterans' dependents is not only an ethical matter, it is a financial necessity.

Dr. Kenneth Kizer, Under Secretary for Health, supports the notion that it makes sense for VHA to treat veterans' dependents. He goes on to support this key provision by stating, "There is no reason why that same physician couldn't treat the wife and

husband as well. From the administrative side, we have, by and large, the capacity to do that if we could retain the funds that would come with that, whether it was Medicare or private insurance or whatever. Those are marginal costs. We already are supporting the infrastructure, so in some cases if it meant adding on additional physicians or other providers that could be done relatively cheaply."

The American Legion recommends that a criterion be developed for selecting the best possible networks that could support this initiative. Several key issues to consider are geographic distribution of facilities, stakeholder support, and Critical Success Factors (Coopers and Lybrand, 1998). These factors are Leadership, Organization Structure, Accountability, Human Resource Management, and Technology.

#### **MEDICARE SUBVENTION**

The American Legion supports Medicare subvention for the treatment of nonservice-connected conditions of Medicare-eligible veterans within the VA health care system. Medicare-eligible veterans should be able to select VA as their primary health care provider under Medicare+Choice. Medicare-eligible veterans being treated for non service-connected conditions are currently billed by VA. VA cannot bill Medicare. Therefore, VA subsidizes Medicare. A veteran is financially penalized for going to VA rather than a private health care provider for the treatment of non service-connected conditions. VA can provide quality health care to Medicare-eligible veterans at a reduced rate, because of its infrastructure, economy of scale, and purchasing power.

#### **SUMMARY**

It is painfully obvious to The American Legion that the Balanced Budget Act of 1997 is creating damaging effects throughout VHA. For the past two years, funding has been frozen at the FY 1997 level. Apart from insubstantial third-party reimbursements, Congress has not provided adequate funding for the medical programs and services of the Department.

Funding for VA medical care is dangerously low, and VHA has not been able to meet its third-party reimbursement projections since enactment of the Balanced Budget Act. For FY 2000, the Administration once again presents unrealistic third-party reimbursement projections. The results of insufficient funding over the past several years will have its greatest impact during FY 2000. The Administration proposes to reduce full-time employment by nearly 7,000 positions in order to adjust to insufficient funding. If this happens, VHA facilities will be cutting into the bone, as there is no fat left to trim. Networks that lose FTE will be forced to close programs in order to protect patient safety. Veterans will have nowhere to go.

Many facilities have already closed programs, without prior approval of Central Office. Others are planning to close inpatient services due to a low census. In many cases, a low census is not a reflection of patient demand, but rather administrative actions. Instead of seeking to bring in new business, as would be accomplished through the *GI Bill of Health*, VA is making many irreversible decisions to downsize programs and services to save dollars.

For FY 2000, the Administration proposes \$17.3 billion in budget authority for medical care. This level is unchanged from current year services. In order to compensate for cost-of-living increases, medical inflation, new activations, and other clinical requirements, the Administration projects FY 2000 MCCF recoveries of approximately \$750 million. This is a projected increase of \$124 million above FY 1999.

For FY 1998, MCCF recoveries totaled \$560 million, with a cost obligation of \$102 million. Under the best of circumstances, it is highly doubtful that MCCF collections will net \$750 million during FY 2000. Without a direct increase in federal discretionary appropriations for VHA programs and services in FY 2000, VHA will be forced to accelerate the recent downsizing and consolidation trends.

The American Legion acknowledges that over the past few years it was important to improve VHA's internal efficiencies rather than pump more dollars into an old system. However, there is no further room to improve internal efficiencies without damaging the core programs. It even appears that Members of Congress who are responsible for VHA oversight have come to the same conclusion. It is time to develop a premium support system to supplement taxpayer dollars to strengthen and maintain VHA.

Congress can no longer merely react to VHA's funding problems. During the hearings on eligibility reform a few years ago, The American Legion testified that the system would collapse upon itself if the funding mechanisms were not reformed along with eligibility. That is exactly what is occurring today.

The American Legion once again recommends that Congress closely examine the *GI Bill of Health*, and commit to pilot testing the proposal. A limited *GI Bill of Health* demonstration program can easily be incorporated into a Medicare subvention pilot program.

At a minimum, Congress must develop alternative approaches to ensure that veterans and service members have access to VA medical care, paid for by either federal appropriations or through other revenue sources. Veterans deserve more than they are currently getting. These steps need to be taken in order for this Congress and the current Administration to protect the health care rights of this Nation's veterans.

Mr. Chairman, that completes this statement.

DEPARTMENT OF THE ARMY  
 ARLINGTON AND SOLDIERS' AND AIRMEN'S HOME NATIONAL CEMETERY  
 BUDGET JUSTIFICATION, FISCAL YEAR 2000  
 CEMETRIAL EXPENSES, DEPARTMENT OF THE ARMY

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## GENERAL STATEMENT

Arlington and Soldiers' and Airmen's Home National Cemeteries function as principal national shrines where public honor and recognition are accorded deceased persons interred/inurned in a setting of peace, reverence and natural beauty. Operational responsibility for these cemeteries is vested in the Secretary of the Army.

At the close of FY 1998 the remains of 272,195 persons were interred/inurned in these cemeteries. Of this total, 233,747 persons were interred and 23,809 remains inurned in the Columbarium in Arlington National Cemetery, and 14,639 remains were interred in the Soldiers' and Airmen's Home National Cemetery. There were 3,604 interments and 2,034 inurnments by cemetery labor in FY 1998. It is estimated there will be 3,600 interments and 2,100 inurnments in FY 1999, and 3,700 interments and 2,150 inurnments in FY 2000.

In addition to its principal function as a national cemetery, Arlington is the site of many nonfuneral ceremonies each year. In FY 1998, approximately 2,700 such ceremonies were conducted. A like number of ceremonies is anticipated for Fiscal Years 1999 and 2000. Arlington National Cemetery has approximately 4 million visitors annually. This budget includes \$25,000 for continuation of 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 Performance and Results Act and the National Partnership for Reinventing Government. In addition, a donation of \$250,000 was recently accepted by the Secretary of the Army for replacing trees on Arlington National Cemetery grounds, above that of normal maintenance.

LEAD-OFF TABULAR STATEMENT  
( \$ in Thousands )

Brought forward to FY 1998:

Unobligated balance end of FY 1997 -----	\$ 310
Appropriation, FY 1998 -----	11,815
Recovery from prior year obligations -----	0
Obligations, FY 1998 -----	11,985
Unobligated balance available end of FY 1998 -----	140

Funds carried forward to FY 1999:

Unobligated balance end of FY 1998 -----	140
Appropriation, FY 1999 -----	11,666
Recovery from prior year obligations -----	634
Obligations, FY 1999 -----	12,440

Appropriation Request:

Appropriation Request, FY 2000 -----	12,473
Obligations, FY 2000 -----	12,473
Increase in estimated obligations, FY 2000 -----	33
Increase in appropriation request, FY 2000 -----	807

RECONCILIATION OF OBLIGATIONS AND APPROPRIATIONS  
(\$ in Thousands)

	Operations & Maintenance	Administration	Construction	Totals
A. FY 1998 Obligations	\$8,751	\$590	\$2,644	\$11,985
B. FY 1998 Appropriation	\$8,779	599	2,437	11,815
C. FY 1999 Obligations	9,491	964	1,985	12,440
D. FY 1999 Appropriation	9,401	914	1,351	11,666
E. Recovery FY Obligations			634	634
F. FY 2000 Obligations	10,133	928	1,412	12,473
G. FY 2000 Appropriation	10,133	928	1,412	12,473
H. FY 2000 Increase or Decrease				
Appropriation (Line G Minus D)	+ 732 1/	+ 14 2/	+ 61 3/	+ 807
Obligations (Line F Minus C)	+ 642	- 36	- 573	+ 33

Justification:

1/ See Page 4

2/ See Page 5

3/ See Page 6

## JUSTIFICATION

- 1/ Operation and Maintenance of Arlington and Soldiers' & Airmen's Home National Cemeteries \$10,133,000

Appropriation Increase	\$732,000
Obligation Increase	\$642,000

Funds requested will provide for the cost of daily operations necessary to support an average of 20 interments/inurnments daily and for maintenance of approximately 628 acres. The remains of over 272,000 persons occupy existing graves and niches. In addition to the graves, there are over 18 miles of roadways and walkways, and a number of historic sites and other buildings and structures located throughout the cemetery that require recurring maintenance. The Tomb of the Unknowns, the Memorial Amphitheater, the Visitors Center, the Administration Building, the Columbarium, and the graves of Presidents Kennedy and Taft are among the more well known edifices, and historic sites that require constant maintenance. Facilities must also be maintained and equipped to house and repair cemetery vehicles and equipment.

Approximately 2,700 non-funeral events are projected for FY 2000 that will require the use of cemetery personnel, equipment and supplies to conduct these ceremonies. These ceremonies may involve the participation of the President and Vice President of the United States, Cabinet Officials, Members of Congress, Governors, Foreign Heads of State, and other military and political dignitaries.

A combination of commercial contractual services and civilian personnel are utilized to accomplish the operation and maintenance activities. Ground maintenance, guide service, headstones realignment, information reception at the new visitors center and custodial service are major functions performed by private firms. Most other functions, including the projected 5,850 interments/inurnments in FY 2000, will be accomplished by cemetery personnel utilizing 96 workyears. Increases in the amount for contractual services in FY 2000 and in the outyears is consistent with the National Partnership for Reinventing Government and will allow us to reduce personnel and enhance the appearance of Arlington National Cemetery. Funding of \$200,000 is included for development of a comprehensive automation plan to improve operations wherever possible. For example, computer automation of grave site locations, of maintaining records of interment could enhance visitors experiences of Arlington National Cemetery.

JUSTIFICATION  
- Continued -

2/ Administration \$928,000

Appropriation Increase \$ 14,000  
Obligation Decrease \$ 36,000

This activity, utilizing 6 workyears, performs the essential management and administrative functions to include staff supervision of Arlington and Soldiers' and Airmen's Home National Cemeteries; responding to correspondence from The White House, Congress, other government agencies, and the general public; planning and programming, to include all construction projects; budget preparation; resource management; implementing policy decisions, to include interment/inurnment eligibility; and development and maintenance of significant statistical data essential to cemetery operations.

Funds requested will provide for the compensation and benefits and the reimbursable support costs associated with reimbursable finance and accounting support, personnel support, procurement, property accountability and funds certification support provided by others.

JUSTIFICATION  
- Continued -

3/ Construction at Arlington National Cemetery \$1,412,000

Appropriation Increase	\$ 61,000
Obligation Decrease	\$ 573,000

In order to ensure that buildings, structures and other physical facilities are adequate to meet requirements dictated by its mission, Arlington National Cemetery requires an ongoing program to construct and renovate buildings, structures, roadways and walkways, and to develop parcels of land to make them suitable for gravesites. Also, in 1967 the Congress approved an Arlington National Cemetery Master Plan authorizing construction of 28 projects. To date, all of these projects have been funded or partially funded.

Funds requested for FY 2000 will provide for design of a vehicle storage facility at the Facilities Maintenance Complex, continuation of the graveliner program, minor repair of the cemetery roads, continuation of preparation of a utilization plan for expanding the Arlington National Cemetery on contiguous Department of Defense lands and development of a ten year capitalization plan.

DEPARTMENT OF DEFENSE - CIVIL  
CEMETERIAL EXPENSES, ARMY  
FEDERAL FUNDS

General and Special Funds

SALARIES AND EXPENSES

For necessary expenses, as authorized by law, for maintenance, operation, and improvement of Arlington National Cemetery and Soldiers' and Airmen's Home National Cemetery, including the purchase of [two passenger motor vehicles] one passenger motor vehicle for replacement only, and not to exceed \$1,000 for official reception and representation expenses; [\$11,666,000] \$12,473,000, to remain available until expended.

## LANGUAGE CHANGES

There are two proposed changes in the 2000 appropriation language.

Decrease the number of passenger motor vehicles for replacement from two to one.

Increase the amount to be appropriated from \$11,666,000 to \$12,473,000.

VEHICLE DATA

Type	Number	Replacement Criteria		
		Mileage	Age	Other
Trucks, 4x2's under 12,500 lbs.	3		X	
Sedans	1			X

OBJECT CLASSIFICATION  
(\$ in Thousands)

	FY 1998 Actual	FY 1999 President's Budget	FY 1999 Current Estimate	FY 2000 Estimate	Increase/ Decrease
11.9 Personnel compensation -----	84,057	84,183	84,033	84,047	\$ + 14
12.0 Personnel benefits -----	940	920	910	905	- 5
21.0 Travel and transportation of persons	6	4	4	4	
22.0 Transportation of things -----	2	3	3	4	+ 1
23.2 Communications, utilities and rent	374	390	390	414	+ 24
24.0 Printing and reproduction -----	35	50	50	50	
25.0 Other services -----	3,491	4,798	5,098	5,638	+ 540
26.0 Supplies and materials -----	552	468	468	515	+ 47
31.0 Equipment -----	314	263	263	379	+ 116
32.0 Land and structures -----	2,203	1,221	1,221	517	- 704
<b>Total direct obligations</b>	<b>811,984</b>	<b>812,300</b>	<b>812,440</b>	<b>812,473</b>	<b>\$ + 33</b>

OTHER SERVICES, OBJECT CLASS 25  
(\$ in Thousands)

	FY 1998 Actual	FY 1999 President's Budget	FY 1999 Current Estimate	FY 2000 Estimate	Increase/ Decrease
	\$ 30	\$ 35	\$ 35	\$ 40	\$ + 5
Maintenance of Equipment					
Maintenance of Roads & Walks	50	150	150	215	+ 65
Maintenance of Buildings	53	130	130	184	+ 54
Maintenance of Flagstaffs & Monuments	3	5	5	14	+ 9
Information/Guide Contract	760	775	775	840	+ 65
Grounds Maintenance Contract	1,175	1,288	1,538	1,755	+ 217
Custodial Contract	0	110	110	110	
Headstone Set, Clean and Realignment	130	142	142	153	+ 11
Tree Maintenance	410	663	663	698	+ 35
Other Recurring Contracts	253	232	232	223	- 9
Construction Contracts	218	500	500	438	- 62
Graveliners	310	335	335	335	
Support Agreements	99	433	483	433	- 50
Automation Plan				200	+ 200
<b>TOTAL</b>	<b>\$3,491</b>	<b>\$4,798</b>	<b>\$5,098</b>	<b>\$5,638</b>	<b>\$ + 540</b>

PROGRAM AND FINANCING  
(\$ in Thousands)

	FY 1998 Actual	FY 1999 President's Budget	FY 1999 Current Estimate	FY 2000 Estimate
<b>Program by Activities</b>				
1. Operation and maintenance ----	\$ 8,751	\$ 9,401	\$ 9,491	\$10,133
2. Administration -----	590	914	964	928
3. Special construction, Arlington National Cemetery	2,644	1,985	1,985	1,412
10.00 Total obligations -----	11,985	12,300	12,440	12,473

**Financing:**

17.00 Recovery from prior year obligations	--	- 634	- 634	--
21.40 Unobligated balance available, start of year -----	- 310	--	- 140	--
24.40 Unobligated balance available, end of year -----	140	--	--	--
40.00 Appropriation -----	11,815	11,666	11,666	12,473

**Relation of obligations to outlays**

73.10 Obligations incurred, net -----	11,985	12,300	12,440	12,473
72.40 Obligated balance, start of year	5,888	6,403	5,895	5,301
74.40 Obligated balance, end of year -	- 5,895	- 6,659	- 5,301	- 5,874
73.45 Adjustments in unexpired accounts	--	- 634	- 634	--
90.00 Outlays -----	11,978	11,400	12,400	11,900

DETAIL OF PERMANENT POSITIONS

Grade	FY 1998 Actual	FY 1999 President's Budget	FY 1999 Current Estimate	FY 2000 Estimate
SB8	0	0	1	1
GB/GM-15	1	1	0	0
GB/GM-14	1	1	1	1
GB/GM-13	1	1	1	1
GB-12	6	6	6	6
GB-11	3	3	3	3
GB-10	1	1	1	1
GB-09	1	1	2	1
GB-08	1	1	2	2
GB-07	10	10	6	6
GB-06	1	2	4	4
GB-05	8	8	1	1
GB-04	5	5	8	8
			5	5
Subtotal	39	40	39	39
Ungraded	63	72	63	63
Total Permanent Positions	102	112	102	102
Unfilled Positions, End of Year	15			
Total Permanent Employment, End of Year	102	112	102	102

NUMBER OF CIVILIAN PERSONNEL AND WORKYEARS AT END OF YEAR

	FY 1998 Actual		FY 1999 President's Budget		FY 1999 Current Estimate		FY 2000 Estimate	
	Full-time Permanent Positions	Work Year Total						
0851 Operations & Maintenance	96	96	106	106	96	96	96	96
0854 Administration	6	6	6	6	6	6	6	6
Total	102	102	112	112	102	102	102	102
End Strength/Workyears								

PERSONNEL SUMMARY

	FY 1998 Actual	FY 1999 President's Budget	FY 1999 Current Estimate	FY 2000 Estimate
Total number permanent positions	102	112	102	102
Total compensable workyears:				
Full-time equivalent employment	102	112	102	102
Full-time equivalent of overtime and holiday hours	2	1	1	1
Average GS grade	7.59	7.66	7.72	7.80
Average GS salary	\$35,462	\$37,577	\$38,704	\$39,617
Average salary of ungraded positions	\$33,290	\$34,392	\$33,588	\$34,038

STATUS OF ARLINGTON AND SOLDIERS' AND AIRMEN'S HOME NATIONAL CEMETERIES  
30 SEPTEMBER 1998

	Gravesite Capacity Developed Area	Gravesite Capacity Undeveloped Area	Total Gravesite Capacity	Total Gravesites Used	Total Gravesites Available	Projected Closing Date
Arlington National Cemetery	232,339	35,750	268,089	203,605	64,484	2025
Soldiers' and Airmen's Home National Cemetery	14,009	0	14,009	13,662	347	2010

STATUS OF COLUMBARIUM AT ARLINGTON NATIONAL CEMETERY  
31 DECEMBER 1998

	Niche Capacity Developed	Niche Capacity Undeveloped	Total Niche Capacity	Total Niches Used	Projected Closing Date
	31,300	21,300	52,600	20,900	2015



AMERICAN BATTLE MONUMENTS COMMISSION

Appropriation Request for Fiscal Year 2000

1<sup>st</sup> Session, 106<sup>th</sup> Congress of the United States

Submitted to the  
Committee on Veterans Affairs,  
Subcommittee on Benefits

February 1999

American Battle Monuments Commission  
 Fiscal Year 2000 Appropriation Request  
 Salaries and Expenses

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PROPOSED APPROPRIATION LANGUAGE

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; \$28,431,000 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, 1966.)

## 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, 83,243 of World War II, and 750 of the Mexican American War. Additionally, 5,957 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, commemorate 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 \$360,000,000. Our facilities range in age from 70 to 50 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. Accordingly, we are prioritizing our maintenance and engineering funds very carefully to ensure the most effective utilization of our available resources. 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. Some of the maintenance and care is performed by casual labor.

During FY 1988 we conducted an independent, comprehensive manpower study of our cemeteries. This study will help us define the manpower requirements for each of our cemeteries. To ensure that we are taking advantage of streamlining opportunities from additional outsourcing and automation and to maintain productivity and efficiency incentives, ABMC and OMB will jointly review the manpower survey. This review will consider the changing capital / labor ratio regarding the work week and employee standards. We will develop a comprehensive long term automation, employment, and funding plan. We will also undertake a joint study to determine if automation, technology, and outsourcing improvements can reduce the growing costs of foreign employment.

Based on receipt of requested funding in our Fiscal Year 2000 President's Budget, we anticipate our backlog of maintenance, repair, and capital improvements will be \$3,000,000 at the end of the Fiscal Year.

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 Commissioner'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. During Fiscal Year 1988, we experienced exchange rate gains of approximately \$1.9 Million. Based on the revised budget rates and the current exchange rates of the dollar against foreign currencies, we anticipate experiencing losses during Fiscal Year 2000. For the third year, we have repriced our budget to conform to the Department of Defense foreign currency exchange rates.

As a service and maintenance organization ABMC's operations are labor intensive. During Fiscal 1988, 58% 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.

In addition to its other activities, ABMC provides information and assistance on request by relatives and friends of the War Dead interned 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, 1983, 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 memorial will be funded through private donations. The first public solicitation for the capital campaign began in January 1987. (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. 121-138d).

SUMMARY OF ABMC  
BUDGET AUTHORITY  
(\$ In Millions)

	FY 98 Budget Authority Actual	FY 98 Budget Authority Estimate	FY 00 Budget Authority Estimate
Budget Account 74-0100-0-1-705			
Salaries & Expenses	\$27	\$28	\$26
Transferred To FCFA	-2	...	...
Transferred From FCFA	...	1	1
Trust Fund Contributions * (World War II Memorial Fund)	10	14	10
Total ABMC	\$35	\$41	\$37

\* Budget Authority is equal to expected obligations.

LEAD OFF TABULAR STATEMENT  
SALARIES AND EXPENSES

	<u>AMOUNT</u> <u>(THOUSANDS)</u>	<u>FULL-TIME</u> <u>EQUIVALENT</u> <u>PERSONNEL</u> <u>AUTHORIZATION</u>	<u>AVERAGE</u> <u>EMPLOYMENT</u>
1. Fiscal 1998 Appropriation	26,897	362	362
Transferred to Foreign Currency Fluctuation Account	-1,949		
Transferred from Foreign Currency Fluctuation Account to Offset Losses	***		
Transfer from U.S. State Dept (CASS Costs	205		
Unobligated balance End of Year	-288		
Budget Authority	24,885		
Unobligated balance transferred to Foreign Currency Fluctuation Account	-379		
Total Obligations	24,508		
2. Fiscal 1998 Appropriation	26,431	362	362
Budget Authority	26,431		
Total Obligations *	26,431		
3. Fiscal 2000 Appropriation	26,467	364	364
Budget Authority	26,467		
Total Obligations *	26,467		

\* Note: Page 6 reflects estimated currency gains or losses which would be funded through the foreign currency fluctuation account.

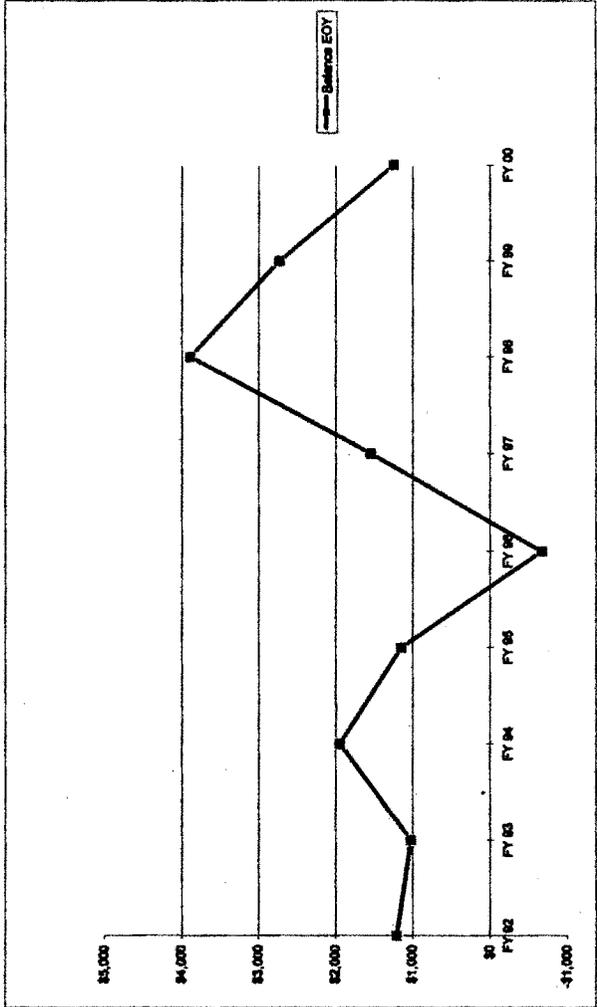
FOREIGN CURRENCY FLUCTUATION

74-0101-0-1-705 FINANCING:	<u>1988</u> Actual	<u>1989</u> Estimate	<u>2000</u> Estimate
21.4001 Unobligated Balance			
Start of Year	-1,548	-3,892	-2,727
24.4001 Unobligated Balance End of			
Year	3,892	2,727	1,247
39.0001 Budget Authority	2,346	-1,165	-1,460
 <b>Budget Authority</b>			
41.0001 Transferred to Other Accounts	0	0	0
42.0001 Transferred from Other			
Accounts	0	0	0
43.0001 Appropriation (Total)	0	0	0

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. Monthly history and estimates of losses and FCFA balances are shown on the chart on the following page.

AMERICAN BATTLE MONUMENTS COMMISSION FOREIGN CURRENCY FLUCTUATION FY 1999-FY 2000									
Month	FY 99			FY 00			FY 00		
	GAINS/LOSSES	REPLINSMNT	BALANCE	GAINS/LOSSES	REPLINSMNT	BALANCE	GAINS/LOSSES	REPLINSMNT	BALANCE
B/E			\$1,644,787			\$1,644,787			\$2,726,878
Oct	\$110,474	\$0	\$1,656,241	\$6,000	\$0	\$3,698,878	-\$126,000		\$2,901,878
Nov	\$118,911		1,775,152	\$6,000		3,902,878	-\$110,000		2,491,878
Dec	\$96,020		1,851,172	\$0,000		3,911,878	-\$125,000		2,366,878
Jan	\$151,781		2,072,953	-\$116,000		3,795,878	-\$120,000		2,266,878
Feb	\$137,198		2,160,132	-\$190,000		3,646,878	-\$136,000		2,111,878
Mar	\$181,436		2,331,568	-\$106,000		3,461,878	-\$146,000		1,965,878
Apr	\$213,651		2,545,219	-\$125,000		3,386,878	-\$115,000		1,851,878
May	\$194,655		2,739,874	-\$135,000		3,221,878	-\$120,000		1,731,878
Jun	\$157,523		2,897,397	-\$115,000		3,106,878	-\$116,000		1,616,878
Jul	\$252,590		3,149,987	-\$120,000		2,986,878	-\$110,000		1,506,878
Aug	\$183,867		3,333,854	-\$110,000		2,876,878	-\$136,000		1,371,878
Sep	\$160,711		3,494,565	-\$160,000		2,726,878	-\$129,000		1,246,878
	\$1,944,786	\$0	\$3,494,866	\$3,196,800	\$0	\$3,726,878	-\$1,490,000	\$0	\$1,246,878
		Adjustment	397,313						
		Total	\$3,891,878						
Note: 1st Quarter FY 99 Actual. Remainder FY 99 Est. FY 2000 Estimated for Planning Purposes.									

AMERICAN BATTLE MONUMENTS COMMISSION  
END OF YEAR BALANCE  
FOREIGN CURRENCY FLUCTUATION ACCOUNT  
FY 1992 THROUGH FY 2000  
(\$ in Thousands)



Note: Losses for FY 98 Reprogrammed from Operations.

STATEMENT OF PERSONNEL

	1999 Actual	1999 Estimate	2000 Estimate
Total Number of Full-Time Permanent Positions	362	362	364
Total Compensable Work Years (FTE)	362	362	364
Full-Time Equivalent (FTE) of Overtime and Holiday Pay	4	4	4
Average GS Grade	10.9	10.7	10.7
Average GS Salary	41,951	43,353	45,387
Average Salary of Ungraded Positions	22,824	24,204	27,720

**STATEMENT OF  
INCREASES AND DECREASES BY ACTIVITY**  
(In Thousands)

	Administration and U.S. Memorials	European Comerelles and Memorials	Mediterranean Comerelles and Memorials	Asian Comerelles and Memorials	Latin Comerelles and Memorials	Totals
1. Fiscal 1998 Obligations (Actual)	2,863	16,822	3,451	667	403	24,506
2. Fiscal 1998 Obligations (Est)	3,268	18,067	3,681	1,040	387	26,431
Change from 1998	403	1,235	230	73	-18	1,625
3. Fiscal 2000 Obligations (Est)	3,870	16,971	3,857	1,333	435	26,466
Change from 1998	604	-1,086	176	283	46	35

STATEMENT OF  
INCREASES AND DECREASES BY OBJECT CLASSIFICATION  
(in Thousands)

	11	12	13	21	22	23	24	25	26	31	32	52	Total
Fiscal 1998 Obligations (Actual)	10,016	3,921	243	288	241	1,072	69	2,542	1,202	1,263	3,612	-3	24,506
Fiscal 1999 Obligations (Est)	10,448	4,138	76	278	159	1,378	107	2,291	1,495	1,357	4,707	0	26,431
Changes from 1998	432	217	-168	-20	-82	304	6	-251	293	64	1,095	3	1,925
Fiscal 2000 Obligations (Est)	11,756	4,468	157	331	141	1,445	69	2,417	1,588	1,087	3,005	1	26,466
Changes from 1999	1,311	330	82	53	-18	69	-38	126	91	-270	-1,702	1	35

AMERICAN BATTLE MONUMENTS COMMISSION  
CHANGES BY OBJECT CLASSIFICATION

- This appropriation request provides \$28,486,528 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 \$35,528 from the current year. We have re-priced our budget to conform to the foreign currency exchange rates utilized by the Department of Defense.
11. Personnel Compensation. \$11,759,000 is requested for salaries of 5 military, 56 U.S. civilian and 308 foreign national employees indigenous to the foreign countries where our installations are located. Included in the request are Ingrade Increases, promotions, and cost of living increases for all employees. These increases include the addition of 2 FTE over our FY 98 Budget and our budget re-ricing based on foreign currency rate changes, resulting in a net increase \$1,311,000 from our FY 98 budget.
12. Personnel Benefits. \$4,488,000 is requested for personnel benefits. 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; bonuses; and FN family allowances. Increases include adjustments for foreign currency re-ricing resulting in an increase of \$330,000 more than our FY 98 budget.
13. Benefits for Former Personnel. \$157,000 is requested for severance pay of FN and GS employees, \$82,000 more than FY 98.
21. Travel and Transportation of Persons. \$331,000 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; \$53,000 more than FY 98. Increases are associated in part, with the staff travel in the execution of accelerated maintenance and engineering projects resulting from the Congressional add in FY 98.
22. Transportation of Things. \$141,000 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; \$18,000 less than FY 98.

AMERICAN BATTLE MONUMENTS COMMISSION  
CHANGES BY OBJECT CLASSIFICATION

23. **Rent, Communications, and Utilities.** \$1,445,000 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); \$69,000 more than our FY 99 budget of which \$23,445 is directly attributable to the change in foreign currency exchange rates.
24. **Printing and Reproduction.** \$69,000 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; \$39,000 less than FY 99.
25. **Other Services.** \$2,417,000 is requested for contractual maintenance and repairs and vehicular insurance in those countries that require such coverage by law; \$126,000 more than FY 99. Funding includes provisions for the development of a maintenance data base and establishment of an information systems contract.
26. **Supplies and Materials.** \$1,586,000 is requested to replenish stockages of plantings and seeds; horticultural, repair and utility, custodial and office supplies; petroleum's, oils and lubricants; tires and tubes; and spare replacement parts for vehicles and equipment; \$91,000 more than FY 99. Increases are attributable to the procurement of replacement headstones in the European and Mediterranean Regions and supplies associated with the new accounting system. The balance of the increase is attributable to the procurement of previously deferred supply items and the change in foreign currency exchange rates.
31. **Equipment.** \$1,087,000 is requested for the replacement of worn-out and uneconomically repairable vehicles, equipment and furniture; \$270,000 less than FY 99.
32. **Land and Structures.** \$3,005,000 is requested for capital improvements; \$1,702,000 less than FY 99. This large decrease is due to the Congressional add on in FY 99 which is partially offset by the impact of the foreign currency repricing.

AMERICAN BATTLE MONUMENTS COMMISSION  
CHANGES BY ACTIVITY

General. This Appropriation Request provides \$26,468,528 for the administration, operation, maintenance, and supervision of 24 burial grounds and 31 monuments, memorials, markers, and offices around the world. This represents an increase of \$35,526 from our FY 99 Appropriation. Included in the budget is an increase of two FTE positions, one personnel specialist for the European Region and one Systems Accountant for the Headquarters in Arlington, VA.

Administration and U.S. Memorials. \$3,870,461 is requested for the ABMC Headquarters office, \$604,000 more than FY 99, 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 Headquarters 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. Funding includes \$20,000 for the procurement of an automated maintenance data base system, \$80,000 to establish an information systems contract, and \$1,000,000 for worldwide engineering and maintenance projects.

European Cemeteries and Memorials. \$16,870,857 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, \$1,086,000 less than FY 99. This decrease is due to reduced funding for engineering and maintenance projects and equipment.

Mediterranean Cemeteries and Memorials. \$3,857,066 is requested for the Mediterranean Region to administer, supervise, operate, and maintain four burial sites, two monuments/markers, and one office, \$178,000 more than FY 99. These installations are located in Southern France, Italy, North Africa, and Gibraltar. Increases are due to increased costs of State Department support (ICASS), rental costs and increased costs associated with the repricing of foreign currency exchange rates.

AMERICAN BATTLE MONUMENTS COMMISSION  
CHANGES BY ACTIVITY

Asian Cemeteries and Memorials. \$1,333,025 is requested for the Manila American Cemetery and Memorial to administer, operate, and maintain one burial ground and one separate memorial; \$265,000 more than FY 99. Increased funding is due to planned completion of long delayed maintenance and engineering projects.

Latin Cemeteries and Memorials. \$435,097 is requested for the operation and maintenance of two burial grounds in Panama and Mexico; \$49,000 more than FY 99. Funding increases are in the area of maintenance and engineering projects.

FY 1988 VISITORS TO ABMC  
CEMETERIES, MONUMENTS, AND MEMORIALS

<b>U.S. INSTALLATIONS:</b>	<b>TOTAL:</b>	<b>4,815,514</b>	<b>MEDITERRANEAN INSTALLATIONS</b>	<b>TOTAL:</b>	<b>423,488</b>
East Coast Memorial	980,102		Florence Cemetery	36,012	
Honolulu Memorial	3,835,412		North Africa Cemetery	9,163	
			Rhone Cemetery	27,236	
			Sicily-Rome Cemetery	351,077	
				<b>TOTAL:</b>	<b>423,488</b>
<b>EUROPEAN INSTALLATIONS:</b>	<b>TOTAL:</b>	<b>3,468,858</b>	<b>ASIAN INSTALLATIONS:</b>	<b>TOTAL:</b>	<b>117,075</b>
Aisne-Merne	38,661		Manila American Cemetery	117,075	
Ardennes Cemetery	231,890				
Brittany Cemetery	26,731				
Brookwood Cemetery	12,806		<b>LATIN AMERICAN INSTALLATIONS:</b>	<b>TOTAL:</b>	<b>31,478</b>
Cambridge Cemetery	202,868		Corozal Cemetery	31,020	
Epinal Cemetery	53,044		Mexico City Cemetery	458	
Flanders Field Cemetery	6,096				
Heint-Chapelle Cemetery	798,496				
Lorraine Cemetery	116,148				
Luxembourg Cemetery	134,577				
Meuse-Argonne Cemetery	134,370				
Netherlands Cemetery	306,183				
Normandy Cemetery	1,297,400				
Oise-Aisne Cemetery	36,027		<b>TOTAL FY 1988 VISITORS:</b>	<b>8,854,210</b>	
Saint Mihiel Cemetery	43,066				
Somme Cemetery	7,555				
Suresnes Cemetery	15,618				

## WORLD WAR II MEMORIAL PROJECT BACKGROUND & STATUS

### I. BACKGROUND

President 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 DC, or its environs. It will be the first national memorial dedicated to all who served during that war, and will recognize the commitment and achievement of the entire nation. Moreover, the legislation directs that ABMC obtain funds to construct the Memorial from private donations.

### II. SITE AND DESIGN

The first step was to select an appropriate site using an open, cooperative process that followed all of the provisions of law and all of the procedural steps regarding the placement of memorials in the nation's capital.

Following nearly a year of careful consideration and after the merits of nine prominent locations were evaluated by the federal agencies responsible for memorial oversight, the Rainbow Pool site, a 7.4-acre rectangular area at the east end of the Reflecting Pool between the Lincoln Memorial and the Washington Monument was approved. 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. The Lincoln Memorial, Washington Monument, and the World War II Memorial, will together 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.

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 announced the winning design team for the Memorial in a White House ceremony. The winner was selected through a two-stage, open competition modeled on the General Services Administration's Design Excellence Program. Friedrich St. Florian, a former dean of the Rhode Island School of Design, was selected from more than 400 submissions in a nationwide competition. Professor St. Florian was selected from among six finalist submissions that included four prominent architectural firms and a graduate student.

On July 24, 1997, in a public hearing, the Commission of Fine Arts (CFA) approved many elements of the memorial and the design concept of the World War II Memorial, but voiced concern over the mass and scale of the interior space of the concept as presented. The CFA unanimously reaffirmed the Rainbow Pool site and requested that the design be given further study and resubmitted at a later date.

On July 31, 1997, in a public hearing, the National Capital Planning Commission (NCPCC) reaffirmed its approval of the Rainbow Pool site, and like the CFA, requested design modifications and an analysis of various environmental considerations.

## WORLD WAR II MEMORIAL PROJECT BACKGROUND & STATUS

On May 12, 1988, the National Park Service, on behalf of the ABMC, forwarded Professor St. Florian's revised design concept to the CFA and the NCPG for their consideration and approval. On May 21, 1988, in a public hearing, the CFA "unanimously and enthusiastically" approved the location, site plan, and revised design concept. On July 8, 1988, in a public hearing, the NCPG overwhelmingly approved the revised design concept of the World War II Memorial.

### III. FUNDING AND FUND-RAISING

As noted above, the World War II Memorial is to be funded primarily through private contributions. However, Congress did authorize a total of \$4,787,000 for the Memorial during Fiscal Years 1983, 1984, and 1985 from the surcharge proceeds of the World War II Commemorative Coin sales. Also, the Department of Defense transferred \$5,000,000 for the Memorial in FY 1988 from funding authorized to commemorate the 50th Anniversary of World War II.

To solicit contributions for the construction of the World War II Memorial, the ABMC created a capital campaign staff of professional fund-raisers. To lead their efforts, former Senator Bob Dole was named the National Chairman of the World War II Memorial Campaign on March 19, 1987. Additionally, on August 19, 1987, the ABMC announced that Mr. Frederick W. Smith, founder of Federal Express and chairman/CEO of FDX Corporation, would team with Senator Dole as National Co-Chairman of the World War II Memorial Campaign.

The public fund-raising campaign for the World War II Memorial effectively began in mid 1987 when Senator Dole became the National Campaign Chairman. The Capital Campaign fund raising efforts of the ABMC were positive during FY 1987 and FY 1988. At the close of fiscal year 1988, \$38.7M had been raised from all sources: government, corporations, foundations, and veteran's organizations. Additionally, more than 170,000 private individuals contributed in response to the ABMC direct mail solicitations. This was accomplished without the benefit of an approved design concept. As of December 31, 1988, revenue from all sources totaled more than \$49.1 million. Many of these contributions were secured prior to the July 1988 National Capital Planning Commission approval of the design concept. As national awareness of the effort grows, the response of the giving public has been more positive.

In 1989 the World War II Memorial drive will initiate a national public service ad campaign through the Ad Council. Cause-related marketing activities will begin with companies that have expressed interest in bringing the Memorial to their consumer base. The introduction of new films, e.g., *Saving Private Ryan*, has substantially raised awareness of the sacrifice of the WWII generation and the planned recognition through the National World War II Memorial. Mr. Tom Hanks, star of *Saving Private Ryan*, has volunteered his support to the World War II Memorial Project's Public Service Advertising (PSA) Campaign. He will be featured in television, radio, and print public service ads. Distribution of these PSA's is scheduled to run for two years beginning in March 1989 and running through 2000. In addition, prominent corporate and public sector leaders have been enlisted to assist with the solicitation and advocacy process.

The ABMC has established prudent estimates of the veracious giving constituents. To date the campaign has been led by corporate and foundation giving, and we project continued positive response. Many corporations played an integral role in the World War II effort. More than \$40M is targeted from corporations and foundations.

## WORLD WAR II MEMORIAL PROJECT BACKGROUND & STATUS

Millions of interested and committed individuals are becoming involved in the respective campaigns of veterans groups led by a \$7.5M commitment of the VFW. These groups are enthusiastically supporting the campaign. We expect to raise \$15M from this giving segment.

Civic organizations are beginning to step forward with fund-raising goals for their respective membership. The Daughters of the American Revolution, the Freemasons, the Elks, and many others are establishing membership giving programs and aggressive targets. A recent resolution of endorsement by the Executive Council of the AFL-CIO is the first step to the involvement and awareness of the sons and daughters of those who served in the war effort. The goal for this constituency is \$15M.

Individuals of affluence are being cultivated for major gifts and should accelerate the total level of support during calendar year 1999. Direct Mail has helped us educate the giving public and continues to provide a profitable return for each dollar invested. As of December 31, 1998 more than 200,000 individuals have participated. Over \$30M in gross income is estimated from this group.

The synergistic effect of national awareness, the immediacy of the need to recognize this extraordinary generation, and the general nation-wide interest to honor the individuals who paved the way for present day America and the values which they so quietly exemplified, make our fund raising goals for FY 1999 and FY 2000 both reasonable and attainable.

### IV. CHALLENGES

ABMC faces several significant challenges. Our greatest challenge is to ensure that construction is completed so that as many of the World War II generation as possible will live to see and be honored by the Memorial. Our goal is to break ground for the Memorial in the year 2000. However, this is dependent on our ability to raise the required funding.

To meet the requirements of the Commemorative Works Act of 1986, ABMC must obtain a construction permit from the Secretary of the Interior within seven years of the legislation authorizing the Memorial, i.e., by May 25, 2000. Before the permit will be issued, all construction costs for the project must be available. Even if the ABMC is as successful in FY 1999 and FY 2000, as it has been these past two years, it still will not meet the requirement to have all funds available to defray the total costs of the Memorial's construction by May 2000. ABMC could be hampered in realizing the full benefits of its efforts by limitations on the use of intellectual property and acceptance of voluntary services from the public and the inability to continue accepting planned giving of funds from contributors in the future.

### V. PROPOSED LEGISLATION

To respond to these challenges, the ABMC is proposing legislation, which would extend the authorization to obtain a construction permit for the Memorial until 2005. The current authority on the Memorial's construction permit lapses in May 2000. In addition the legislative proposal allows ABMC necessary intellectual property authority, confirms ABMC's authority to accept voluntary services in furtherance of the activities of the Commission and permits future acceptance of funds. The Office of Management and Budget advises that, from the standpoint of the Administration's program, there is no objection to the presentation of this proposal for the consideration of Congress.

WORLD WAR II MEMORIAL PROJECT  
FUNDING SUMMARY  
(8003)

	FY93	FY94	FY95	FY96	FY97	FY98	FY99	FY00	FY01	FY02	FY03	FY04	FY05	TOTAL
	ANNUAL	ANNUAL	ANNUAL	PROGRAM										
<b>OPERATIONS</b>														
<b>REVENUE</b>														
Coin Sale	3447	1285	34	0	0	31	0	0	0	0	0	0	0	4,797
Investment Earnings (4.5%, eff FY95)	5	174	276	356	419	610	380	639	1,229	2,283	3,009	3,078	1,860	14,965
P.O.D.	0	0	0	5000	0	0	0	0	0	0	0	0	0	5,000
Fundraising (includes Venues)	1	4	0	0	10,983	16,135	28,620	30,430	21,570	13,850	13,867	0	0	133,070
Total Revenue	3,453	1,463	318	5,366	11,462	16,776	29,010	31,039	22,799	18,163	16,876	3,078	1,860	158,916
<b>EXPENSE</b>														
Project Cost	0	0	0	289	1152	1815	4,085	0	0	0	0	96,836	0	102,867
Other Svcs	0	0	283	264	4819	5596	5,879	4,718	3,391	2,913	100	100	0	27,833
Payroll	0	68	177	301	608	1485	3,180	3,350	2,197	1,810	500	500	500	14,984
Travel & Transportation	0	3	58	81	117	68	148	189	127	104	0	0	0	873
Equipment	0	0	18	4	59	108	138	51	37	30	0	0	0	443
Office Expense	0	0	4	4	115	203	1,205	1,894	1,000	750	40	40	25	5,340
Dedication Ceremony	0	0	0	0	0	0	0	0	0	0	600	0	0	600
Total Expenses	0	71	540	943	7,168	9,043	14,423	10,242	6,752	5,607	97,078	940	5,325	159,050
<b>NET RESULTS (Operations)</b>	3,453	1,392	(222)	4,423	4,294	7,733	14,487	20,827	16,047	10,486	(60,202)	2,438	(3,465)	880
<b>BALANCE OF WWII MEMORIAL FUND</b>														
<b>CUMULATIVE RESULTS</b>	3,453	4,846	4,623	9,046	13,280	21,013	35,500	56,327	72,374	82,870	2,309	4,748	880	

**WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES**  
**CHAIRMAN STUMP TO DEPARTMENT OF VETERANS AFFAIRS**

Questions from the Honorable Bob Stump

**Question 1:** As you know, the House passed HR 4567 last year, which included provisions for Medicare subvention. Assuming enactment of a pilot program this year, when will any substantial revenue be realized?

**Answer:** Up to now all proposals for a pilot VA Medicare subvention initiative call for a 3-year demonstration and a ceiling of \$50 million a year. That, of course, is a limitation on any revenue VA will receive. Any substantial revenue will be based on approval to extend Medicare subvention to the entire VA healthcare system. We would hope that could happen as soon as the demonstration proves successful.

**Question 2:** There appear to be no initiatives in the current budget request indicating a commitment to the planning necessary to go forward with construction of additional national cemeteries beyond 2000. Given that the opening of new cemeteries require four to five years from initial planning to opening, what are (a) your immediate plans/needs for such planning funds, (b) in what amount, and (c) for what locations?

**Answer:** The FY 2000 budget request does not include funding for planning the development of new national cemeteries. The VA is currently constructing four new national cemeteries in geographic areas that were identified in the 1987 and 1994 Reports to Congress on the National Cemetery Administration. This volume of construction is unprecedented in the history of NCA since its inception during the Civil War. After these four new cemeteries open later this year, VA's plans are to review the need for establishment of additional new national cemeteries.

Funding for planning new national cemeteries will be determined within the framework of VA's strategic planning and budgeting process, after the new national cemeteries under construction are completed.

By the turn of the century, six national cemeteries will be completed and operational from the original 1987 Congressional report list of areas in greatest need for a national cemetery. The seven remaining areas identified as being in greatest need from the combined listings of the 1987 report, and subsequent 1994 update, are Atlanta, Georgia; Detroit, Michigan; Miami, Florida; Oklahoma City/Lawton (Fort Sill), Oklahoma; Pittsburgh, Pennsylvania; Sacramento, California; and St. Louis Missouri. These locations will be the priority areas under future consideration.

The St. Louis metropolitan area is currently served by Jefferson Barracks National Cemetery. When the 1994 congressional report was issued, Jefferson Barracks was projected to deplete its inventory of gravesites by 2002. Subsequent to the 1994 report, additional land was acquired to extend the service period of the cemetery. This additional land will allow NCA to continue to meet the needs of St. Louis area veterans to 2010.

**Question 3:** In answering a question at the budget hearing regarding proposed staffing reductions in FY 2000, Dr. Kizer indicated that there had been a reduction of approximately 4,300 in VHA employment last year. In fact, based on a review of actual employment levels identified in VA budget documents for FY 1999 and FY 2000 it appears that the net employment reduction for FY 1998 was only 1,367. In light of the above, please either clarify Dr. Kizer's response or provide a correction for the record.

**Answer:** Dr. Kizer was provided incorrect information. The effective FTE reduction in VHA in 1998 was 3,606 FTE, not 4,300 FTE. The net employment

reduction of 1,367 in 1998 (186,135 in 1997 compared to 184,768 in 1998), is the difference between the actual reduction of 3,606 FTE being offset by the transfer of 2,239 FTE from the MCCR account into Medical Care. The Balanced Budget Act of 1997, Public Law 105-33, shifted the retention of medical collections along with the administration expense (2,239 FTE) to the Medical Care appropriation starting in 1998.

Question 4: The questions raised by the Chairman of the Subcommittee on Health were intended to underscore the belief that a reduction of nearly 7,000 FTEE in FY 2000 is vast in scope and would require employing all available personnel tools, including reductions-in-force and staffing adjustments. A February 8, 1999 memorandum from the Under Secretary for Health to the Secretary, which has come to our attention, confirms that view. In that memorandum, the Under Secretary expressed the belief that "we are in a serious and precarious situation and that if we do not institute these difficult changes [facility integrations, bed reductions, program consolidations and mission changes and accompanying reductions-in-force and staffing adjustments] in a timely manner, then we face the very real prospect of far more problematic decisions, e.g., mandatory employee furloughs, severe curtailment of services or elimination of programs, and possible unnecessary facility closures." A February 13 account of this subject in the Washington Post reported that the Secretary "said yesterday he did not disagree with Kizer's reasoning." Mr. Secretary, please respond to the following:

a. Do you agree or disagree with Dr. Kizer's assessment in that memorandum that the FY 2000 budget proposal, and especially the \$1.4 billion of management efficiencies pose very serious financial challenges and that the situation is "precarious"?

Answer: I agree with Dr. Kizer that \$1.4 billion in management efficiencies pose a challenge for our system.

b. Do you disagree with any substantive aspect of Dr. Kizer's assessment? If so, what aspect and on what basis?

Answer: I understand the Under Secretary's viewpoint that management action should not be delayed in order for the VA to reach our budgetary goals next fiscal year. Reductions-in-force should be the last management action taken after all alternatives have been reviewed.

c. The February 13 Washington Post story reported that "West said he would be meeting with Kizer soon to plan for dealing with the problems his memo raised." Please advise the Committee when that meeting took place and what the results of the meeting were. Please furnish any response to that memorandum and any decision documents relating to the Under Secretary's recommendations.

Answer: As a key member of the VA leadership team, I meet regularly and often with the Under Secretary on a variety of issues. In regards to RIFs, to date I have approved eleven RIF and staffing adjustment requests—the entire number transmitted for my approval.

d. Dr. Kizer's February 8 memorandum warns that the failure to take prompt steps in anticipation of "limitations inherent in the proposed FY 2000 budget" will result in the need to make far more problematic cuts later. It does not follow, however, that instituting sweeping "program adjustments" now, in anticipation of the FY 2000 budget, will not have adverse affects on access, timeliness and quality of care, does it?

Answer: We have and will continue to have facility integrations, bed reductions, program consolidations and mission changes. These actions reflect necessary shifts in patient care service delivery and practices. According to Dr. Kizer, he

needs these tools to continue these actions. Our goal is to improve veterans' access, timeliness and quality of care.

e. Mr. Secretary, with respect to the line of questions raised at the hearing by the Chairman of the Subcommittee on Health, please:

1. Confirm the accuracy of our understanding that you failed to take any final action on any reduction in force or staffing adjustment proposed for any VHA field facility during his tenure.

Answer: During my tenure, I have approved eleven VHA field RIF/staffing adjustment requests. The first three requests I received as Secretary of Veterans Affairs, were subject to intense scrutiny. I asked that a detailed review be conducted of the Department's approach in deciding when the use of these procedures is justified. Additionally, I approved a reduction in force request for VHA's Headquarters staff. However, additional funding was added to VA's FY 99 Appropriations thereby obviating the need to carry out the Headquarters RIF.

2. Confirm the accuracy of our information that in calendar years 1996 and 1997, the incumbent officials in the Office of the Secretary approved 58 separate reductions in force or staffing adjustments proposed by VHA field facilities or field offices (24 in 1996 and 34 in 1997).

Answer: These numbers are accurate.

3. Advise the Committee, upon reflection, whether you stand by your response at the hearing to the question, "Mr. Secretary, have you or your staff given instructions at any time during your tenure to the effect that VHA or VHA officials should not send you proposed reductions in force or staffing adjustments?"

Answer: Since shortly after my arrival at VA, I have worked with my senior staff to devise alternatives to RIFs and Staffing Adjustments. One such alternative is renewed authority to offer voluntary separation incentives (buyouts), a legislative initiative which we tried unsuccessfully to get enacted last year. Enactment of this proposal was not successful, however, I have resubmitted this request to the current Congress.

I point with pride to the manner in which VA has used earlier buyout authorities. We perceive buyout authority as a useful personnel management tool that, first, is fair to our employees and, second, can be tailored to meet our specific downsizing and restructuring needs.

To answer your question more directly, in late summer of 1998, I asked VHA to delay its processing of RIF and Staffing Adjustment requests until we were able to assess more accurately the chances of obtaining renewed buyout authority. The buyout authority was not provided by the last Congress. We have resumed the processing of RIF and Staffing Adjustment requests from the field. As of May 5, 1999, I have signed eleven such requests.

Question 5: With respect to the incomplete response to pre-hearing question 1, please explain the reasoning and methodology by which a shortfall of \$1.145 billion is identified as involving a reduction of 6,949 FTEE, and enactment of emergency care legislation, involving an estimated cost \$244 million in FY 2000, is associated with a reduction of 1,580 FTEE?

- Given that payroll costs are estimated in the FY 2000 budget to be \$60,236 per FTEE, payroll savings associated with the reduction of 6949 FTEE appear to amount to less than half of the projected \$1.145 billion in savings; what factors other than payroll costs are built into this savings estimate?

- The budget appears to link the proposed \$1.14 billion in management efficiencies and savings to the "30-20-10" strategy. To the extent that "30/20/10" is simply a goal, rather than a reliable accounting formula, isn't it quite possible that the FTEE cuts associated with achieving that management savings projection are themselves a very soft number, and – even if \$1.14 billion were a reliable number – that a greater reduction in staffing might therefore be needed to achieve the savings target?

Answer: In addition to payroll savings, the FY 2000 Budget assumed management efficiencies in operations and methodologies of conducting business. The budget was based on plans to implement improved procurement practices and better management of capital assets.

The budget estimate for Medical Care in FY 2000 was based on an examination of the experience of previous years in which large reductions in staffing have been made. As plans are developed at the medical center and VISN levels, the Department will have a more accurate estimate of the actual reduction in employment. The actual composition of FTE reductions and other efficiencies may vary from the estimate to some degree, either for a greater or lesser reduction in staffing based on the unique health care needs and decisions made within each VISN level.

Question 6: For purposes of the FY 2000 budget's performance goal of decreasing bed days of care in FY 2000 to 1,328 per 1,000 unique patients, and ongoing efforts to "rightsize" the VA healthcare system, is there a "right-sized" target for the number of acute care beds which (optimally) should be closed in FY 2000?

Answer: Just how many acute care beds will be retained in each network will be determined at the network level. Of course, headquarters will review and approve all the changes. In general, we believe that the number of acute care beds in the future will inevitably decline as more and more of acute care will be shifted to outpatient clinics. This trend is typical of the entire healthcare industry, not just the Department of Veterans Affairs. VA plans to monitor all upcoming changes in clinical practice and intends to solicit patient opinion concerning the quality of care provided.

Question 7: In responding to prehearing question 7 regarding construction priorities, the Department indicated that the requested information would be furnished in the so-called "Section 204 [strategic planning] report" which was due on January 31, 1999. The response indicated that the report would be submitted "shortly". Please furnish us that report.

Answer: The report was transmitted to the Congress by the Principal Deputy Assistant Secretary for Congressional Affairs on February 26, 1999. A copy of the report is attached.

Question 8: In responding to the prehearing question 8, the Department indicated that six projects on the FY 1999 list of priority medical construction projects were not included in the latest network strategic plan submissions. In addition to the three identified in the response, which other FY 1999 priority projects are no longer network priorities? Please inform the Committee of the priority status and scoring of the Washington, DC major construction project authorized by Congress last session.

Answer: The three projects you inquire about are Washington, DC (OP Clinic Expansion), Portland (Vancouver Campus Improvement) and Buffalo (HVAC/Environmental Improvements). Buffalo and Portland chose not to resubmit a FY 2000 Capital Investment Proposal Application. Washington, D.C. submitted an application for FY 2000 and initially failed validation by the VA

Capital Investment Panel (VACIP) due to issues with their workload projections and alternatives explored. The project was prioritized and was 25 out of 31 Capital Investment Proposals and received a score of .355. Proposals reviewed included major construction, leases, information technology, equipment submitted by VHA, VBA, NCA and staff offices. The Washington, DC VA Medical Center opted not to update their original submission based on the issues identified above (workloads and alternatives). The facility has since dropped the project, as it was not included in the Network's strategic plan for FY 2001.

Questions from the Honorable Michael Bilirakis

Question 1: Since the early stages of the project, the VA has planned to construct a 100 bed SCI center. However, the Administration's budget includes \$17.5 million for the construction of a 70 bed SCI center. Why was the project modified?

Answer: A need for 100 SCI beds at Tampa was originally projected in the late 1980's but it is now out of date. Since that time overall bed utilization (hospital length of stay) has declined while outpatient and home care utilization has increased. VA Medical Center Tampa currently operates 57 of 60 authorized acute spinal cord injury beds and 38 beds for patients requiring rehabilitation, for a total of 95 beds. (Of the 60 authorized SCI beds, three are out-of-service to accommodate other patient care activities and SCI equipment storage.) The current combined average daily census (ADC) for SCI/Rehab is 62 (37.5 ADC for SCI plus 24.5 ADC for Rehab).

In a study completed in August 1998, the need for acute SCI/Rehab beds was projected to decline to 63 by 2010 and 49 by 2020. Surplus beds, as they become available, will be converted to use for SCI long term care. Long term care patients requiring special care services will be admitted to Tampa SCI beds. Patients requiring special care services will be admitted to the Tampa SCI. Patients that can be supported in a nursing home will be placed in VA and community facilities, based on the quality of services offered, the need for hospital support relative to the location of the nursing home, individual SCI patient's needs and desires, and cost effectiveness.

Question 2: In March 1998, I met with the Deputy Secretary Gober and Dr. Garthwaite to discuss the status of the SCI project. At that time, I was informed that the VA was evaluating the scope of the project to determine if any adjustments were needed. Following this review, I was informed that VA had decided to retain the project's original design for a 100 bed SCI unit. I would like to receive copies of any documentation associated with this review.

Answer: As noted in the response to Question 1, future bed projections for the Tampa project were re-evaluated in August 1998. Attached are the workload projections and the justification for beds allocated for the project.

**VAMC TAMPA, FL**  
**Justification for SCI/ Rehabilitation Center Workload**

**Background:** A major construction project scheduled for FY 2000 at VAMC Tampa will correct significant deficiencies in Spinal Cord Injury (SCI) treatment space, functionality, patient privacy, life safety codes, and barriers to the handicapped. As part of this construction, Tampa plans to add, over time, long-term SCI beds. To accommodate these goals, the SCI program will be relocated into new contiguous space at the ground level, consistent with VA criteria. (SCI beds are now located above the ground floor level, on the first and the fifth floors.)

Phase I of the project, which includes a new central energy plant at Tampa, was funded in the FY97 budget. Phase II is planned for FY 2000 and will correct the functional deficiencies in SCI treatment space noted above, and provide long-term SCI beds. (Currently, Tampa only has capability to provide intensive rehabilitation and sustaining care to SCI patients.) Adequate space for an expanding outpatient SCI workload will also be included. The Rehabilitation Medicine, which also has functional space deficiencies, will be relocated with SCI into a **70-bed SCI/ Rehabilitation Center**.

The Tampa facility's mission includes provision of care to veterans with spinal cord injuries/ dysfunction (SCI/D) within the State of Florida, except for those living in

VAMC Miami's service area (i.e., the southeast part of the state). Included are veterans living in the service areas of VAMCs Tampa, Bay Pines, Gainesville and Lake City, as well as the Florida panhandle portion of VAMC Biloxi's service area. No facilities within the Network currently provide long-term SCI care.

**Current/ Projected Bed Needs:** Tampa currently has authorized 60 SCI beds, none of which are long-term: 34 beds on the first floor (which is not on the ground floor), and 26 beds on the fifth floor. The current arrangement of non-contiguous wards has been detrimental to good supervision and to unit morale, and does not meet VA SCI standards. Unsatisfactory bathroom facilities prevent patients from receiving adequate baths, showers or bowel care. Totally against rehabilitative principles, patients often must receive bowel care in bed, in their rooms, which is contrary to basic hygiene and dehumanizing. Rehabilitation is limited due to inadequate space; physical and occupational therapy stations are woefully inadequate.

In FY98, VAMC Tampa had 327 hospital beds, including 98 SCI and Rehabilitation Medicine beds (60 + 38). Combined SCI and Rehabilitation Medicine beds, excluding long-term SCI beds, are projected to decrease to 63 beds (37+ 26) by 2010, and decrease further to 49 beds (29 + 20) by 2020, as shown below:

<u>Bed Section</u>	<u>FY98 Bed Level</u>	<u>2010 Bed Projections</u>	<u>2020 Bed Projections</u>	<u>2020 Bed Allocations</u>
Medicine	111	87	71	71
Neurology	7	4	4	4
Surgery	61	44	35	35
Psychiatry	50	26	20	20
Spinal Cord	60	37	29	25
Long-term SCI	0	0	0	30
<u>Rehabilitation</u>	<u>38</u>	<u>26</u>	<u>20</u>	<u>15</u>
TOTAL	327	225	179	200

**Forty** SCI/Rehab beds (25 + 15) are allocated for 2020, plus **30** new long-term SCI beds, for a total of **70** beds. The clinical mix of beds would be 30 high acuity beds, 30 low acuity beds, and 10 ventilator beds.

There are currently an estimated 3,000 veterans with SCI disabilities living within Tampa's SCI service area, and another 3-4,000 veterans with spinal cord dysfunction (e.g., multiple sclerosis, cord compression, disk disease, etc.). In FY97, according to data from the Allocation Resource Center, 630 SCI/D veterans received inpatient care on Tampa's SCI unit and/or outpatient care at Tampa. An ambitious goal of increasing VA's market share from 9.6 to 15 percent at Tampa would mean an overall increase of 350 SCI/D veterans served. (15% - 9.6% = 5.4%) (6,500 SCI/D vets x 0.54 = 350 SCI/D vets) Since 75 percent of these SCI/D patients will require hospitalization during the year, this equates to about 262 SCI/D additional veterans receiving inpatient care, or a 55 percent increase in inpatients served if they can be accommodated. A portion of this additional workload would consist of long-term SCI patients from the Tampa service area, as well as the rest of the Network.

The standard approach is to use a computerized program where future bed projections are derived from trending inpatient workload for each age group to the target year (2020) and applying these projected utilization rates (inpatients treated per 1,000 veteran population) to the estimated 2020 veteran population by age group. Lengths of stay rates by age group, which are part of the equation, are also trended and applied to future (2020) veteran population by age group. These calculations are shown below:

2020		2020		2020		2020	
2020 Vet Pop by Age Group X	Pts. Trtd. Rates by Age Group =	2020 Pts. Trtd. by Age Group X	ALOS Rates by Age Group =	2020 SDOC by Age Group /	2020 ADC /	Occ. Rate =	2020 Beds

The SCI veteran population in Tampa's service area (excluding those with spinal cord dysfunction) is projected to decrease 33% from 2,999 in 1997 to 2,004 in 2020. Likewise, the number of SCI patients requiring intensive rehabilitation and/or sustaining care is projected to decline by 2020. On the other hand, the number of generally older patients in need of long-term SCI and TBI care is projected to stay constant or slightly increase. Since Tampa currently has no long-term SCI program, this workload component has been identified (based on the number of long-term SCI/D veterans within Tampa's SCI catchment area who would use this service) and projected to 2020 using the same approach. SCI patients treated rates and average lengths of stay rates (by age group) at VAMC Hampton, which has a long-term SCI unit, were applied to Tampa's SCI veteran population (by age group) to determine the long-term bed component.

**Long-Term SCI Beds:** Based on the number of SCI/D patients that now must be housed in nursing home beds within the Tampa, Bay Pines, Gainesville and Lake City service areas, 30 long-term SCI beds are allocated. Since none of the VISN 8 medical facilities, including Tampa, have long-term SCI beds, such a unit would serve as a Network resource. A 10-bed ventilator unit for respiratory-dependent quadriplegic patients would be included. A recent (5/98) survey showed 40 SCI/D patients in community nursing home (CNH) beds and another 33 SCI/D patients occupying VA nursing home care (NHCU) beds at these four facilities, as follows:

<u>Facility</u>	<u>CNH</u>	<u>NHCU</u>	<u>Total</u>
Tampa	19	12	31
Bay Pines	8	7	15
Gainesville	9	7	16
<u>Lake City</u>	<u>4</u>	<u>7</u>	<u>11</u>
Total	40	33	73

This category of patient generally resides in nursing home facilities, or is often inadequately maintained at home by a relative or caregiver. Patient care in both of these settings is often inadequate due to insufficient staff time and knowledge to provide for special needs of paralyzed patients. Special problems relating to bladder and bowel care, skin care, management of spastically and tendon contractures, other forms of physiotherapy, and social and recreational activities are poorly addressed, which reduces quality of life and hastens the onset of acute conditions requiring hospitalization. Re-hospitalization of SCI patients from community nursing homes to VAMC Tampa is 55 percent, over twice the rate of SCI patients admitted from other settings.

An additional 10-12 patients with spinal cord dysfunction (e.g., multiple sclerosis, or cord compression due to metastatic or disk disease) currently occupy medical beds at Tampa. An estimated 45 SCD patients are located in medicine services at all four facilities; the needs of these patients might better be addressed in an SCI unit.

Between FY94 and FY97, average lengths of stay in Tampa's SCI unit decreased from 49.2 to 35.3 days. Because of the drop in lengths of stay, SCI bed days of care (BDOC) at Tampa decreased from 21,773 to 14,951 although SCI hospital admissions increased from 442 to 482 during this time period. BDOC, excluding long-term SCI, are projected to decrease to 10,049 by 2020. An additional 18,458 BDOC are projected for long-term SCI care by 2020, for a total of 28,507 BDOC. Average lengths of stay for the short-term SCI beds at Tampa are projected to decrease to 26.2 days by 2020 (with variations by age group). On the other hand, average lengths of stay for long-term SCI by 2020 are estimated at 214.2 days based on projections at a VA facility (Hampton, VA) with only long-term SCI beds. Because the lengths of stay for long-term SCI/D patients will be 8 times longer, and this component of the SCI patient population will remain fairly constant, there should be no problem keeping SCI beds full. (The combined average SCI/D length of stay by 2020 would be 61.5 days.)

**Outpatient workload:** Between FY94 and FY97, outpatient visits by SCI patients increased from 2,884 to 4,794, and SCI home care (HBPC) visits increased from

918 to 2,159. Total outpatient visits at Tampa, excluding its satellite clinics, increased 19 percent in just one year, to over 316,000 visits in FY97 over FY96. Since FY94, when 217,900 visits were provided, total visits at Tampa have increased 45 percent. A domino project planned for Tampa in 2002, Ambulatory Care Backfill, will address the serious deficiency in space for ambulatory care. The vacated SCI space will be used to meet some of these needs. In addition, activities in six temporary buildings will be brought in-house.

Question 3: How will the VA meet the demands for SCI services with only 70 beds?

Answer: The proposed number of beds are expected to meet or exceed demand for services of Tampa. However, if the demand for SCI services exceeds hospital bed availability (70 beds) at Tampa, then a minor project will be initiated to add the necessary beds using the original design. In addition, a VISN8/PVA Partnership to address the special needs of long-term SCI patients has been established to make better use of community resources that might be available (e.g., assisted living arrangements, attendant care).

Question 4: As I understand it, the design and construction documents have already been completed for the 100-bed unit. Will the project have to be redesigned as a 70-bed unit? If so, how much will the redesign cost and how much time will it require?

Answer: The bed reduction from 100 to 70 beds will require only minor redesign, with no delay in construction. One 30-bed wing will be removed from the design, and other minor space modifications to the design will be made, all prior to FY 2000. These modifications will cost an estimated \$250,000 and take less than 3 months to complete. These minor design changes will allow us to easily add a 30 bed wing at a later date if warranted.

Question 5: Assuming Congress appropriates the necessary funds for the unit, when would construction begin on the SCI center?

Answer: Tampa VAMC is scheduled to award a construction contract in March 2000.

Question 6: What is the status of the relocation of the Port Richey Outpatient Clinic?

Answer: Construction of the relocated Port Richey SOC began March 1, 1999, with an estimated completion date of January 2000. The contractor is Heidorn and Heidorn of Schickshinny, PA. Construction has been delayed several months due to changes in the 100-year water table requirements and the need to get permits from the Southwest Florida Water Management District and the Pasco County Commission. The estimated cost of construction is \$870,000. This is a lease project (15 year term with a 5 year option).

Question 7: Does VERA take into account capital expenses such as activation and increased lease costs for new larger facilities? If not, why not?

Answer: VERA pays the 22 VISNs for the projected number and health status of veterans in their network. Networks must decide whether care should be provided through the activation of new VA space or through leases in non-VA facilities, or both.

Question 8: The San Juan Medical Center suffered \$5 million in damages during Hurricane George. According to a recent editorial in a Florida newspaper, VISN 8 was forced to use healthcare dollars to make the necessary repairs to the medical center. Why was the VISN forced to use healthcare dollars to make these repairs? Does the VA have any type of contingency fund, which could have been used for these repairs?

Answer: Each VISN maintains its own reserve fund for contingencies such as these.

Question 9: I understand that the 1999 VERA allocations were based on 1997 workloads. Is my understanding correct, and if so, why is there a two-year lag between funding and workload?

Answer: The "two-year lag between funding and workload" is the result of an interaction of time frames necessary for the closure and validation of national databases, the subsequent creation of secondary data bases necessary to support the VERA, and the need to release allocations in advance of the fiscal year to enable VISNs and facilities to plan activities based on the anticipated funding. For example, the FY 1998 data that is being used for the FY 2000 allocations is derived from data bases which Networks have until December 1998 to complete and correct. The creation of secondary data bases is being completed and validated now, and preliminary allocations for FY 2000, which begin in six months are being developed for release to the networks as soon as possible.

Question 10: Given that workloads have changed with the implementation of the Veterans Healthcare Eligibility Act of 1996, what mechanism is being put in place to shorten the lag between VERA allocations and workload?

Answer: While there is only a three month delay between the completion of the data bases and the release of preliminary VERA allocations, as discussed above, during the subsequent year there are on-going monitoring activities that can identify any large changes in workload.

Secondly, the data necessary to populate databases to assess the impact of the eligibility reform will not be available for consideration for use until the FY 2001 network allocation process. At that time, there will be an analysis of the

relationships between enrollment and utilization, as well as other factors relevant to utilization of these databases for VERA allocation purposes.

Questions from the Honorable Sonny Callahan

Question 1: As you may know, \$1.5 million was included in the FY 1998 VA, HUD appropriations bill to expand the existing National Cemetery at Mobile, Alabama. Officials from the National Cemetery Administration have been working to find suitable land to expand the cemetery, but have not been able to bring the project to fruition. The committee is interested to know what further steps are being taken to expand the National Cemetery at Mobile?

Answer: It was originally anticipated that property belonging to the city of Mobile which was relatively close to Mobile National Cemetery could be made available for expansion of the cemetery. When that land was examined, in close coordination with city officials, it was determined that it was not suitable for use as a cemetery due to geotechnical and environmental reasons. It was at that time that NCA officials, including the Acting Under Secretary for Memorial Affairs who visited the site, broached the idea of purchasing land from the adjacent Springhill Temple Cemetery. After careful consideration, the idea was rejected since Springhill believed that there would be a need for them to keep the land for future use. In the absence of viable options for expanding Mobile National Cemetery to provide for casket burials, NCA will evaluate the potential establishment of columbaria to serve local veterans.

Question 2: The committee has been made aware that negotiations to purchase land from a nearby Jewish cemetery for purposes of expanding the National Cemetery failed. The committee is interested to know if any other plot of land has been identified for possible expansion.

Answer: To date, no other suitable plot of land has been identified or offered for expansion of the Mobile National Cemetery.

Question 3: Do officials at the National Cemetery Administration understand that there is a widespread consensus in favor of the National Cemetery Administration's assessment of the Hartwell Field site as being an unsuitable site for expansion of the cemetery and that they should not be under pressure to further consider this site?

Answer: Yes. The National Cemetery Administration understands that there is not pressure to consider the Hartwell Field site for expansion of the Mobile National Cemetery. It is widely accepted that the Hartwell Field site is unsuitable for development as a national cemetery due to the presence of paupers gravesites, poor drainage, and sub-surface demolition debris.

Question 4: If suitable land cannot be located near the existing cemetery, are officials at the National Cemetery Administration aware that exploring the expansion of the National Cemetery to other areas in Mobile will be beneficial to veterans and their families who will rely on this cemetery?

Answer: The National Cemetery Administration (NCA) strives to assure that the burial needs of veterans are met by providing reasonable access to a burial option in a national or state veterans cemetery. Reasonable access is defined as having a first-interment option (whether for either casketed remains or cremated remains) available within 75 miles of the veteran's residence. Currently, 96 percent of veterans in the Mobile area are served by the Barrancas National Cemetery in Pensacola, Florida and the Biloxi National Cemetery in Biloxi, Mississippi.

NCA will evaluate the potential establishment of columbaria at Mobile National Cemetery. The use of columbaria is a very suitable approach to providing for future interment needs. A columbaria with state-of-the-art features can be designed and constructed at Mobile. If establishment of columbaria is not a viable option for the Mobile community, establishment of a state veterans cemetery would be an effective way to provide additional burial space for the limited, local veteran population. Through the State Cemetery Grants Program, VA will fund 100 percent of the cost of establishing a state veterans cemetery, including the initial operating equipment. A veterans' cemetery operated and maintained by the state is a complement to the federal system in providing service to veterans.

Questions from the Honorable Steve Buyer

**Question 1: Why did VA propose to allow HUD to receive five percent of the proceeds from the disposal of excess VA properties?**

**Answer:** VA, in collaboration with the Office of Management and Budget (OMB), proposed the idea of providing ten percent, not five percent, to HUD's Homeless Assistance Grants program. In our proposal for asset disposal authority the VA wanted to show "good faith" in complying with the intent of the Stewart B. McKinney Homeless Assistance Act that requires VA and other Government agencies to offer excess property to homeless organizations. Additionally, VA plans to use five percent of the net proceeds in support of its own programs that are targeted to homeless veterans.

- What is the value to veterans from this proposal? How does this proposal improve the VA programs and services?

**Answer:** Any program that provides supplemental funding for HUD's homeless grant program will benefit those veterans who may access those programs. VA estimates that, on any given night, approximately 250,000 veterans are homeless and living in emergency shelters or on the streets. These veterans represent approximately one-third of the homeless adult population. VA will use its share of the proceeds to modernize the work place with state-of-the-art equipment, better information and communications capabilities, handicap accessibility improvements and the elimination of spatial and safety deficiencies. All those improvements culminating in a safe, more efficient and aesthetically pleasing workplace for both the VA employee and our clientele. All this and no additional cost to the taxpayer. Please see the answer to question 1a, if this question applies to the disposal proposal itself.

If the questions pertain to the disposal proposal itself, it will allow VA to better serve veterans by redirecting scarce resources currently spent on recurring needs such as, maintenance and operations costs of excess properties, to more critical needs such as medical care for veterans. In addition, the proceeds from the sale would be used to fund non-recurring needs that includes improving the VA's infrastructure by new construction or through the renovation of existing space, and purchasing capital equipment such as boilers, chillers, medical equipment and information technology items. Through these types of capital enhancements the VA will improve its infrastructure, increase its information technology capabilities and provide better accommodations and service to veterans.

**Question 2: Why not invest the ten percent of the proceeds received from the disposal of VA's excess properties to improving other VA benefit programs?**

**Answer:** As stated in the response to Question 1, excess property must be offered to homeless organizations. Consequently, we are attempting to show "good faith" with the "McKinney Act" by providing ten percent of the net proceeds to HUD.

**Question 3: Is the veterans population facing a shortage of burial space within the National Cemetery System?**

**Answer:** The National Cemetery Administration (NCA) is increasing access to burial space for veterans. NCA strives to assure that the burial needs of veterans are met by providing reasonable access to a burial option in a national or state veterans cemetery within 75 miles of the veterans residence. NCA is working to achieve this goal by completing the construction of new national cemeteries, expanding existing national cemeteries to ensure uninterrupted

service delivery, and working in partnership with the States to establish State veterans cemeteries through the State Cemetery Grants Program. In FY 1998, 68.6 percent of veterans were served by a burial option in a national or state veterans cemetery. The goal is to increase the percentage of veterans served to 77.1 percent by FY 2000, and to 80 percent by FY 2004.

By the turn of the century, six national cemeteries will be operational from the 1987 and 1994 Reports to Congress identifying areas in greatest need for a national cemetery. Four of these new national cemeteries are currently under construction in the areas Chicago, Illinois; Dallas/Ft. Worth, Texas; Saratoga, New York; and Cleveland, Ohio. This growth is unprecedented since the Civil War. After these four new cemeteries are open later this year, VA will evaluate the potential establishment of additional new national cemeteries in the other remaining geographic areas identified in the two Reports.

In addition to completing the construction of new national cemeteries, more than 20 expansion projects will be completed and additional land acquired at 12 existing national cemeteries over the next two years which will extend service delivery periods at these cemeteries. Also over the next two years, seven new state veterans cemeteries are scheduled to begin providing service to over 357,000 veterans

**Question 4:** Why has the Administration proposed to increase the amount of money in FY 2000 that MCCF must collect, when the MCCF failed to collect the full amount required last fiscal year?

**Answer:** VA continues to believe that the collection projections are realistic goals. Keeping the money is an incentive as shown by approximately 8 percent increase in revenues in FY 1998 over FY 1997 collections. This increase occurred during a period when inpatient workload was declining, an area that historically has contributed the greatest amount towards our third party recoveries. First party collections are increasing, and we expect that along with new patients, inpatient collections will increase. Performance goals and key process measures have been set for each Network and are monitored on a monthly basis.

VHA is currently in the process of implementing several initiatives that will improve revenues and position us for Medicare subvention as follows:

**Pre-registration**—Involves contacting patients scheduled for outpatient visits to remind the patients of their appointment and to update patient information. A test of this concept at ten medical centers resulted in an estimated \$6 million increase in recoveries. Pre-registration software is now mandatory at all locations and we anticipate substantial improvement in the identification of third party insurers and the resulting recoveries.

**HCFA Match**—Approximately 5 percent 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 currently pursuing a match of Medicare and VA records to identify primary payer data. This is done through software obtained through Blue Cross/Blue Shield (BCBS) of Texas. If the estimate is correct and VA mirrors the private sector, potential recoveries from this group may total between \$60 to \$97 million.

**Compliance**—Will ensure that coding and documentation for billing and medical records purposes are accurate and in conformance with industry standards and will support reasonable charges.

**Reasonable Charges**—Will allow VA to bill health care insurance companies using community-based charges for medical care for the treatment of non-service-connected conditions. VA will be able to bill inpatient DRG charges and

professional fees, and outpatient facility charges as well as professional charges. The estimated annual increase in third party collections due to the implementation of reasonable charges is \$44 million. We soon expect to publish in the Federal Register the final regulation implementing reasonable charges.

Medicare Remittance Advice (MRA)—Will enable VA to receive a Medicare-equivalent explanation of benefits document that will be used by Medicare supplemental insurers to determine their appropriate payment to VA. We expect this initiative will generate collections of \$2 million per year. The MRA initiative is being coordinated with implementation of reasonable charges.

Electronic Data Interchange (EDI)—Will enable VA to nationally transmit data through a clearinghouse to all third party payers. This should result in more timely payments by ensuring that bills are transmitted and verified electronically by the payer. This initiative deals with cost savings as opposed to increased collections. Annual projected savings are \$26.4 million to process 5.5 million claims. Savings for FY 1999 will be roughly one fourth of that amount due to incremental implementation beginning in summer 1999.

Attachment to Hon. Bob Stump Question #7

Attachment



DEPARTMENT OF VETERANS AFFAIRS  
PRINCIPAL DEPUTY ASSISTANT SECRETARY  
FOR CONGRESSIONAL AFFAIRS  
WASHINGTON DC 20420

February 26, 1999

The Honorable Barbara A. Mikulski  
Ranking Member  
Subcommittee on VA, HUD  
and Independent Agencies  
Committee on Appropriations  
United States Senate  
Washington, DC 20510

Dear Senator Mikulski:

On behalf of the Department of Veterans Affairs, I am pleased to submit the annual report required by Public Law 104-262, Section 204 (b)(4)(3)(d)(1), listing the current priorities of the Department for proposed major medical construction projects. As required by the law, the report includes the following items:

- the relative priority and rank scoring of each major medical construction project;
- the projected cost of each project; and
- a description of the factors that were used to rank projects.

We are pleased to report the progress that the Department is making in the prioritization and selection of major medical construction projects which support the delivery of health care services to our veterans.

If you have any questions, please contact me or Mr. Charlie Likel, Congressional Relations Officer, at (202) 273-5615. Similar letters are being sent to other appropriate Congressional Committee Members.

Sincerely,

A handwritten signature in cursive script that reads "Sheila Clarke McCready".

Sheila Clarke McCready

Enclosure

Department of Veterans Affairs

Report in Response to Public Law 104-262  
Veterans' Health Care Eligibility Reform Act of 1996  
Section 204 (b)(4)(3)(d)(1)

United States Code  
Title 38, Section 8107

212

Priority Major Medical Construction Projects

February 1999

This report is submitted in accordance with United States Code – Title 38, Section 8107 and the "Veterans Health Care Eligibility Reform Act of 1996," PL 104-262, Section 204. The report identifies the major medical construction projects that have the highest priority within the Department of Veterans Affairs (VA).

#### Veterans Health Administration Re-Engineering

Veterans Health Administration (VHA) is embarked on major organizational re-engineering. The planned changes will refocus health care delivery from an inpatient, hospital based model to managed care, ambulatory delivery of services. Since September 1994, 52% (27 319) of VHA acute care hospital beds have been closed. Inpatient admissions decreased 32% (284,596 fewer admissions). Bed days of care per 1,000 patients dropped by 62%, from 3,930 to 1,333, between FY 1995 and FY 1998. 59% of substance abuse treatment programs (112 of 190) shifted from inpatient based to outpatient based from FY 1994 to FY 1998. Inpatient post-traumatic stress disorder (PTSD) units decreased by 52% (21 of 40 units), outpatient PTSD units increased 13% (87 to 98 units) and residential PTSD units increased by 90% (10 to 19 units).

The conscious planned decrease in inpatient programs has occurred with a commensurate increase in ambulatory care to improve veteran access and the quality of care. 263 new community-based outpatient clinics (CBOCs) have been sited, or are in the process of being sited, from savings realized in other areas. Approximately 150 more CBOCs are anticipated within the next 24 months. Ambulatory care visits increased by 35% between FY 1994 and FY 1998 (9.2 million additional visits), with a total of 35.8 million visits handled in FY 1998. Ambulatory surgeries increased from 35% of all surgeries, to 70% in FY 1998.

The number of veterans receiving care within VHA has increased, while the locus of care has shifted. Between FY 1995 and FY 1998, the number of patients treated by VA increased by over 18%, (from 2.9 million veterans to 3.4 million). The number of homeless veterans treated increased by 19%, blind rehabilitation patients treated by 53%, and psychiatric & substance abuse patients treated by 8%.

The scale of change within VHA has caused facility managers to become tentative toward developing and submitting major capital initiatives. This uncertainty will continue until there is clarification on some key issues: e.g., program changes, alternative treatment delivery approaches, workload shifts, consolidations, integration, funding and alternative revenue sources. The report does not contain twenty projects. Only those projects that have been vetted through the Department's capital investment process and passed validity check with all significant issues resolved can be presented as top VA priorities. As other projects complete the capital investment methodological review, they will be considered for inclusion on the priority listing.

**DEPARTMENT OF VETERANS AFFAIRS  
PRIORITY MAJOR MEDICAL CONSTRUCTION PROJECTS  
FY 2000 PRIORITIES**

Medical Center	Project Title	Project Category	Score	Construction Costs	Non-Recurring Costs	Recurring Costs
Cleveland, OH	Clinical & Surg. Consolidation	Ambulatory Care	.656	19,850,000	N/A	N/A
Kansas City, MO	New Surgical Suite & PACU	Clinical Improvements	.600	13,000,000	2,800,000	7,484,415
Murfreesboro, TN	Psychiatric & Patient Privacy	Patient Environment	.476	12,700,000	2,408,575	4,777,858
Tampa, FL	Spinal Cord Injury Unit	Patient Environment	.442	17,500,000	7,433,371	17,192,487
Atlanta, GA	Modernize Patient Wards	Patient Environment	.433	12,400,000	N/A	N/A
Fargo, ND	Environmental Improvements	Patient Environment	.365	11,700,000	N/A	N/A
San Diego, CA	Seismic Corrections	Infrastructure	.350	31,000,000	N/A	N/A
1 Cleveland - Project not selected due to phasing considerations relative to the Ambulatory Care Addition, funded in Fiscal Year 1999.						
2 Murfreesboro - Total project cost is \$14 million. Project has an estimated cost of \$23,000,000. \$5,500,000 remains from Phase 1 and therefore \$17,500,000 is needed for FY 2000 project completion.						
3 Tampa - Phase 2 of this project has an estimated cost of \$12.7 million in available funds and therefore \$12.7 million is needed for FY 2000 project completion.						

**VA Capital Investment Methodology**

The planning methodology employed to prioritize major medical construction projects conforms to the guidance of the Office of Management and Budget, "Capital Programming Guide," Supplement to Office of Management and Budget Circular A-11, Part 3: "Planning, Budgeting, and Acquisition of Capital Assets." The first application of this guidance was undertaken in the preparation of the FY 1999 VA budget submission.

Recognizing the need to enhance capital asset planning, VA employed a consultant to refine the initial VA capital investment planning process employed for FY 1999 budget development. This refined methodology incorporates best practices from the public and private sectors; offers a more objective and scientific method for reviewing and prioritizing capital investments; and is tied more closely to Departmental goals and objectives.

The refined prioritization and selection process consists of two steps: validation and priority scoring. The validity step is conducted to insure the data provided is complete and that the underlying planning assumptions are acceptable and supportable. Projects that passed the validity check were evaluated and prioritized by the VA Capital Investment Board. It is expected that this planning process will be continually refined in response to the constantly changing needs of the Department.

The Department's scoring methodology addresses 20 attributes under five scoring categories. The five categories are One-VA Customer Service; Return on Taxpayer Investment; High Performing Workforce; Risk; and Comparison to Alternatives. The first three categories relate to the Department's strategic goals and the remaining two assess improvement in business practices. Weights were determined for the five categories by the analytical hierarchy process, which employs pair-wise comparisons. This established the relative weights among the categories. The attributes within each category were similarly weighted using the pair-wise, analytical hierarchy method.

A panel of raters, representing the VA Administrations and Executive offices, evaluated the impact that each project would have toward achieving the benefits envisioned in the 20 attributes. For example, a rater might assess a project as having a "very significant" impact toward achieving increased customer access. Other raters might assess the project as having a moderate, minimal or no impact. The assessments of all raters were averaged to arrive at the panel score for each attribute. Attribute scores were multiplied by the category weights to determine the project score. The highest score that a project could receive is 1.00.

The five categories and their 20 attributes are presented below.

1. One-VA Customer Service (Category weight = .555)
  - ◆ Increase in Customer Access
  - ◆ Increase in Quality of Service
  - ◆ Decrease in Waiting Time
  - ◆ Increase in Benefits or Services
  - ◆ Increase in Number of Customers
2. Return on Taxpayer Investment (Category Weight = .194)
  - ◆ Reduction in the Cost per Customer
  - ◆ Number of Customers Benefited
  - ◆ Increase in Direct Revenues
  - ◆ Cost-effectiveness
3. High Performing Work Force (Category Weight = .140)
  - ◆ Improved Recruitment and Retention of Employees
  - ◆ Increased Training and Development Opportunities for Employees
  - ◆ Improved Employee Morale

4. Risk (Category Weight = .061)
  - ◆ Risk Relative to Achieving Projected Benefits
  - ◆ Risk Relative to Achieving Projected Costs
  - ◆ Risk Relative to Meeting the Projected Implementation Schedule
  - ◆ Risk of Resource Obsolescence
  
5. Comparison to Alternatives (Category Weight = .050)
  - ◆ How well does each Alternative Achieve One-VA Customer Service
  - ◆ How well does each Alternative Achieve a Return on Taxpayer Investment
  - ◆ How well does each Alternative Achieve a High Performing Workforce
  - ◆ How well does each Alternative Address the Risk Attributes

Planning for the FY 2000 major medical construction program began with the submission of Veterans Integrated Service Network (VISN) strategic plans in November 1997. Capital Asset Submissions were requested for major medical construction projects in May 1998. Applications were validated in July and scored by the Capital Asset Board in August.

#### Changes from Previous Submission

The FY 1999 VA Appropriation provided funding for six projects. Five of those projects were included on the FY 1999 list of priority medical construction projects. These projects are not reflected on the FY 2000 list of priority medical construction projects.

Cleveland, OH	Ambulatory Care Addition & Renovations
Denver, CO	Parking Structure
Long Beach, CA	Clinical Consolidation/Seismic Correction
San Juan, PR	Seismic Corrections
Tucson, AZ	Ambulatory Care Addition

The following major medical construction projects completed the capital investment process but were not included in the FY 2000 Budget because of outstanding issues. These issues will be thoroughly addressed before the project is considered a priority.

**Palo Alto, CA – Geropsychiatric Nursing Home Project:**

- ◆ Can Palo Alto convert some of the 260 existing general nursing home beds to this use by making greater use of community nursing home contracts for its less complex nursing home patients?
- ◆ What opportunities are there to convert existing medical, surgical, and other inpatient space?

**West Haven, CT – Medical and Surgical Wards Renovation:**

- ◆ What is the minimum census level necessary in a tertiary care hospital to ensure that high standards of quality are maintained?
- ◆ What opportunities are there for contracting for services with providers located in the neighborhoods where veterans live?
- ◆ What opportunities exist for contracting certain services to the Yale Medical School?

**Dallas, TX – Mental Health Addition:**

- ◆ How will the projected decline in the local patient population (~32% by 2020) affect the need for the clinic's services?
- ◆ What increase in workload can be supported by VA's out-year budget projections?
- ◆ How does the project fit into the VISN's long-term mental health strategy – would Dallas replace Waco as the Network's primary VA inpatient psychiatric facility?
- ◆ What opportunities are there to convert existing medical, surgical or other inpatient space?

Seven projects were on the FY 1999 list of priority medical construction projects but not included in the latest Network Strategic Plan submissions. The Networks are re-evaluating their capital assets needs or have determined that their goals and objectives could be achieved through the minor construction program, leasing, programmatic changes, or other initiatives.

Buffalo, NY	HVAC/Environmental Improvements
Hines, IL	Outpatient Clinic
Milwaukee, WI	Ambulatory Care Addition
Portland, OR	Vancouver Campus Improvements
Long Beach, CA	Seismic Corrections, Buildings 2,3,7
Salisbury, NC	Environmental Enhancements
Washington, DC	Outpatient Clinic Expansion

Attachment to Hon. Michael Bilirakis Question #2

**Major Construction and Major Leases Special Requirements**

**P2. Workloads for VAMC Tampa**

Projected Inpt. Workload	Current		2000		2005		2010		2015		2020	
	Beds	ADC	Beds	ADC	Beds	ADC	Beds	ADC	Beds	ADC	Beds	ADC
Hospital Total	327	233	257	218	275	238	281	226	245	214	230	201
Medicine / Surgery	179	127	148	126	146	124	135	115	122	104	110	94
Psychiatry	50	36	34	29	30	26	26	22	23	20	20	17
SCI / Rehab	98	70	75	64	74	63	63	54	56	48	49	42
Long Term SCI*	0	40	42	40	43	41	44	42	42	40	38	36

Notes: Projected and allocated beds are based on occupancy rates of 85% (acute care) and 95% (long term care).  
 \* Patients with spinal cord injury/dysfunction currently in CNHs would be placed in long-term SCI unit following completion of project.

Allocated Inpt. Workload	Current		2000		2005		2010		2015		2020	
	Beds	ADC	Beds	ADC	Beds	ADC	Beds	ADC	Beds	ADC	Beds	ADC
SCI / Rehab	98	70	75	64	60	57	55	52	48	46	40	38
Long Term SCI	0	0	0	0	10	9	15	14	22	21	30	29

Projected Outpt. Workload	FY97		2000		2005		2010		2015		2020	
	Actual	ADC	Projected	ADC								
Total Outpt. Visits	316,096		323,392		324,202		315,242		286,697		267,103	
Total Clinic Slops	550,236		554,490		544,490		519,803		468,852		430,078	
SCI/Rehab. Visits	83,392		85,317		86,530		83,167		75,636		70,467	

**P3. Veteran Population Basis for VAMC Tampa**

Projected Population Base	1997		2000		2005		2010		2015		2020	
	Medicine / Surgery	Psychiatry	Spinal Cord Injury	Outpatient	Category A (Med/Surg)	Medicine / Surgery	Psychiatry	Spinal Cord Injury	Outpatient	Category A (Med/Surg)	Medicine / Surgery	Psychiatry
Medicine / Surgery	464,507		454,608		426,592		391,412		354,689		318,437	
Psychiatry	367,304		358,627		335,790		307,724		278,847		253,158	
Spinal Cord Injury	2,999		2,953		2,784		2,545		2,279		2,004	
Outpatient	284,526		278,951		258,011		235,218		211,798		189,049	
Category A (Med/Surg)	183,480		179,570		168,504		154,608		140,102		125,763	

## Questions from the Honorable Lane Evans

Question 1: The Administration budget shows \$34 billion in tobacco legislation receipts for the five-year period beginning FY 2000 through FY 2004. How much of these receipts will VA receive for tobacco-related health care costs?

Answer: Table S-8 on page 378 of the President's Budget displays the projected receipts raised from tobacco excise taxes. The \$8 billion in revenues for FY 2000 are attributable to tobacco-related health care costs in four Federal programs also presented in the chart of which, VA represents \$4 billion. These tax revenues are not earmarked. VA's costs are funded in the budget and are not contingent upon tobacco receipts.

Question 2: What is your best estimate of VA's annual tobacco-related health care costs in this fiscal year and in fiscal year 2000?

Answer: We estimate the cost of tobacco-related health care to be approximately \$4 billion annually for FY 1999 and 2000.

Question 3: A major theme of the Administration's proposed budget is "Preparing for the 21<sup>st</sup> Century". "Strengthening Health Care" is a major issue addressed. There is, however, no reference to VA health care. Is there no need to strengthen VA health care in the 21<sup>st</sup> century? Please comment on this omission.

Answer: There was no omission of veterans health care from the "Strengthening Health Care" chapter. Page 92 describes the VA within this context.

Question 4: According to the budget documents, "A new public health initiative will strengthen the health care safety-net for uninsured and other at-risk individuals." Specifically how will this new public health initiative strengthen the VA health care safety-net for uninsured and other at-risk individuals? How can the VA safety-net be strengthened? What is the cost of strengthening the VA safety-net? How much in new resources is provided in the proposed VA budget for strengthening the VA safety-net next year?

Answer: Although the VA's foremost mission is to care for the service-disabled (Priority Groups 1-3), we are committed to provide services for uninsured, lower-income veterans. The initiative to strengthen the health safety-net for the uninsured is intended to foster greater coordination between various providers of free or low cost health services. The VA provides such services and could benefit from this program, which would initially be funded at \$25 million in FY 2000. It is important to note that the VA has already made significant improvements in recent years to strengthen the *safety net* for *uninsured* veterans. The transition to primary care and creation of health networks have improved the coordination of services. From FY 1997 through FY 1998, 95 new Community Based Outpatient Clinics have been opened, improving access in under served areas. The results are dramatic: in FY 2000, VA will treat 500,000 more veterans and provide 7.5 million more outpatient visits than it did two years ago. VA's request for FY 2000 continues the focus on uninsured veterans, with plans to serve 12,000 more homeless veterans, and address the high prevalence of Hepatitis C among lower-income veterans.

Question 5: Is VA's third party collection program equal to the best program in either private or public sector? How does it compare to the best?

Answer: Because of perceived weaknesses in VA's Third Party collection program, VHA contracted with Coopers and Lybrand (C&L) in September 1997 to conduct a major management review of the program. Coopers and Lybrand found that by most industry standards, as well as VA's internal standards, VA hospitals fell short of the optimum performance demonstrated by for-profit and not-for-profit hospitals. C&L also pointed out that although the steps of the revenue cycle process are generally the same in the private sector and VA, many unique VA characteristics must be considered when making performance comparisons.

- Our profile of insured patients is different from that of the private sector in two important ways: Private sector hospitals bill all patients and most private sector patients have primary health care insurance and or Medicare coverage. More importantly they have an incentive to inform the provider of their coverage in order to prevent having to self-pay. VA only bills certain veterans and those veterans do not feel a strong incentive to provide insurance information. They are not required to self-pay what their third party insurer does not cover.
- Two major payers, Medicare and Medicaid, account for about 54 percent of most private hospital revenues, helping to improve performance through their standardized processes and paying on time. In contrast, VA hospitals have no predominant, large payers and must bill hundreds of different insurance companies. Because VA cannot bill Medicare, this has complicated billing "medigap" insurers who depend on Medicare for an explanation of benefit (EOB) prior to payment. This has resulted in "medigap" payers often refusing to pay.

Having said all this, many of our basic internal processes need improvement. We are working to improve those processes. Based on study recommendations, we have implemented a three-phased program for improvements: Cash, Process Compliance and Redesign.

- **Cash**—The main thrust is to collect funds due VA and prevent further revenue losses. Under the cash phase VISNs are aggressively pursuing existing receivables (for services already billed) as well as concentrating on utilization review (UR) and charge capture (for services provided but improperly billed or not billed at all).
- **Process Compliance**—This phase requires VISN leadership to immediately take corrective actions to bring hospital programs into full compliance with revenue cycle guidelines and regulations, as well as with established best practices. It also requires VISN-level standardization of applicable front-end processes such as insurance identification, means testing, medical documentation and coding to bring them up to industry standards. This will help reduce costs, and strengthen all processes in the revenue cycle.
- **Redesign**—VHA is investigating the benefits of centralization of the "back-end processes", such as billing, collections and follow-up. This could be internally at the VISN or National level, or through a contractor. Centralization of copayment processing, and consolidated debt management are underway, as well as a national contract for third party delinquent payments. However, before deciding whether expanded contracting out is a viable alternative, VHA must have insurance identification, means testing, medical documentation and coding (front-end processes) up to

industry standards in order for a vendor to be interested in undertaking a contract.

Question 6: In VA's proposed budget, third-party collections over the next three years are projected to be approximately \$750 million, \$900 million and \$1.1 billion. Recently GAO reported, "For each of the last 6 fiscal years, VA's collections averaged about \$544 million..." Is this Administration willing to risk the health care of veterans on VA actually achieving these goals? Given VA's collections record, isn't it time for VA to abandon this third-party collection experiment and again rely on appropriations for veterans health care?

Answer: First of all, please note that the figures cited above in this question, as third party collection estimates, are projections for all alternative revenue, not just third party. This includes third party insurance reimbursements, pharmacy prescription co-payments, nursing home and hospital per diems, first party means tests inpatient and outpatient co-payments, as well as tort feisor, no-fault automobile insurance and workers compensation recoveries. VA continues to believe that the collection projections are realistic goals. Keeping the money is an incentive as shown by approximately 8 percent increase in revenues in FY 1998 over FY 1997 collections. This increase occurred during a period when inpatient workload was declining, an area that historically has contributed the greatest amount towards our third party recoveries. First party collections are increasing, and we expect that along with new patients, inpatient collections will increase. Performance goals and key process measures have been set for each Network and are monitored on a monthly basis.

VHA is currently in the process of implementing several initiatives that will improve revenues and position us for Medicare subvention as follows:

Pre-registration—Involves contacting patients scheduled for outpatient visits to remind the patients of their appointment and to update patient information. A test of this concept at ten medical centers resulted in an estimated \$6 million increase in recoveries. Pre-registration software is now mandatory at all locations and we anticipate substantial improvement in the identification of third party insurers and the resulting recoveries.

HCFA Match—Approximately 5 percent of the Medicare eligible population possess 3<sup>rd</sup> party primary, full coverage, reimbursable insurance as a result of their full-time employment or the employment of a spouse. MCCR is currently pursuing a match of Medicare and VA records to identify primary payer data. This is done through software obtained through Blue Cross/Blue Shield (BCBS) of Texas. If the estimate is correct and VA mirrors the private sector, potential recoveries from this group may total between \$60 to \$97 million.

Compliance—Will ensure that coding and documentation for billing and medical records purposes are accurate and in conformance with industry standards and will support reasonable charges.

Reasonable Charges—Will allow VA to bill health care insurance companies using community-based charges for medical care for the treatment of non-service-connected conditions. VA will be able to bill inpatient DRG charges and professional fees, and outpatient facility charges as well as for professional charges.

Medicare Remittance Advice (MRA)—Will enable VA to receive a Medicare-equivalent explanation of benefits document that will be used by Medicare supplemental insurers to determine their appropriate payment to VA. We expect this initiative will generate collections of \$2 million per year. The MRA initiative will be coordinated with implementation of reasonable charges.

Electronic Data Interchange (EDI)—Will enable VA to nationally transmit data through a clearinghouse to all third party payers. This should result in more timely payments by ensuring that bills are transmitted and verified electronically by the payer. This initiative deals with cost savings as opposed to increased collections. Annual projected savings are \$26.4 million to process 5.5 million claims. Savings for FY 1999 will be roughly one fourth of that amount due to incremental implementation beginning in summer 1999.

Question 7: What is the total cost of all VA health care equipment needs for which resources are not provided in the proposed budget?

Answer: The Medical Care budget request provides the resources to support currently identified major equipment needs.

Question 8: What objective measures does VA use to evaluate its Five Star Service?

Answer: Five Star Service refers to world class customer service and can be best described as superior service when measured against the best in the business. VA has demonstrated through unprecedented improvements in the delivery of health care that it can be measured against the best in the health care industry. Providing world class customer service is one of VA's goals.

To maintain exceptional customer service, VA has designed and implemented a wide range of state-of-the-art instruments directed at meeting the complex needs of the veteran population. These instruments include a world class veteran survey protocol that provides feedback from tens of thousands of veterans and is benchmarked with industry standards to permit comparisons with the private sector. The survey produces highly reliable, valid data on veterans who are inpatients, veterans who are outpatients, and veterans who are in need of specialized services, e.g., gulf war veterans and other special veteran populations. A second instrument that qualifies as a best practice is the presence of a system-wide patient advocacy program at all VA health care facilities. This program is staffed by highly trained, full time specialists who proactively address the concerns of veterans and their families prior to, during, and after patient treatment.

VHA strives to improve customer service through a comprehensive performance management system that holds managers accountable through performance agreements for results achieved. On an annual basis, managers must demonstrate that they are maintaining a system that ensures veterans receive the highest quality health care possible. In addition, VHA has established a Service Evaluation and Action Team (SEAT) within each Veterans Integrated Service Network to enhance the organizations responsiveness to veterans needs and service satisfaction. The SEAT's primary goal is to improve communication with veterans, their families, and other stakeholders and to improve the responsiveness of VA health care delivery. In consultation with veterans service organizations, VHA is now in the process of designing a customer report card system that will be made available to patients and stakeholders as a means of assessing VA health care quality, treatment options, etc. from a national, regional, and facility perspective.

Question 9: Explain the dramatic difference in VA's projected annual health care cost for newly enrolled veterans compared to previous users in the same priority for care category.

Answer: We believe VA's cost for new enrollees is lower because of three reasons: (1) veterans with costly and chronic care needs are more likely to be a past system user; (2) many veterans have enrolled for VA care as a safety net in

case they become seriously ill or disabled; and, (3) younger, healthier veterans enroll as a safety net because they do not have health insurance. We have tracked new users over past users in our recent past few years. VA's database supports this difference in costs.

Question 10: The number of veterans 85 and older is expected to increase to about 1.3 million in 2010. This is a four-fold increase from 1995. What is VA's estimated annual cost per patient to provide care to the oldest of the old?

Answer: Current data reflect that the average cost per patient treated over the age of 85 is \$8,160. In the future, as more users reach this age, VA expects overall expenditures in this age category to increase significantly.

Question 11: Recently GAO reported, "VA lacks outcome measures and data to assess (the) impact of managed care initiatives." GAO said, "we and others have reported numerous concerns with VA's outcome data. These concerns are similar to those with VA's access data and include inconsistent, incompatible, and inaccurate databases; changes in data definitions over time; and a lack of timely and useful reporting of information ...." I welcome your response.

Answer: There is no question that accurate, consistent and meaningful data from VA's national databases are critical to decision making, performance measurement and outcomes assessment, which, in turn, are essential to achieving equity of access. VHA corporate data users and information managers had previously recognized the concerns GAO has reported and are actively taking corrective actions to address the primary causes of the problems. The VHA Chief Information Officer is leading VHA's efforts to: (1) identify, categorize and analyze corporate data issues and priorities; (2) develop a comprehensive data strategy that produces and maintains a high degree of data integrity and quality; and, (3) define on-going responsibilities and processes for ensuring data quality.

During December 8 through 10, 1998, VHA sponsored a Data Quality Summit to begin the process of addressing the multiple data quality issues that exist throughout VHA. The 150 Summit participants included representatives from the VISN offices, medical centers and from Financial, Information, Planning and Decision Support offices. There was consensus among the attendees that a Data Quality Council, chaired by the Deputy Under Secretary for Health, should be established (with inclusion of a subgroup of data users) to address VA's data priorities, including issues raised by GAO. The Council and subgroup will also establish specific policies, accountabilities and implementation plans for data quality action items recommended by the Summit participants. In addition to establishment of the Data Quality Council, the participants recommended the following:

- Creating a standard process for stabilizing processes that support the organization's vision and that support ongoing maintenance of data quality such as; certifying data, defining data, and measuring data validity, accuracy and completeness.
- Establishing a data quality education, training and communication structure.
- Focusing efforts on data that support the patient access processes.

These action items will be implemented as the first steps toward developing a data quality program throughout VHA.

Question 12: Last year, I asked Dr. Kizer to explain his comment of a year ago that [without an agreement allowing VA to obtain funds from Medicare,] veterans' health care will soon "hit the wall." Dr. Kizer told me, "Hit the wall" in this case means that (VA) can achieve legitimate efficiencies for only so long before we have to start further rationing of services if there is no way of offsetting inflation and the higher cost of doing business." Identify the services VHA has rationed to offset inflation and the higher cost of doing business? How will VHA further ration services to offset inflation and the higher cost of doing business? Is each and every one of the efficiencies envisioned in the FY 2000 Budget Submission legitimate?

Answer: Our policy is not to ration services. We offer the full spectrum of quality healthcare to the patients that we enroll for care. Management efficiencies make up the difference when available resources (appropriation, MCCF resources, reimbursements, prior year funds available, etc.) cannot cover the increased cost of inflation and payroll. In our management system, efficiencies are planned at the VISN level. In the past, they constituted better ways to operate VA's healthcare system, which included consolidation of administrative and clinical functions, procurement savings, shifting to more appropriate care settings (e.g., inpatient to outpatient and home care) and other reengineering initiatives. In the future, we expect future management savings from staffing adjustments, new integrations and other efficiencies in providing services. Under the auspices of the Veterans' Healthcare Eligibility Reform Act, PL 104-262, we will continue to assess the number of veterans enrolled and their treatment requirements with our overall resource availability. The budget does not detail the specific facility by facility management efficiency actions needed for FY 2000. These actions will be determined and set into place at the VISN level, with appropriate corporate guidance.

Question 13: The VA health care budget is static at least during the next five years. When will VA health care hit the wall?

Answer: As referred to in the previous question, we will make an assessment each year of the number of veterans that we can enroll to receive health care services from the VA. At this time, we cannot accurately predict what those decisions will be.

Question 14: How much will VA spend to train the new 440 FTEE who will process compensation and pension claims? How much in new resources is included in the budget for this training? If these new 440 FTEE receive effective training, when will these 440 FTEE make the maximum contribution to timely and accurate processing of compensation and pension claims? Will any of this training occur in FY 1999?

Answer: We have targeted significant money to develop training packages to educate and train adjudicators over the next few years. VBA's FY 2000 budget for the Compensation and Pension business lines focuses on the design and development of computer based training and performance support systems (TPSS) for the core service delivery positions of the reengineered environment. This is a long term project over the next two to three years consisting of multimedia training modules, case-based performance tests, training coordinator guides, and computer-managed instruction software.

TPSS modules are being developed using contractor support. In FY 1999 and 2000, \$8,747,000 and \$4,883,000 respectively is needed for TPSS development for the training of adjudicators and in support of training coordinators, as well as other training packages for claims processors. This includes transition training packages for the reengineered Veterans Service Representative position and supporting claims development training.

The additional FTE resources initiative is committed to the training and development of 440 new claims adjudicators in FY 2000. C&P Service, in

conjunction with the Office of Employment Development and Training, has approximately \$4.0 million allocated for training programs needed to develop expertise and proficiency in adjudication activities.

It is important to note that VBA has developed a plan to recruit and train employees in a manner that will yield the highest performance and retention of these employees. This initiative is called the Opportunity Program. The first session occurred in 1998 with the hiring of approximately 75 new employees and 25 internal employees to fill 3 key positions, Veteran's Services Representative, Vocational Rehabilitation Counselor and Employment Specialist.

These employees participated in a four week training program that included an orientation to the VA and three weeks of technical training. There was also a Post-Academy Technical Training Plan that went to the field to be utilized throughout the following year with all employees.

Opportunity 1999 is currently underway and has been redesigned to begin with a thorough orientation with an emphasis on knowing and understanding the business, the organizational values, mission, vision, and which will instill cultural and organizational awareness.

The C&P and VR&C business lines are currently developing a comprehensive technical training program that will be deployed in field offices for new and transitioning employees. A variety of delivery modes will be used at the local work site, at the SDN level, via satellite, etc.

Generally, a non-rating Veterans Claims Examiner (VCE) is considered a trainee for a two-year period while they achieve expertise in the full range of journey level duties, (i.e., development of all compensation and pension claims as well as award decisions). Similarly, a Rating VCE, generally, requires three years of training to achieve expertise in the preparation of legally binding decisions establishing entitlement to disability compensation or pension, DIC, and evaluation of appeals.

We anticipate that the new FTE hired in FY 2000 will come on board as Veterans Service Representatives (VSRs), a redesigned position that combines the skills of public contact and claims adjudication. As these trainees gain experience and competence, it is anticipated that journey-level VSRs will be promoted to rating VSRs, augmenting the number of decisionmakers in the rating activity. It is assumed that most VSRs will be considered trainees for a two-year period before attaining full certification. Likewise, most trainee Rating VSRs would undergo an extensive three (3) year training period before attaining full certification. With certification, we would anticipate maximum contribution to timely and accurate processing of claims.

Technical training coupled with the cultural and organizational awareness will provide employees with the tools necessary to succeed.

Question 15: The FY 2000 Congressional Submission reports that the VA Capital Investment Board uses best practices from the public and private sectors. Identify the best practices used by the VA Capital Investment Board.

Answer: During FY 98, VA hired an outside contractor to provide the Department with a best practices study of capital investment planning. The goal was to identify practices that can help VA meet its strategic goals, and satisfy requirements of the Office of Management and Budget (OMB) and the Congress (GPRA, Clinger-Cohen Act). The contractor completed a survey of federal, state, profit, and non-profit organizations to identify best practices including decision methodologies used to rate and rank capital investment initiatives. As part of his federal survey the contractor interviewed representatives from OMB, the Department of Defense, Department of Energy, Department of Commerce, NASA, and FAA. The non-federal survey is comprised of respondents from the

states of Virginia, Rhode Island, and Washington, as well as the University of Minnesota, the University of Massachusetts, and Cornell University. The survey of private businesses included Xerox, Motorola, Group Health, Hewlett Packard, and PepsiCo. The results of the survey, including a review of literature, were collected and analyzed to identify the various methods of evaluating and ranking capital investment based on principles of strategic planning, finance, and sophisticated capital budgeting techniques.

The contractor completed a benchmarking study of best practices from public and private entities. Those results were published as "*Capital Investments: A Survey of Best Practices*" and distributed to VA field elements and placed on the internet. The best practices were incorporated into our process and were actualized and operationalized. The implementation efforts concluded with the development of a "*Capital Investments: Methodology Guide*" to serve as a basic reference guide for use in developing capital investment proposals for inclusion in the VA Capital Plan (VACP).

Twenty-eight 'best practices' were identified and a majority were recommended for immediate implementation for the FY 2000 Call for Capital Investment Proposals. These include:

- Competing Different Types of Capital in a Strategic Framework
- Use Asset-Specific Discount Rates
- Leasing as a Risk Solution for IT
- Mixing Diverse Criteria in Decision Analysis
- Competitive Shopping
- Prototypes, Simulation, and Pilot Tests
- Customer Satisfaction Surveys
- Benchmarking
- Timing Capital Expenditures
- Top Down and Bottom Up Management
- Make Budget Data Comparable
- Flexibility
- Using Feedback and Self-Evaluation in the Decision-Making Process
- Evaluating Agency Functional Activities and Identifying Alternatives
- Integrating Performance Measures Into the Budget Process
- Scoring Projects Based on Strategic and Technical Content
- Decision-Making Across Functions
- Post Implementation Review
- Managing Cost and Schedule Risks
- Link Strategy, Mission, and Budget

If so desired, VA would be pleased to provide the Committee with copies of the studies "*Capital Investments: A Survey of Best Practices*", "*Capital Investments: Methodology Guide*", and the "*FY 2000 Department Capital Plan*" which would further explain the practices and how they were incorporated into the Departments capital planning process.

Question 16: How will the \$450,000 proposed in the FY 2000 Congressional submission for oversight associated with arming VA police officers be used? Describe the goals and measures of the effectiveness of this oversight.

Answer: These resources will be used to offset the payroll, travel, and other costs associated with hiring four new inspectors in Human Resources and Administration's (HR&A), Office of Security and Law Enforcement (OSLE). These inspectors will have the dual responsibilities of overseeing VHA facilities as they establish firearm programs and of conducting cyclical program inspections of VHA police operations.

At the present time, we anticipate arming VA police officers at approximately 16 additional VA medical facilities per year. The four Inspectors will be responsible for overseeing all aspects of the preparations by these facilities to arm their officers. They will conduct on-site inspections of all phases of each facility's preparation including the adequacy of training and a careful review of all firearm policy documents produced by each facility. They will ensure that each facility is in full compliance with VA policy prior to the officers being armed.

In addition to their firearm program responsibilities, the new inspectors will conduct recurring inspections of armed VA police forces on a two rather than four-year cycle. The increased frequency is necessary to ensure the long-range effectiveness and safety of the firearm program. A four-year inspection cycle is no longer sufficient now that officers are being armed.

This oversight program will be considered effective if each newly armed VA police officer has received a careful review of his/her background, has proper policy guidance, is provided with up-to-date equipment, and has undergone a state of the art comprehensive firearm training program. An effective VA firearm program will be carefully designed and closely monitored.

Question 17: There is no increase in medical care budget authority over the five-year period FY 2000 through 2004. Describe the consequences of this on VA health care timeliness, quality and access. How much less health care purchasing power will VA have in FY 2004 than in FY 1999?

Answer: The budget assumes that networks will continue to generate management efficiency savings along with available and requested resources to cover budgetary requirements. As an example of our success, in FY 1998 actual obligations per patient decreased 6.9 percent, 10.3 percent in constant dollars, while the number of patients increased 9.2 percent. At the same time, quality measures increased and patient satisfaction rates improved. As far as FY 2000-2004, we will continue to assess our financial position yearly in relation to enrollment. If needed, access may be restricted to veterans in higher priority groups if the assessment indicates insufficient resources. There will be no sacrifice to timeliness or quality of health care to our veterans served.

The loss of purchasing power in FY 2004, based on FY 1999, is estimated to be 24.7 percent based on anticipated payroll and inflation changes, cumulated, during this time span.

Question 18: The Supply Fund finances an asset management service. Describe the responsibilities, goals and effectiveness of this asset management service.

Answer: Somerville Asset Management Service is located in Somerville, NJ. Originally acquired from the Department of Defense, the Somerville facility consist of 165.3 acres of land and 22 buildings that, until 1994, were utilized as one of VA's three centralized materiel distribution warehousing depots. When centralized warehouse distribution facilities were discontinued, the property continued to be utilized for other VA activities. Some activities are new. Others have historically been based from that location.

The Somerville Asset Management Service administers a variety of programs to provide direct support to VHA facilities, Department of Defense (DoD), Federal Bureau of Prisons, the National Acquisition Center (NAC), Indian Health System and other government agencies to include the following:

- Providing warehouse and office rental space to tenants; U.S. Marshall Service, New Jersey State Police, New Jersey Healthcare System, Veterans Industries, Somerset County Board of Elections, and U.S Public Service.
- Installing and repairing all silver recovery equipment located at 500 plus nationwide VA facilities, Alaska, Puerto Rico and the Philippines to ensure maximum silver recovery. Responsibilities also include accountability, inventory and sale of scrap x-ray film, silver and precious metals; written guidance to medical facilities encompassing all phases of the silver and precious metals program; and one-on-one customer service to VA medical facilities to ensure compliance with EPA limits regarding discharge of x-ray solution into sewer systems.
- Ensuring all radiology and computerized topography equipment purchased by the NAC for VA facilities and other government agencies meets Federal standards under CFR 21 and performs as advertised by the vendor or manufacturer from which it was purchased. Also responsible for writing federal standards, related specifications and testing procedure manuals.
- Ensuring nationwide VA facility laundry/textile equipment and systems meet Federal, OSHA, NFPA standards and specifications required by the manufacturer and/or contracts issued for purchase of equipment. In addition, provide customer service related functions to include, but not limited to, assessment of laundry equipment, specifications, and building, electrical and plumbing configurations. Quality Assurance Specialists provide technical expertise by participating in bid evaluations and contract negotiations.
- Receiving, cataloging, and storing excess clothing, blankets, sleeping bags, etc. (collected principally at no cost from other government agencies). These materials are sorted and distributed nationwide in support of the Mental Health and Behavioral Sciences Service assistance program for homeless veterans.
- Receiving, storing and re-shipping (in consolidated transport containers) supplies and equipment purchased for operation of the VA Medical Center Puerto Rico.
- Providing short-term warehousing and other accommodations, on request, to a variety of VA medical facilities. For example, the property was utilized to save commercial storage costs associated with storage, break-bulk, and sorted distribution of the chairs, desks and engineered building furniture purchased for the remodeled VA central office project.

Each of these ongoing and periodic activities is essential and is integral to the sustained delivery of quality, effective medical services for our Nation's veterans.

Due to the facility's changed role, the Office of Acquisition and Materiel Management is working with the Office of Facilities Management, Asset and Enterprise Development Office, to designate the Somerville Asset Management Service facility as an Enhanced-Use Lease Project to obtain the highest and best use to accomplish the VA goals and objectives. A business plan has been completed and is presently undergoing review before obtaining approval of the Secretary.

Question 19: This year GAO reported VA has not yet institutionalized a disciplined policy for selecting, controlling, and evaluating information technology investments. Information technology accounted for approximately \$1 billion of VA's fiscal year 1999 budget request. At the time of the budget request, VA decision-makers did not have current and complete information, such as cost, benefit, schedule, risk, and performance data at the project level, which is essential to making sound investment decisions. In addition, VA's process for controlling and evaluating its investment portfolio has deficiencies in in-process and post-implementation reviews.

- Does VA have an institutionalized and disciplined process for selecting, controlling, and evaluating information technology investments? If so, provide a detailed description of the process.

Answer: Subsequent to GAO's last review of this matter, VA has institutionalized and exercised a process for selecting, controlling, and evaluating information technology investments. For review of FY 1999 budget requests, VA put in place a process to review, evaluate, and select capital investments. Improvements were made for the FY 2000 process. All capital investments were subject to this scrutiny, including information technology (IT) acquisitions. Thresholds are in place that determine whether a given initiative is subject to capital investment review. For IT, these thresholds work out to approximately 1.5 percent of an organization's total IT budget. Additionally, highly sensitive projects (due to their visibility, requirements for interorganizational coordination, risk, etc.) are subject to this process. Organizations interested in pursuing IT initiatives meeting the requirements of capital investment review must submit an application that includes a summary of the project and appropriate cost, schedule and goal information in support of the summary narrative.

These IT proposals undergo Departmental review at two separate levels—*technical*, then *strategic* (in addition to vetting processes implemented within submitting organizations) during development of the budget—the CIO Investment Panel, on behalf of the CIO Council, followed by the VA Capital Investment Board (VACIB). After a screening process to remove efforts not fully developed, each level has the independent opportunity to approve or disapprove of a project's inclusion in the Department's budget. The final decisions are made by the VACIB. The flow associated with this review process is laid out in the VA IT Strategic Plan, which is available at <http://www.va.gov/orim/cio/vaitsp/index.htm>.

After being selected for funding within the Department's budget, and after appropriated dollars have been provided to the project, each effort (including IT) is subject to an execution review. These execution reviews occur quarterly (for most projects). Execution reviews determine whether a project is still on track as per its submitted capital plan, are submitted by the organization having project control, and become part of the review process in future years.

In addition to the execution reviews, the Chief Information Officer conducts periodic in-process and post-implementation reviews of IT capital investment projects. These reviews, like the execution reviews, become part of the overall capital investment record for the project.

Further information, including "Capital Investments: Methodology Guide", is available at <http://www.va.gov/budget/capital/Guidetoc.htm>.

- Do VA information technology decision-makers today have current and complete information, such as cost, benefit, schedule, risk, and performance data at the project level, which is essential to making sound investment decisions? If so, provide current and complete information for project level technology decisions.

Answer: VA decision-makers have current and complete information on which to base sound IT investment decisions. The capital investment process reviews all capital investments, including IT, that exceed certain, pre-defined thresholds. Each organization undertaking a capital investment must submit an application in accordance with the VA Capital Investment Methodology Guide. These applications require key project data: total acquisition costs anticipated over the life of the project; total recurring costs over the life of the project; benefits expected; return on investment; performance goals; workforce effects; discussions on risks and their mitigation; effects on VA's customer service capabilities, key schedule milestones, etc.

Coincidentally to the review of proposals submitted by program officials, VA continues to refine the process. The Department recognizes that, because the capital investment process is relatively new (being in place now only for two years), there is room for maturation and growth. For example, as a result of careful study and deliberation, VA has decided to increase the attention paid to IT in the development of its capital investment portfolio. The CIO Council last year reviewed and ranked IT initiatives based on the same criteria as the Departmental reviews by the VACIB. This year, a more narrow focus is under the purview of the CIO Council; this group has opted to focus their reviews and recommendations solely on IT matters. This is demonstrated by the creation of a separate section of the investment application dedicated solely to capturing IT-related information.

As a final note, for FY 2000 some 18 projects were subject to some measure of capital investment review. Eight of these projects were returned to the sponsoring organization during CIO Council review for further development; of the remainder, some were either rejected later or modified when reviewed by the VACIB.

The Office of Management and Budget has provided an implicit endorsement of VA's capital investment activities; in the FY 2000 Passback. OMB refused to fund activities that would not survive the Department's capital planning process.

Question 20: Describe VA's plan to establish national cemeteries to meet the needs of veterans who live in Atlanta, Miami, Sacramento and other major metropolitan areas, which today lack a national cemetery to meet the needs of veterans. Why did VA not request initial funding for one or more of these projects in the fiscal year 2000 budget?

Answer: The VA is currently constructing four new national cemeteries in geographic areas that were identified in the 1987 and 1994 Reports to Congress on the National Cemetery Administration (NCA). These new cemeteries will be located in the Albany, New York; Chicago, Illinois; Dallas/Ft. Worth, Texas, and Cleveland, Ohio vicinities. This volume of construction is unprecedented in the history of NCA since its inception during the Civil War. After these four new cemeteries open later this year, VA will evaluate the potential establishment of additional new national cemeteries in Atlanta, Miami, Sacramento and the other remaining geographic areas identified in the two reports.

Question 21: Which major metropolitan areas, in priority order, have the highest priority for VA establishing a new national cemetery?

Answer: By the turn of the century, six national cemeteries will be completed and operational from the original 1987 Congressional report list of areas in greatest need for a national cemetery. The seven areas identified as being in greatest need from the combined listings of the 1987 report, and subsequent 1994 update, still remaining are identified below in alphabetical order:

Atlanta, Georgia

Detroit, Michigan

Miami, Florida

Oklahoma City/Lawton (Fort Sill), Oklahoma

Pittsburgh, Pennsylvania

Sacramento, California

St. Louis, Missouri

The listings in the two reports to Congress were depictions of veteran population, not priority rankings. The listings did not commit VA to build national cemeteries in each location, nor did they rank the order in which they may be built.

The St. Louis metropolitan area is currently served by Jefferson Barracks National Cemetery. When the 1994 Congressional report was issued, Jefferson Barracks was projected to deplete its inventory of gravesites by 2002. Subsequent to the 1994 report, and addressing the continued need for St. Louis, additional land has been acquired to extend the service period of the cemetery to 2010, and \$7.5 million was included in the FY 1999 appropriations bill to develop this additional land for burial operations.

Question 22: What factors are responsible for the poor performance of VA's Vocational Rehabilitation Program?

Answer: The VR&C program has faced many challenges to improving its performance. Some of these challenges are a lack of focus on employment as the program's outcome, inadequate information management infrastructure which has limited our ability to articulate and demonstrate the state of the program and to facilitate case management, no centralized quality assurance program for a number of years, and a "one size fits all" case management approach to serving program participants.

The VR&C program is instituting initiatives that will address performance shortfalls. First, the VR&C Balanced Scorecard, which was deployed nationwide in October 1998, focuses on, among other things, the veteran's attainment of employment and rehabilitation, particularly veterans with serious employment handicaps. Second, we are strengthening the program's information technology capability to support data collection and management and to enhance case management of veterans participating in the rehabilitation process. Quality assurance programs were reinstated in October 1998 at both the regional office and national levels. And, case management strategies, such as an "on-time" approach to identify veterans at-risk of dropping out of the program will be developed to facilitate appropriate services to help veterans overcome their at risk circumstances.

Question 23: The VA is proposing to collocate the operations of the Hines Delivery Center at the Austin Automation Center. What are the results of the cost-benefits analysis of this action? If a cost-benefits analysis has not yet been completed, please provide the expected completion date.

Answer: The Veterans Benefits Administration, in conjunction with the Office of the Acting Assistant Secretary for Information and Technology and Chief Information Officer, fully supports the OMB Directive 96-02, Consolidation of Agency Data Centers. We have engaged the services of a private contractor to explore the costs of relocating the Benefits Delivery Network processing to the Austin Automation Center. The final product will be available by mid-March. This effort is to collocate the processing of the Benefit Delivery Network not the collocation of the full Hines Benefit Delivery Center.

Question 24: Proposed regulations were issued on June 3, 1998 to provide assurance that veterans refinancing a home loan would not be increasing the total amount of their indebtedness. Final regulations were scheduled for publication by December 1998 and still have not been issued. When will these regulations be issued? How will the proposed reductions in loan guaranty staff impact the ability of the VA to issue regulations in a timely manner?

Answer: Proposed regulations on Interest Rate Reduction Refinancing Loans (IRRRLs) were published on June 3, 1998. Under these regulations, generally to obtain an IRRRL the veteran's monthly mortgage payments would have to decrease. Also, the rule would provide that the loan being refinanced could not be delinquent or the veteran seeking the loan meet certain credit standard provisions.

VA received an unexpectedly high volume of comments on this regulatory package which must be reviewed and addressed in the Federal Register publication of the final regulatory package. Senior department officials are currently reviewing the final regulations; which we expect will be published shortly.

Changes in the loan guaranty staff should not have a significant effect on VA's ability to issue regulations in a timely manner.

Question 25: The VA health care budget includes a new initiative for treatment of veterans with Hepatitis C. The Benefits Administration budget does not mention Hepatitis C. Has VBA considered whether, and to what extent, the new health initiatives may result in an increase in applications for compensation and pension and what were the conclusions of this consideration by VBA?

Answer: VBA has considered the fact that the new health initiative may result in an increase in the number of compensation and pension claims. However, information on the rate of infected veterans is still inconclusive. Likewise, veterans' awareness of the potential seriousness of this disease and its rate of infection is uncertain. For these reasons, we believe that it is too early for VBA to predict the effect Hepatitis C may have on our workload. We are currently tracking Hepatitis C claims through our new Veterans Information Tracker and Adjudication Log (VITAL) system and have not seen significant activity in these types of claims. From November through mid-January only thirty-three (33) Hepatitis C claims were determined to be service-connected. Forty (40) Hepatitis C claims were denied with only 217 claims pending. We will continue to closely monitor Hepatitis C workload trends and watch for any new information regarding this disease. During the FY 2001 budget formulation cycle, which is currently under way, if significant activity in this area is noted, we will address its impact on workload and performance in that submission.

Question 26: VBA pays compensation and pension benefits of almost \$20 billion dollars per year. The STAR quality assurance trial indicated that over a third of the claims for rating related cases are incorrectly decided. However VBA requests only nine FTE to be designated for the quality assurance program. How can VBA justify devoting such minimal staff to such an important function?

Answer: VBA has made the commitment both at the local and national levels to dedicate the resources necessary to the Systematic Technical Accuracy Review (STAR) program. While we are requesting an additional nine FTE in FY 2000 to support STAR, this increase is in no way representative of the level of resources we are dedicating and will continue to dedicate to this program. We have assigned our most experienced and talented currently existing staff members to conduct the STAR reviews at the regional offices and in Central Office. It is a commitment to quality that VBA considers an absolute priority.

Question 27: The budget assumes that the A-76 study proposed for property management activities in the home loan program will result in a reduction of 100 FTE who can be transferred into claims adjudication. Describe VA's contingency plans if the study does not result in the efficiencies projected.

Answer: We are confident that the A-76 study will yield some efficiencies because it is designed, in part, to identify the most efficient means for the Government to continue the property management function. However, the budget request also includes \$5 million for career transition activities related to the property management staff. If the entire 100 FTE savings cannot be realized, a portion of these funds will be available to fund FTE.

Question 28: Have the skills and abilities of current property management personnel been evaluated to determine if the skills and abilities needed to perform the claims adjudication function are present? Please provide a profile of the age and years of government service of the 276 employees who would be transferred into Claims Adjudication.

Answer: The 276 represents the combined effects of new hires and redirecting employees from offices experiencing losses through program efficiencies and management improvements. VBA has not targeted a specific number of employees from each business line that will be redirected, therefore, it is impossible to provide the profile requested. We will look at all employees on a case by case basis to determine the best fit for each individual and the organization. We are confident that this level of review coupled with our extensive training program (as discussed previously in the answer to question 14) will produce qualified and productive claims adjudicators regardless of previous work experience.

Question 29: I am very supportive of VBA's Balanced Scorecard and believe it will be an effective means for determining objectives and priorities and for measuring progress achieved. I am concerned, however, about the effect of the Balanced Scorecard on the business lines other than Compensation and Pension. What safeguards are you taking to ensure that regional office directors understand that they cannot improve their delivery of compensation and pension benefits at the expense of the other VBA programs? Describe how the effectiveness of these safeguards is determined and provide the date and results of the last evaluation of these safeguards.

Answer: In all of our meetings and training sessions on the Balanced Scorecard, we have emphasized the responsibility each director has for insuring the integrity of program delivery in all business lines. This responsibility extends beyond the individual regional office to the Service Delivery Network (SDN) level and to the national level. Even though a director may be responsible for delivery of only the Compensation and Pension and VR&C programs at his/her regional office, all directors within the SDN understand that they are jointly responsible for insuring the effective delivery of Loan Guaranty and Education benefits within their SDN as well. This responsibility for all business lines must be weighed in any decision at the local or SDN level that involves reallocation of resources or reprioritization of workloads. Specifically related to resources, the overtime resources available to us this fiscal year were distributed by business line. In allocating these resources to the SDNs, we have asked the directors not to redistribute these funds across program lines.

At every Leadership meeting, we have made it a practice to analyze VBA's performance across all business lines. Each SDN is responsible for identifying significant gaps in performance and discussing actions the SDN has taken to remedy those gaps. The SDN team representatives and the Service Directors also jointly review performance at the national level. This continuous review

process assures that we are assessing the impact of our decisions across business lines and that we are constantly evaluating the level of service delivery in all program areas. Additionally, the individual performance evaluations for regional office directors this fiscal year will include an assessment of both the SDN's performance and the national performance in all business lines.

We believe that the actions outlined above, together with all of the other workload management and information reporting systems that we already have in place, will assure program integrity is maintained in all business lines.

Question 30: Please provide details on VA's initiative to provide benefits delivery at military discharge sites. How many FTE are dedicated to this initiative? Are VA staff assigned full-time to the 20 largest military separation points? Do these VA staff participate in TAP training?

Answer: There are 81 full time regional office personnel who are outbased either at military discharge sites or nearby claims processing operations. This figure includes rating specialists, veterans service representatives, a veterans benefits counselor, senior claims examiners, clerks, military service coordinators (MSCs), vocational rehabilitation and counseling personnel, a field investigator, and work studies.

VA staff are assigned full time at or nearby a number of the top 20 separation points. These include Camp Pendleton, Great Lakes Naval Training operations, Norfolk area Naval operations, Fort Hood, Fort Lewis, Randolph AFB, Fort Campbell, Fort Knox, Fort Stewart, Fort Benning and Jacksonville, FL Naval operations.

TAP briefings are conducted at all these operations. However, it differs from site to site whether the staff conducting the briefings, primarily MSCs, are outbased with other personnel or provide their services on an itinerant basis.

Question 31: How are separating servicemembers made aware that assistance is available from VA personnel? Are similar services provided at overseas bases? Is information also provided regarding housing, education, and vocational rehabilitation benefits? If not, why not?

Answer: Service members are informed of the assistance that VA may provide in a variety of ways including facility or base publications, news releases, announcements, electronic bulletin boards, etc.

TAP briefings are conducted at overseas bases including Germany, Korea, Japan, etc. We do not at present have overseas claims processing operations. However, we are presently investigating what services we may be able to provide service members at overseas locations. We believe that we may be able to take claims, examine claimed disabilities, provide vocational rehabilitation and training counseling, entitlement to education benefits, home loan assistance, and perhaps in cooperation with the Department of Labor provide job counseling assistance.

Presently, at the top 20 and other active pre-discharge operations, ratings are being prepared which provide vocational rehabilitation entitlement. VR&C personnel are a part of the outbased claims processing operations at two military bases. Our aim is to provide full transition assistance with respect to VA benefits to all separating service members to include Loan Guaranty home loan assistance, vocational rehabilitation, information about insurance and education benefits, and potential enrollment into the VA health care system.

Question 32: The Administration budget does not include a request for funding for additional new cemeteries. Statistics are clear that veterans' burial needs will increase significantly over the next decade. Because the process for new cemetery development is lengthy, why didn't you initiate that process in this budget?

Answer: In planning for the burial needs of veterans, NCA carefully considers veteran demographic data. Based on the 1990 census, the annual number of veteran deaths will continue to increase from 550,000 in 1998 to a peak of 620,000 in 2008. After 2008, the mortality rate of veterans will begin to slowly decline, but remain high for many years. For example, veteran deaths are projected to be 615,000 in 2010, 577,000 in 2015, and 525,000 in 2020.

Given this demographic data, VA recognizes the burial needs of veterans are increasing. By the turn of the century, six national cemeteries will be completed and operational from the 1987 and 1994 Reports to Congress on areas in greatest need for a national cemetery. After these new cemeteries are opened, VA will evaluate the potential establishment of additional new national cemeteries in the other remaining geographic areas identified in the two reports.

Extending the service delivery period of existing national cemeteries by acquiring and developing additional land continues to be a key strategy to ensure uninterrupted service to veterans. For example, the FY 2000 budget includes Major Construction funds to extend the service delivery capabilities of Leavenworth National Cemetery. In addition, NCA has established a partnership with the States to establish, expand, or improve state veterans cemeteries through the State Cemetery Grants Program. Over the next two years, seven new state veterans cemeteries are scheduled to begin providing service to over 357,000 veterans.

Question 33: I understand that there are national cemeteries that do not have sprinkler systems and others that do not water the grass often enough to keep it green. Also because of fiscal restrictions, some cemeteries cannot clean headstones more often than once every two or three years. There is a significant amount of preventive maintenance that should be done but, because of lack of funding, is postponed until real problems develop.

Answer: A major challenge facing the National Cemetery Administration is to ensure that all national cemeteries are maintained in a manner befitting their status as national shrines. Regular, ongoing maintenance is required in burial sections as well as in the infrastructure of 115 national cemeteries. In 1998, these cemeteries consisted of 2.3 million gravesites, over 6,000 developed acres (acreage no longer in its natural state), over 400 buildings, and other infrastructure such as roads, boundary walls, irrigation systems, and monuments.

The number of interments performed at national cemeteries has been steadily increasing due to the rapidly increasing mortality of WWII and Korean War veterans, and a higher utilization of burial services among Vietnam era veterans. Annual interments have increased from 58,400 in 1989 to 76,700 in 1998, and will continue to increase over the next decade. It has been necessary to redirect some NCA maintenance resources to interment operations in order to meet the annual interment workload increases. This increasing burial workload also has a compounding effect on NCA maintenance requirements.

NCA will continue to focus maintenance resources on the most critical needs to prevent significant maintenance problems from developing. In addition, NCA is reviewing national cemeteries with long-standing turf problems caused by the lack of irrigation systems. For example, a minor construction irrigation project is planned to provide a solution to turf problems experienced at Quantico National Cemetery. Also, all new national cemeteries currently under construction will have modern irrigation systems in place.

Question 34: What level of funding would be required to ensure that all of our national cemeteries are as well maintained as those administered by the American Battle Monuments Commission?

Answer: Interment operations are no longer conducted at veterans cemeteries under the jurisdiction of the American Battle Monuments Commission (ABMC). The ABMC budget is dedicated exclusively to maintenance operations. Because national cemeteries administered by the National Cemetery Administration (NCA) continue to conduct interments, maintenance of burial sections in national cemeteries is much more difficult and challenging than at inactive cemeteries where interments are not performed. For example, interments in national cemeteries often must be performed in established burial sections in all kinds of weather conditions; this requires continuous repair and renovation of those burial sections.

NCA strives to maintain its national cemeteries as national shrines which provide veterans with a final resting place that reflects the dignity, honor, and respect that they have earned. A key objective of the NCA performance plan is to ensure that the appearance of national cemeteries is rated excellent by its customers. NCA is performing surveys of the families of individuals who are interred in national cemeteries, and of other visitors, to measure how the public perceives the appearance of the cemeteries. Information obtained directly from its customers is an excellent yardstick by which to assess maintenance conditions at individual facilities as well as the overall system. During FY 1998, 77 percent of survey respondents rated the appearance of national cemeteries as excellent. NCA's strategic goal is to have 100 percent of survey respondents rate the appearance of its national cemeteries as excellent by 2003. To meet this strategic goal will be a challenge, and the data collected from customer surveys will be an important tool to ensure that NCA maintenance resources address those issues most important to its customers.

Question 35: The basic burial allowance for veterans who receive compensation or pension was increased from \$150 to \$300 in 1978. There has been no increase in that benefit since then. Has the Department ever sent to OMB a request to increase this benefit? If not, why not? By what percentage have funeral expenses increased since 1978? What would be the cost of increasing this benefit from \$300 to \$600?

Answer: The last time a proposal was sent to the Office of Management and Budget was October 1993.

Internal estimates of funeral trends are not available at this time. Private organizations, such as the Federated Funeral Directors of America (FFDA) have reported that since 1978, the cost of an average funeral has risen six to seven percent annually. (Source: California Public Interest Research Group [CALPIRG], 1998 Report: Why are Funeral Prices So High? The High Cost of Corporate Takeovers.)

If the NSC Burial Allowance is doubled to \$600, our preliminary cost estimates show that the cost for FY 2000 would be \$24,630,000. Five year costs (2000-2004) for this proposal are estimated to be \$121,260,000. (These costs are based on the following assumptions: Every applicant receives the full \$300 burial allowance; the increase is effective on allowances paid on or after October 1, 1999; the caseload estimates as per FY 2000 Congressional Budget Submission; and no additional administrative costs would be incurred as no additional processing activities would be needed. Also note, this proposal could be understating the costs. Potentially, if the proposed rate is considered more of an incentive, a higher rate of survivors could apply for this benefit. This increased application rate has not been taken into consideration for this estimate.)

Question 36: The Education Service's initiatives to replace the current system of manual eligibility and entitlement processing with an expert system and to deliver monthly checks electronically are laudable. When will these new systems be in place?

Answer: The first phase of the Expert System for MGIB (Active) has been installed and has been expanded once. It is processing about 15% of the reenrollment information now being received electronically. The next enhancement will be installed in June 1999.

The Expert System for MGIB (Reserve) is in the design phase. Implementation is scheduled for January 2000. It is contingent on the installation of the redesigned MGIB (Reserve) benefit payment system in late fall 1999. A Y2K moratorium on installations in late 1999 could defer both into mid-2000.

Question 37: Is the reduction in Education Service FTE linked to the installation of these new systems? In the event that, as so often happens, it takes longer than expected to implement these new systems, what steps will be taken to ensure that customer service is not adversely affected?

Answer: FTE levels are being monitored quarterly in order to make adjustments as required.

Question 38: The Insurance program is initiating an imaging system to provide electronic storage of insurance records and on-line access. In the spirit of "One VA", did anyone from the Insurance program discuss their initiative with the Education Service? Are the two systems similar and different?

Answer: Yes, the Insurance Service did talk with the imaging project manager for the Education Service and made an on-site visit to the St. Louis Regional Office where the prototype system was installed. They also visited several private sector companies with imaging systems and the CHAMPVA office in Denver, Colorado which had installed an imaging system. After viewing the system at CHAMPVA, the Insurance Service decided that the software used in their system was more flexible, offered more options and better fit the needs and applications of the Insurance program. Therefore, Insurance decided to purchase the same off-the-shelf software used by CHAMPVA and customize it for their application. It should be noted that both the Insurance and Education systems use ".tif" format images, and will therefore be highly compatible.

Question 39: VA has recently instituted a toll-free telephone number (1-888-GI Bill) for veterans to get the latest information on VA education benefits. General questions will be answered through an automated system, but education case managers will answer specific questions during regular business hours.

Answer: See response to question 40.

Question 40: The Department has significant problems with blocked and abandoned calls. What are you doing to ensure that veterans using this toll-free number will not get a busy signal or wait for an extended period of time to talk with a person who can answer their questions?

Answer: On February 1, 1999, we expanded access to the national toll free education phone number (1-888-GI BILL-1) to the entire country. Calls to this number are routed to the appropriate Education Regional Processing Office (RPO). Overflow (if all the lines at an RPO are busy) calls are being routed to St.

Paul which previously provided a similar overflow service to regional offices located in the former Central Area. The St. Paul overflow unit is a temporary measure until we can shift more FTE into the RPO's. The old Central Area overflow was terminated on January 15<sup>th</sup>, so the staff could be given two weeks of training to answer the education calls, which is the reason for the slight jump in January's blocked call rate.

With the routing of almost 20% of the calls (those dealing with education issues) that were previously directed to the RO's to the RPO's, we expect this to have a favorable impact on the 1-800-827-1000 blocked call rate. All education calls are being routed first through the National Automated Response System (N-ARS) which is answering over 30% of the calls with a generic or a case specific interactive voice response. Callers who want to talk to an employee are routed to an RPO based on the area code they are calling from.

The other major installation on February 1, 1999, involved the expansion of the N-ARS platform to a total of 6 regional offices, Houston, Winston-Salem, Roanoke, Nashville, St. Paul and Des Moines. St. Paul and Des Moines were prototype stations and have had their calls routed through N-ARS for over a year. The four (4) additional stations were selected because of their high blocked call rates. The initial data we have which covers only the first two weeks of February indicates that the blocked call rate for the six (6) stations combined was 16%. At this time last year, the latter four stations had blocked call rates in the 60 to 80% range. We will evaluate the impact on the national blocked call rate as soon as we receive the February data for the entire country. Early next month, we will finalize our plans for rolling out the N-ARS platform for the entire country by December 31, 1999.

In June 1999, we will implement another major phone project, the Virtual Call Center (VCC) prototype, allows us to route calls within a Service Delivery Networks (SDN). When all the lines are busy at the regional office the call was originally directed to, that call will be routed to another regional office within the same SDN.

Our current national blocked call rate for FYTD 99 is 43% which is down from 60% at the same time last year. We ended FY 98 with a 52% blocked call rate. We are obviously not satisfied with a 43% rate and expect the projects that are underway to drive that number down significantly. Our balanced scorecard target for FY 99 is 30%, but we expect to be below that rate by September 1999.

We will be happy to share with you the results of our initiatives in improving our phone access as we proceed through the year.

Question 41: What effect would the recommended FTE reductions in the Education Service have on this telephone service? How many FTE are currently devoted to this service? How many FTE are devoted in FY 2000?

Answer: No impact. We are budgeting the same number of FTE to support toll-free service in FY 2000 as in FY 1999. 100 FTE have been budgeted for this service in FY 1999 and 100 FTE are budgeted for this service in FY 2000. As stated above, we will continue to evaluate the blocked call rates.

Question 42: GPRA requires the VBA business lines to conduct surveys, focus groups, and identify, collect, and analyze data. They cannot fulfill these responsibilities, however, unless they are provided an adequate level of funding.

Answer: See response to question 43.

Question 43: Please provide me with the funding level for these activities that each business line received for fiscal years 1997, 1998, 1999, and 2000. Please also describe the activities carried out by each business line and the results of each activity.

Answer: VBA is committed to the full implementation of GPRA. Its use of the Balanced Scorecard with the measures of accuracy, speed, unit cost, customer satisfaction and employee development starting in FY 1999 is evidence of this commitment. Key to the measures of GPRA and the Scorecard is an assessment of customer and employee satisfaction through the survey process.

The Surveys and Research Staff, now part of the newly formed Data Management Office, directs survey efforts that relate and lead to customer satisfaction information about the program areas of Compensation & Pension, Education, Loan Guaranty, and Vocational Rehabilitation and Counseling. There is also a similar initiative covering VBA's participation in the 1999 "One VA" Organizational Assessment (employee) Survey. The funds for the survey process for four of the five business lines are noted below. In general, these surveys gauge the customer satisfaction of veterans and beneficiaries who have had experiences in VBA claims or loan processing or vocational rehabilitation and counseling services. To assess their level of satisfaction with these processes, standardized and valid survey methodologies are used. Survey results will furnish data that can be used to monitor regional office, area, and national performance against customer service standards. The results can also be the basis for service improvements and customer measures that could evaluate ongoing reengineering and case management initiatives, as well as other work process improvements.

<u>Cost of Surveys 1997-2000 (Dollars in \$1,000)</u>				
	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>
Employee	60	0	101	0
C&P	430	400	412	424
Education	100	100	103	106
VR&C	48	0	250	258
Loan Guaranty	0	0	250	258
	<u>638</u>	<u>500</u>	<u>1,116</u>	<u>1,046</u>

The Insurance program conducts its own surveys at a cost of approximately \$8,000 each year. This program has ten main "end products," and each month it sends 40 surveys to users of each of these end products, for a total of 4,800 surveys each year. With a return rate of about 60 percent and the inclusion of open ended questions, the surveys provide pertinent customer feedback, which is used to improve operations.

VBA formed a Data Management Office at the end of last fiscal year. This office reflects VBA's efforts to facilitate the availability and use of quality information that supports current and future business needs, and effects improved service delivery. Its staff of some 20 employees is working directly under the Deputy Under Secretary for Management to organize, validate and improve information about veterans and the delivery of VBA benefit services. For FY 1999, the Data Management Office will have initiative funding of approximately \$1,261,000 to pursue its mission through the development of an enterprise wide data warehouse and expanded web based access to veteran and business data. Similar initiative funding is planned for FY 2000.

Question 44: What additional resources, including FTE and new systems, would be required if the Montgomery GI Bill enhancements recommended by the Commission on Servicemembers and Veterans Transition Assistance were enacted?

Answer: The recommendations are still under review. However, if the Transition Commission recommendations were enacted, additional resources may be required to administer the expanded GI Bill program, as would moneys to design and install supporting systems.

Question 45: Although a performance goal of 57% usage of the Montgomery GI Bill in fiscal year 2000 is a laudable goal, I expect it is unattainable unless the benefit provided under this program is significantly increased and the program is amended to permit accelerated usage of the benefit for certain high cost, short term programs. On what basis did the Department determine that the 57% goal was realistic?

Answer: The MGIB usage rate in FY 1998 was 54%. We believe the challenge of attaining the 57% goal is realistic in Fiscal Year 2000. With the additional funds for outreach furnished by Congress in Pub. L. 105-266 last year, we plan an enhanced outreach effort to active duty personnel to encourage them to utilize their MGIB benefits.

Question 46: Surprisingly, the Administration budget includes no new initiatives related to improving employment services provided under the vocational rehabilitation program. As you know, we on this Committee are very concerned about the effectiveness of this program. Additionally, the Transition Commission concluded that, as currently structured and administered, the vocational rehabilitation program is not a success.

Answer: See response to question 47.

Question 47: If you are not proposing new initiatives to improve this program, what actions are you taking that are not included in the budget to ensure that service-disabled veterans receive the services and assistance they deserve and the vocational rehabilitation program is a success?

Answer: We believe that we do have initiatives in place that respond to the Commission's concerns and our focus is on the execution of these initiatives. These initiatives include:

- Performance goals which challenge us to maximize our effectiveness, efficiency, and customer satisfaction.
- Employment services training to improve the skills of our staff.
- Providing effective communications with veterans, management and staff, employers, stakeholders, and others.
- Providing adequate information technology support.

A pilot program calls for ten (10) new Employment Specialists to focus on matching employers' demands with developing skills of program participants. The Employment Specialists will establish networks with employers, on a regional and national basis, to develop employment opportunities for job-ready disabled veterans.

Over 100 VA staff and 300 DOL staff were provided employment services training with the assistance of the National Veterans Training Institute. These people are now working with job-ready veterans and have formed networks to improve the quality of the employment services. A Joint VA/DOL training initiative is scheduled to provide up-to-date information and skills for VA and DOL staff involved in the employment services process. Over 100 additional VA staff will take part in this training and they, in turn, will provide training and assistance to additional staff. We anticipate that the National Veterans Training Institute will be involved in this program

We are developing a transferable work skills analysis tool to help identify prior developed skills, including those obtained through military service, and will enable VR&C staff to better assess the veteran's job readiness during the evaluation and program planning phases of the vocational rehabilitation process.

We are working with DOL to establish an Internet link to America's Job Bank to assist staff and veterans in identifying career opportunities.

Question 48: What efforts have been made by the Vocational Rehabilitation and Counseling Service (VR&C) to test methods of vocational rehabilitation and job placement which are currently used successfully in the private sector and in states' welfare-to-work programs and what were the results?

Answer: We are utilizing a number of positive techniques to assist in the career placement of our job-ready veterans. America's Job Bank (AJB) provides an Internet web site of job vacancies and job-ready candidates. We are working with DOL to integrate our veterans into AJB and allow employers to specifically search for vocational rehabilitation participants. Our local offices have used techniques such as job fairs and communications in local newspapers and radios to promote our veterans. Several of our local offices have established panels of employers to advise our staff on employment trend needs and provide practical advice to job-seeking veterans. As part of the development of a more effective case management system for veterans who are receiving vocational rehabilitation services, we will use the skills of people in public and private sector rehabilitation and employment, as well as academic experts, to review our policies and procedures to determine how our program compares to similar non-government programs.

49. In your budget documents you note that outdated rules inhibit the usage of the Montgomery GI Bill without enhancing program integrity. Specifically, to which rules are you referring? We would welcome your recommendations for any legislative changes that would enhance the GI Bill.

Answer. There are examples where the MGIB program has not kept pace with trends in the delivery of education and training. As we identify specific opportunities for improvement through our program evaluation efforts and other avenues, we will move them through the legislative or regulatory process, as appropriate.

Question 50: I have several questions regarding the Vocational Rehabilitation and Counseling performance plans:

- A VR&C performance goal is that 50% of veterans who exit the VA Vocational Rehabilitation Program will be rehabilitated. What is the current rate?

Answer: Data supplied from the US Department of Education's Rehabilitation Services Administration show that the comparable rehabilitation success rate for State-run programs averages 42 percent. Our record is very favorable when compared to the vocational rehabilitation program provided by State-run programs. As of the end January 1999, the rehabilitation rate was almost 54%, 4% better than our goal.

- You note that there are many reasons why veterans drop out of their vocational rehabilitation programs. Do you now have the system capability to track why individual veterans choose not to complete their programs?

Answer: We do have the ability to individually and categorically track the reasons that veterans drop out of their programs. Our customer satisfaction

survey as well as a study underway with the Booz Allen Hamilton group will also provide us with this type of information.

- What specific actions have been taken to ensure that proper evaluation and planning takes place when a veteran begins his or her program of vocational rehabilitation?

Answer: We recently reinstated quality assurance (QA) program at the regional office, Service Delivery Network (SDN), and headquarters levels. Included in the QA program is an assessment of the evaluation and planning process.

- Describe the current procedure and the changes you will make to improve this procedure.

Answer: Each veteran is provided a comprehensive evaluation which examines the nature and degree of disability, physical and mental capacities, previously developed skills obtained through education, training or experience, and the relative ability of the veteran to achieve suitable employment. If the evaluation determines that a veteran does require a vocational rehabilitation program, a rehabilitation plan is developed, with the veteran, which outlines services needed to achieve the goal of suitable employment.

We will develop a transferable work skills analysis instrument which will help us determine if the veteran has previously developed skills, through education, training, or experience, which can be used to obtain suitable employment in the current job market.

We are also emphasizing the need to focus on the goal of employment from the first contact with the veteran. We will integrate employment skills training throughout the rehabilitation plan rather than wait until the veteran is approaching the end of the rehabilitation program.

- You note that VA has put greater emphasis on the quality of job placements for VR&C participants. How do you define "quality"?

Answer: Our definition of a quality placement stems from the statute that defines a vocational goal as "gainful employment status consistent with a veteran's abilities, interests, and aptitudes" and the needs of the current job market. As shown by data from veterans who were rehabilitated in 1998, the issue of quality involves the success of the veteran. The data show that there is a substantial increase in the average annual earned income as measured at the point of application (\$4,359) and for the first year of employment (\$22,682). Additionally, public policy success is realized when these veterans produce taxable income from their employment.

- You state that training on employment assistance and techniques for VR&C staff will continue. Specifically, which VR&C staff will be trained and how many will be trained? Will the National Veterans Training Institute conduct the training?

Answer: Our training initiatives call for current counseling psychologists and vocational rehabilitation counselors, as well as newly hired employees, to be trained in the new transferable work skills analysis and employment services. Employment specialists and vocational rehabilitation specialists will be provided intensive training in employment services, job development and placement. The trainers will be obtained through the competitive process. National Veterans Training Institute (NVTI) has certainly been a valuable partner and excellent training resource in the past. We would be very pleased if the procurement process allows NVTI to provide training in the future.

Question 51: You note that VA will develop a new transferable skills analysis. When will this be completed? Is this being done in-house or by contract? Are you working with the Department of Defense on this?

Answer: The development of the transferable work skills analysis tool involves VA, DOL and DOD, with the assistance of a contractor. We anticipate the completion of the project by the end of FY 1999 and the implementation with the field in early FY 2000.

Question 52: When will the new national acquisition strategy be fully developed and implemented? How will it differ from the current strategy?

Answer: The national acquisition strategy (NAS) requires each VR&C field manager to complete a detailed analysis of resources, workload, and other factors to determine if contracting is necessary. From the NAS, performance-based contracting will emerge which, we believe, will allow the VR&C program to measure the cost-effectiveness of contracting. Additionally, the NAS features a national contract allowing local vendors to be selected in each Service Delivery Network (SDN), and empowers local VR&C field managers to have input into the selection of vendors in their areas. Following a pilot test in one of the SDNs, we anticipate full implementation early in FY 2000.

Question 53: Historically, VA health care has been taxpayer financed with appropriated dollars to meet the nation's obligation to those who served in uniform. Today, VA is decreasing its reliance on appropriated taxpayer dollars to meet veterans' health care needs. Is veterans' health care less of a national obligation today than before?

Answer: Veterans' health care is no less of a national obligation today, than at any previous time. Non-appropriated resources are available and it is in the veteran's best interest that they be used to enhance VA services. We would hope that the VA's actions would be viewed as positive steps taken to ensure that even in a constrained budget environment, quality VA healthcare would be available to more veterans than would otherwise be possible.

Question 54: Explain why there are long-term institutional care policy and practice differences between Veterans Integrated Service Networks and between facilities within the same Network. Identify in order of importance the determinates of veterans' access to long-term institutional care provided by, or on behalf of, VA.

Answer: Network and facility policy differences regarding access to nursing home care exist for several reasons. First, nursing home care is a "discretionary" service, not mandated by statute and not covered in the Basic Benefits package. Second, nursing home care is very expensive. These two factors create a powerful incentive to provide alternatives to nursing home care. The third factor that affects policy and practice is the local nursing home market/infrastructure, including the presence and size of VA operated Nursing Homes, access to Community Nursing Home beds, and the existence of a State Veterans Home in the service area.

In reviewing the background data from the Federal Advisory Committee on the Future of Long-Term Care, the two equally important determinates in access to VA-sponsored nursing home care is the existence and size of the VA Nursing Home and the existence of a State Veterans Home.

Overall, VA is not satisfied with the widely divergent approaches to nursing home access. The Federal Advisory Committee made important recommendations in this area. VA's internal workgroup on the Committee's Report is developing

implementation plans that will address these concerns and improve access to care and fairness in the process.

Question 55: How many veterans are now enrolled in VA health care? Please provide the number of veterans enrolled by each priority of care category.

Answer: As of December 29, 1998, VA had the following numbers of enrollees:

Unprioritized	708,446
Priority 1	408,601
Priority 2	277,882
Priority 3	498,480
Priority 4	59,599
Priority 5	1,284,015
Priority 6	53,030
Priority 7	409,863
Total	3,699,916

The total adjusted enrollees are 3,699,757, due to mathematical rounding in the prorating procedures. The unassigned priority group results from an absence of a current complete means test on file. We estimate that unprioritized enrollees would be assigned to Priority 5 or 7. This would shift Priority 5 to 1,844,923 and Priority 7 enrollees to 557,242.

Question 56: Identify each VHA Specialized Program (spinal cord injury, PTSD treatment, prosthetics, etc.) which has a waiting list. Provide the number of veterans currently on each waiting list, the extent of delay these veterans will experience in receiving this care from VA, and, explain the cause(s) of these waiting lists.

Answer: The available statistics on waiting time and related statistics for specialized programs (Spinal Cord Injury and Disorders, Blind Rehabilitation, Traumatic Brain Injury, Serious Mental Illness, Substance Abuse, Homeless, and Post-Traumatic Stress Disorder) are contained in Appendix B (attached) of the May 1998, "Maintaining Capacity to Provide for the Specialized Treatment and Rehabilitative Needs of Disabled Veterans." However, the number of veterans on waiting lists, the specific causes for the waiting lists, and information related to prosthetics waiting times are all highly variable, site specific and generally not readily available.

Question 57: For those without a waiting list, provide the length of time required for admission following a request for the service.

Answer: The short answer is that we do not have good data nationally, but believe that we need to get it. Efforts are currently underway to develop this capability.

VHA identifies waiting times in two ways. First is the time lapse between the scheduled appointment time and the time the patient is seen by a clinician, often called "time to be seen." Second is the time lapse between the time a request is made for a non-emergent appointment to a clinic and the actual appointment date, often called "time to next available appointment." Patients with emergent conditions are scheduled by a phone call from one provider (usually a doctor) to another and often result in an "overbooking" of specialty clinic schedules. These personal interactions have not been captured in our data systems (nor in anyone else's, as far as we can determine). Therefore, in the past, VHA has focused its data collection on non-emergent specialty clinic appointments. The time to next available appointment (or the time to any future appointment as dictated by the data collection protocol) is derived from the VISTA Scheduling Package in individual medical centers where the system is used to actually schedule appointments.

Another difficulty in collecting data on specialty and other clinic waiting times in the past was the fact that there is no uniform clinic naming system. Local facilities prefer flexibility in naming clinics because they often use the Scheduling Package to monitor clinician workload. Thus, they build templates that allow them to match clinicians with clinic workload. Having a large variety of names for clinics makes it difficult to compare activity between facilities and to aggregate data beyond the local facility. The challenge is to retain local flexibility while creating a data system that can generate valid, comparable data that can be used to monitor system-wide trends.

Another approach to obtain data on waiting times was VHA's "Primary Care Survey" which was first done in April 1996 and at six-month intervals thereafter until the last iteration in April 1998. These waiting times data were collected by individual facilities and self-reported to Headquarters. VHA has not collated these data at the VISN and national levels because of concerns about validity of this self-reported data.

To address this problem, the Office of Performance and Quality, in collaboration with the Chief Network office and the Performance Measures Workgroup is currently developing a long-term plan that will allow collection of statistically valid data. While the long-term plan is being developed, a short-term solution will be attempted in order to provide preliminary data. This solution will be based on the use of specific clinic identifiers as opposed to the usual "clinic stops" as the source of the data; a tentative plan is to generate data with this approach on a pilot basis within four months. Also, we are working with the Institute for Healthcare Improvement (IHI) in Boston to address this issue. All facilities in the VA system will participate in the IHI Breakthrough Series on Waits and Delays this fiscal year. The final plan for this effort, which will include data collection timelines, will be completed in early May.

Question 58: VA has estimated it will cost an unanticipated \$700 million to address the emerging Hepatitis C epidemic in FY 2000. In addition, the budget submission re-programs 43 FTE from other areas where will these resources come from?

Answer: The budget earmarks an additional \$136 million in FY 2000 (to reach an estimated level of \$250 million) for the evaluation and testing of veterans for Hepatitis C. The budget assumes these resources will be generated from network savings associated with management efficiencies.

Question 59: With a static budget, how will VA restructure its extended care program to meet the growing demand of an aging population?

Answer: Currently, VA has the essential core elements to respond to the demands of an aging veteran population. However, our ability to expand long term care services will depend on the level of available resources.

We are currently considering the recommendations for improving, integrating and expanding long term care services that were put forth by the expert Federal Advisory Committee on the Future of Long-Term Care that completed its report in November 1988, as well as the comments on the report, which our stakeholders have submitted over the past two months. Such recommendations will be linked through a VHA long term care strategy that we hope will provide direction to most effectively meet our long term care needs over the coming decade.

Question 60: As you are aware, veterans have expressed considerable concern about the erosion of special emphasis programs under a decentralized system. What steps is VA taking to redress any erosion that has occurred in these war-related programs for which VA was created? Can we reasonably expect improvements with the budget the Administration has requested?

Answer: Performance and outcome measures have been selected for all Special Programs. These measures will be used to ensure that quality of care is maintained regardless of whether care is provided on an inpatient or outpatient basis. Special programmatic improvements have been accomplished in a variety of areas including SCI where, for example, decision-making for SCI program changes has been centralized to VHA Headquarters, and national patient referral guidelines will be established so that patient referral policies and procedures are uniform across the VA health care system. A system-wide Prosthetic Program Reinvention Project to improve the function and organization of Prosthetics and Sensory Aids Service has also been initiated. Blind Rehabilitation Outpatient Specialists (BROS) have been identified to assist in reducing the waiting time for veterans to be treated at blind rehabilitation centers. In addition, we recently established two telemedicine projects in SCI. VA's Telemedicine in Home Care projects have been funded to use telemedicine to enhance the home care of paralyzed veterans. The Teleconsultation Demonstration Project will utilize telemedicine to enhance communication between geographically dispersed VA facilities and SCI Centers. VA's budget for FY 2000 contains a \$50 million increase for homeless veterans programs and services. These resources will be used to expand outreach, case management and contract residential treatment for homeless veterans. Special initiatives will target services for homeless women veterans. Program changes in mental health special emphasis programs are monitored by VA's Northeast Program Evaluation Center (NEPEC), the Under Secretary for Health's Special Committee on Care of Chronically Mentally Ill Veterans and through other procedures that track VA's capacity and outcomes for programs that serve special veteran populations.

Overall, it can be expected that we will conform to PL 104-262, Section 104, and meet the specialized treatment and rehabilitation needs of disabled veterans.

Question 61: The Independent Budget (IB) asserts that VA has no consistent review process for appeals of clinical decisions. What steps is the Veterans' Health Administration taking to establish a system-wide appeals process, particularly for urgent care? The IB also recommends implementing national "standards" for information disclosure from each Veterans' Integrated Service Network. Does VA believe it is deficient in meeting this part of the President's Executive Order to implement the Consumer Bill of Rights? Compare current VA practices to current best practices in health care.

Answer: There are mechanisms within all VA medical facilities to appeal clinical decisions. Usually this involves the Chief of Staff and the rest of the facility top management. It is correct that there is no standard process throughout VA. For that reason, Dr. Kizer approved a work group recommendation to enter into a national contract with a non-VA body to handle external appeals. A work group is currently developing implementation recommendations to accomplish this. As part of their work, the work group is also examining the internal review process with the goal of making that more consistent and understandable to our employees and those who use the VA system.

VA has previously responded to the President and Vice President on our compliance with the Executive Order implementing the Consumer Bill of Rights. Information Disclosure was one area where we indicated improvement could be made. Although there is a wealth of information concerning the VA system available, there was consensus that VA could do a better job of making this more accessible and available to our patients and their families. With the implementation of eligibility reform, some excellent information materials have been produced and distributed. We are also discussing the idea of a VA Report Card that could be used to provide important information. The entire area of Information Disclosure is under review and additional proposals will be made that we hope will bring VA up to the current best practices in health care.

Question 62: Secretary West, we have been experiencing a lot of difficulties in receiving responses from VA in a timely manner. VA testimony and responses to congressional inquiries are chronically late. What steps, if any are you taking to improve the timeliness of these responses? Please provide your timeliness goal for responses to congressional inquiries in general and inquiries from either the Chairman or Ranking Democratic Members, in particular.

Answer: Please be assured that we are taking actions to improve our performance in providing timely responses to Congressional inquiries.

At my direction, VA is reviewing the Department's procedures for coordinating responses to congressional correspondence. My goal is to dramatically reduce the time it takes to get those responses to you and your colleagues. Given your leadership role on the Committee, I am particularly cognizant of the need to expedite inquiries submitted by Mr. Stump and you. To promote effective communication, I have instructed that interim notices be sent to keep you apprised of anticipated dates for completing reports and other documents.

As you are aware, testimony, reports, and letters sent to Congress must be circulated throughout VA and, in some cases, approved by OMB. These procedures have often led to unacceptable delays in delivering a final product to you and your colleagues on the Veterans Affairs Committee. We are now examining procedural adjustments, to reduce "turnaround" times for clearances.

I am confident that the combination of these undertakings will significantly enhance the timeliness of services provided to you and your colleagues.

Question 63: The budget submission shows that VA was expected to collect \$677 million from third-parties and veterans' copayments in FY 1999; its actual collection is now estimated to be \$625 million. Is this going to affect service delivery in this fiscal year? What are the costs of collections per dollar collected? Compare the total amount of receivables for which VA should initiate collection efforts to the total amount for which VA does not initiate collection efforts? Please explain this difference.

Answer: Service delivery will not be affected. Public Law 105-33 provides for transfer of collections in the Medical Care Collection Fund to the Medical Care Appropriation and for those funds to remain available until expended. FY 1998

receipts totaled \$666.5 million, including \$139.5 million from fourth quarter FY 1997. Of this amount, \$496 million was carried forward into FY 1999. VHA is aware of the need to efficiently manage the flexibility provided with these funds and to ensure that service delivery is not affected in FY 1999 or FY 2000.

What are the costs of collections per dollar collected?

MCCF	FY 92 (\$000)	FY 93 (\$000)	FY 94 (\$000)	FY 95 (\$000)	FY 96 (\$000)	FY 97 (\$000)	FY 98 (\$000)
Collections	\$448,413	\$506,486	\$551,563	\$580,722	\$562,468	\$523,912	\$560,097
Expenditures	\$75,751	\$92,143	\$95,269	\$102,163	\$118,846	\$113,307	\$102,065
Cost to Operate	17%	18%	17%	18%	21%	22%	18%

There are no receivables outstanding for which VA is not initiating a collection effort. A number of laws and policies guide VA's debt collection activities. VA's policies on debt collection can be found in manual MP-4, part VIII. These policies are used by the facilities to determine appropriate collection action. The Debt Collection Improvement Act (DCIA) of 1996 requires the VA to refer delinquent debt over 180 days old to the Department of Treasury for further collection action. This could result in offsetting Federal Salary, Tax Refund, Retired Annuitant Benefit or any other payment made by the Federal Government.

For first party debts, VA sends proper notification as described in MP-4, part VIII. If collection is not voluntary, VA then initiates other collection actions. The first involuntary collection action is offsetting Veteran Benefit payments. Next VA initiates offset through the Treasury Offset Program (TOP) as required by the DCIA 1996. VA is also currently testing procedures that will allow Treasury to Cross Service debts over 180 days old as required by the DCIA 1996.

For third party claims, VA again relies on the guidance provided in MP-4, part VIII. Third party claims have been exempted by Treasury from the TOP and Cross Servicing requirements of the DCIA 1996. However, in an effort to ensure full collection of funds, VA has established a contract with Trans World systems, Inc. for follow up assistance on aging third party claims.

However, when comparing total receivables to total collections for the Medical Care Collection Fund there is a large difference. When looking at these differences, first party and third party percentages need to be reported separated.

The collection ratio for first party receivables is slightly less than 75%. When broken out by the various components it is easier to account for differences. The collection ratio for pharmacy copayments for FY 1998 is 89%. A very respectable ratio by private sector standards. Per diems and means test are in the 65% range. Some of this is the result of the income verification match, which targets veterans who are required to pay for care that occurred many months prior to the bill.

Receivables are over inflated for third party for two major reasons:

1. When VA bills primary carriers, the bill is for the full amount, whereas the private sector adjusts their bills prior to being sent to represent the payment agreed to in the contract. VA cannot make contract adjustments until after payment is received.
2. Seventy percent of our bills are for patients over 65 with Medigap coverage that pays only a small percentage. Because we do not bill Medicare, VA is in litigation with some "medigap" insurers who depend on Medicare for an

explanation of benefit (EOB) prior to payment. This in turn artificially inflates our third party receivables and contributes to the low collection to receivable ratio of 30%.

Question 64: Despite decreasing collections in FY 1999, the Administration estimates that VA's medical collections will increase to \$749 million in FY 2000 this is almost a 20 percent increase in collections. What steps is VA taking to ensure such an increase in collections will occur?

Answer: VA has undertaken a number of initiatives (also see response to Question 6). For example:

Compliance—This initiative will ensure that coding and documentation for billing and medical records purposes are accurate and in conformance with industry standards and will support reasonable charges.

Reasonable Charges—Will allow VA to bill health care insurance companies using community-based charges for medical care for the treatment of non-service-connected conditions. VA will be able to bill inpatient DRG charges and professional fees, and outpatient facility charges, as well as for professional charges.

Medicare Remittance Advice (MRA)—Will enable VA to receive a Medicare-equivalent explanation of benefits document that will be used by Medicare supplemental insurers to determine their appropriate payment to VA. We expect this initiative will generate future net collections of \$2 million per year. The MRA initiative will be coordinated with implementation of reasonable charges.

Electronic Data Interchange (EDI)—Will enable VA to nationally transmit data through a clearinghouse to all third party payers. This should result in more timely payments by ensuring that bills are transmitted and verified electronically by the payer. This initiative deals with cost savings as opposed to increased collections. Annual projected savings are \$26.4 million to process 5.5 million claims. Savings for FY 1999 will be roughly one fourth of that amount due to incremental implementation beginning in summer 1999.

Additional initiatives and more detail on those above are shown in the following chart.

VA Revenue Initiatives

Initiative	Description	Timetable
Insurance Identification	Pre-registration involves contacting patients scheduled for outpatient visits to remind the patients of scheduled appointments and to update VISTA records. This practice was first implemented at seven reengineering pilot sites. In FY 1997 the seven pilot sites generated \$5.6 million dollars (approx. \$800,000 per site) in additional third party revenues just from pre-registration. Due to the success of this pilot, implementation of pre-registration software is now mandatory at all locations.	First Implementation by End of August 1998. Implementation Continues.
Intake Training	Gathering of demographic, employment and insurance information is critical to the success of the third party revenue generation process. A nationwide study of Diagnostic Measures performed in Fall 1997 showed that the intake portion of the revenue generation process is inadequate at the vast majority of VA facilities. The Revenue Office, working with the Employee Education System, has identified a large number of training and performance issues to be addressed, and is working with Network Revenue Teams to provide guidance and training to all VA Intake staff.	Underway Now
Compliance	Compliance will ensure that coding and documentation for billing and medical records purposes are accurate and in conformance with industry standards and will support reasonable charges	Underway Now
Fee Basis	The fee basis program allows certain veterans to be treated by non-VA physicians at VA expense. Once a veteran is authorized fee basis care and receives treatment from a private physician or	Implementation in Progress

Initiative	Description	Timetable
	<p>other medical professional, the bills for that care are submitted to the VA facility authorizing such care. Bills received by VA for fee basis patients are generally submitted on the standard UB-92 or HCFA 1500 forms. In most instances those bills include information on other insurance under which a veteran is covered. By utilizing those bills insurance information can be obtained that was not previously identified during the patient registration process. Once identified, back billing for NSC care provided can be initiated as well as future billing for all other NSC care rendered.</p>	
<p>Medicare Remittance Advice (MRA)</p>	<p>VA is prohibited under current law from billing Medicare for health care services provided to Medicare-eligible veterans. Unlike claims from private hospitals and physicians, VA claims for veterans with Medicare supplemental insurance are not adjudicated by Medicare and are not accompanied with Medicare remittance advice forms when submitted for reimbursement to those insurers. HCFA and VA have entered into an agreement that will enable VA to have Medicare-equivalent adjudication of VA's claims for the cost of non service-connected health care services furnished to all insured Medicare-eligible veterans. The Medicare adjudication of VA claims will be provided by a Medicare Fiscal Intermediary (FI) and Medicare Carrier under contract with HCFA. The Medicare furnished adjudication of VA's claims will be in the form of a Medicare Remittance Advice (MRA) and will be equivalent to the adjudication furnished under the Medicare program to private sector providers of health care services.</p> <p>Note: 70 percent of VA claims are for veterans over the age of 65 with Medicare supplemental insurance.</p>	<p>Planned for September 1999</p>
<p>Medicare On Line Project</p>	<p>VA facilities can verify a veteran's eligibility for Medicare benefits by using Medicare software. The Medicare Online eligibility program can be accessed by VA staff through a simple telecommunication modem link at a cost of 9 cents per minute.</p>	<p>Underway Now</p>
<p>Utilization Review</p>	<p>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 with effective training in effective techniques. With effort, UR staff recovered as much as \$400,000 per medical center in previously denied claims. UR training provided to Revenue Teams in March 98, National UR Conference held April 98 to provide education and training to field staff. Monthly conference calls and training sessions continue.</p>	<p>Underway Now</p>
<p>Benefit Offset</p>	<p>An IG audit determined that by referring delinquent patient copayment and means test debt for 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.</p>	<p>Underway Now</p>
<p>HMO Point of Service Contracts</p>	<p>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.</p>	<p>Underway Now</p>
<p>Revenue Teams</p>	<p>At the direction of the Under Secretary of Health, the CNO and CFO developed the Network Revenue Team concept. Each VISN established a team of experts to assess medical care collection activities within the VISN and make needed changes to:</p> <ol style="list-style-type: none"> <li>(1) assure the VISN reaches its FY 1998 collection goal;</li> <li>(2) improve processes; and,</li> <li>(3) determine future needs in the collection process.</li> </ol> <p>Cost recovery consultants are assisting teams as needed with training and follow-up.</p>	<p>Underway now</p>
<p>Reasonable Charges</p>	<p>Reasonable charges are representative of provider charges in the market of each VAMC, and should result in payment from third party insurers at the prevailing payment rate. DRG based per diems will be used to charge for inpatient facility services, procedure case based charges for outpatient facility services and procedure charges for clinician services. These industry compatible charge formats will allow processing by payer automated processing systems and timely payment. Reasonable</p>	<p>September 1999</p>

Initiative	Description	Timetable
	charges implementation will occur after regulatory approval is received.	
Third party Delinquent Claims	A nationwide fixed fee contract for MCCR delinquent third party claims over 90 days for inpatient health care services provided veterans will help increase delinquent collections. Cost is \$4.75 for each case referred. Each facility individually pays contractor for cases referred.	Underway Now
Third Party EDI	A national solution is being developed for electronic billing of health care payers using ANSI X12 and other national standards as mandated in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). EDI will automate submission and receipt of billing, payment, and related information through computer software modules to VA Integrated Billing and Accounts Receivables software packages. The cross-industry average is \$5* saved for every paper document converted. *The EDI Group, Ltd. VA's savings are projected to be less than this average to start. One reason is that the full-cycle-use of EDI in Health Care billing and collection is still emerging, meaning it has not been widely implemented throughout the Health Care industry. Another factor is the new frontier of implementing national standard transactions as set forth under HIPAA. Software functional requirements are under development.	June – July 1999
Clinician Involvement Learning Maps	Clinician understanding of the importance of their role in revenue generation is critical to the success of the collection process. Several VISN Clinical managers are working with the Revenue office to develop materials for presentation to clinicians on their role and responsibilities. Two PowerPoint presentations developed by Dr. Carter Mecher and Dr. Paul Billings, have been distributed to Network Revenue teams. The Revenue Office and EES are considering the development of a Learning Map program to help all staff understand the revenue process and their roles in relation to it.	Map Being Tested April 1999

Question 65: Estimates of the additional costs of addressing the emerging Hepatitis C epidemic in FY 2000 have ranged from \$135 million to \$700 million. Upon what data is the VA's current estimate based? Specifically, what is the current estimate of prevalence in the enrolled VA user population?

Answer: The Budget estimate is based on a prevalence rate of 5.5 percent. VA is planning a one-day study of patients seeking VA care to better estimate current prevalence among the veterans that we serve. Information from this effort will be provided to the Congress when it is completed.

Question 66: In 1990 this Committee took action to allow VA to recruit nurses and other allied health professionals, who were in high demand and short supply at the time, by giving VA the flexibility to meet local market conditions. The crisis has passed and some nurses have now gone without pay raises for more than 5 years. That was not Congress's intention. The justification for amounts requested for annualization of the 1999 pay raise and the 2000 pay raise indicate VA has included raises for registered nurses. Specifically, will VA provide the same payraise to nurses that it is required to provide "general schedule" employees? How will VA ensure that VISN directors implement the pay raise?

Answer: For the 1999 pay raise, the average increase among VA staff nurses was 3.0 percent. Although the great majority of VA health care facilities passed on at least a part of the general schedule raise, current law vests the power to set pay increases for VA nurses with and at the discretion of the VA health care facility director. Nevertheless, VA's Under Secretary for Health did transmit to the facility directors a December 1998 information letter stating that "my expectation is that all facility Directors will give serious consideration to increasing the beginning rate for each Registered Nurse and Certified Registered Nurse Anesthetist (CRNA) grade by the amount of the January 3, 1999, nationwide GS adjustment."

Question 67: VA's Budget Submission indicates it would like to redirect \$105.9 million from its current operating funds to enhance extended care programs. VA has already made significant changes in the way it provides long-term care. Please identify any guidance HQ has given network or facility directors about restructuring VA long-term care programs.

Answer: VA needs to substantially increase its investment in home and community-based (H&CB) services over the next 3 to 5 years. VA expenditures for H&CB Care increased 19 percent in FY 1998 and continued, sustained growth is indicated. With home care covered in VA's basic benefit, VA also needs to expand these services for the post-acute and long-term care needs of chronically ill and disabled veterans.

VA published a national strategy for home and community-based care on April 1, 1998. The strategy encourages improved planning for, and expansion of, H&CB services. Additional direction is expected as a result of the Federal Advisory Committee's recommendations in this area. Presently, these issues are being considered by an internal VA workgroup, charged with developing action plans for each of the Committee's recommendations.

Question 68: Approximately what share of state veterans' homes daily cost (including any "in kind" service delivery, such as pharmaceutical care) will VA provide in FY 2000?

Answer: Based on updated information, the actual and projected average total cost of care for all State veterans' nursing homes, it is estimated that the VA share for nursing home care will reach the 33 1/3 percent by the end of FY 2000. The VA share for domiciliary care is estimated to be 25.66 percent by the end of FY 2000.

In the few instances where the VA is providing all the pharmaceutical care in the State veterans home, the State has contracted with VA to provide these services. Under this type of contract arrangement, the State home is not charged for the cost of medications VA provides eligible veterans in that State home.

Question 69: Please explain the benefits of implementing VA's Capital Asset Plan versus using its current authority for enhanced use leasing or use of longer-term (99 year) enhanced use leases.

Answer: Having the ability for direct disposal of real property as set forth in the Department's Capital Asset Fund initiative in addition to the other leasing and real property authorities (including enhanced-use leasing) will enable the Department to use the full array of asset management tools to align its property holdings with its mission and strategic planning. VA actions in any particular instance will be directed by agency mission and maximizing the consideration to the government.

Not only would VA's Capital Asset Plan authorize VA to dispose of its unneeded real property, independent of GSA, but would authorize VA to spend 90 percent of proceeds received from disposals, less administrative costs, that are deposited to the Capital Asset Fund, for its non-recurring projects. These expenditures will allow VA to provide for the needs of veterans, without additional appropriations from Congress, for such things as major and minor construction projects, parking expenses, leasing, and the acquisition of needed equipment, etc., for the medical centers.

Question 70: According to Dr. Kizer, all networks planned on Medicare revenues to meet their strategic targets and live within their respective budgets. Specifically, how have networks, which planned on Medicare revenues to meet their strategic targets, lived within their respective budgets without Medicare revenues?

Answer: Networks assumed that prospective Medicare revenues would be capped for three years as contained in the Administration's Medical Subvention proposal. Therefore, network reliance on Medicare revenues in fiscal years 1998 and 1999 was minimal and, for this immediate timeframe, had little impact on their respective budgets. The networks lived within their budgets in FY 1998 through shifting care to an ambulatory care basis and through integration and consolidation of functions. The additional \$278 million provided in FY 1999, and requested again in FY 2000, has offset planned Medicare revenues.

Question 71: Please indicate how well VA currently meets the rights and responsibilities described in the President's Patient Bill of Rights and Responsibilities. Is it the Administration's position that the President's Executive Order requiring all federal agencies to comport to the Patient Bill of Rights does or does not apply to VA medical programs?

Answer: We have responded to the President and Vice President on a number of occasions concerning VA's compliance with the President's Patient Bill of Rights and Responsibilities. We were pleased to report that VA is in compliance with most requirements and that we have actions underway in those areas where we believe work needs to be done: external appeals, information disclosure, and emergency care. The Under Secretary for Health has approved a recommendation for a national contract to handle external appeals and a work group is currently developing implementation plans and strategies. We are also improving the way we provide information to our veterans and their families and currently are considering a Report Card that would be made available to our customers. Finally, although not directly related to the Bill of Rights, our FY 2000 budget contains a legislative proposal to provide emergency health care services to the highest priority veterans in Priorities 1-3. VA has been included in communications from the White House concerning Federal Agency compliance with the Bill of Rights. We agree with the Bill of Rights and are moving forward to meet all its requirements.

Question 72: Please quantify the magnitude of absorption of \$1.4 billion in FY 2000 in terms of facilities, employees, and beds.

Answer: The budget assumes this absorption will be possible through increased management efficiencies. The budget estimates a net reduction of 7,830 FTE and 1,739 average daily census, which is our closest comparison to the information on bed data requested.

Question 73: How much will it cost VA to treat all Priority 7 veterans who enroll in FY 1999?

Answer: Estimating the cost for VA to treat all Priority 7 veterans who enroll in FY 1999 is not possible at this time since not all veterans who have enrolled will present themselves for care. Until VA has more experience with utilization rates for these enrollees we can not accurately estimate the cost of providing for their care.

Question 74: To date has any network applied to HQ for "VHA contingency funds"? Do you anticipate that any networks will require an HQ "bail-out" before the end of FY 1999?

**Answer:** To date no network has requested funds from the National Fund Reserve. At this time, we do not know of any network that is planning to request reserve funds.

**Question 75:** VHA has gotten a lot of favorable press on its "pain care" initiative, yet it has requested no new funds either for this major new initiative or its End-of-Life Care program. Identify the source of new funds required to fund these initiatives?

**Answer:** Much of what needs to be done to implement VA's pain management initiative involves education and evaluation. The infrastructure for the education component is already in place in the Employee Education System. Similarly, the infrastructure for research and evaluation already exists within VA's Health Services Research and Development office.

The appropriate treatment of pain should be an everyday part of the care provided to veterans in all settings. Most of the science is already known. It is rather a matter of changing how care providers think about pain and making the appropriate institutional change. Implementing "Pain as the Fifth Vital Sign" is an important first step, so that the individual who takes the patient's vital signs now includes an assessment of pain. This adds very little in terms of time or effort.

In the acute care setting, appropriate pain management may save money. In postoperative patients good pain relief permits them to get out of bed sooner, thereby decreasing the length of stay in the hospital and more rapid movement into rehabilitation. Their quality of life is also improved.

In patients who experience chronic, non-malignant pain appropriate treatment will decrease the number of visits to emergency departments and clinics and may make it possible for them to enjoy life more and miss fewer days of work.

For patients at the end of life, pain management is critically important in helping patients learn what to expect and how to take pain medications appropriately. The quality of their life is highly dependent on pain control and many patients will continue to be highly productive members of society when pain is managed.

None of these components of the initiative will require significant new resources, but an enhancement of activities we already have underway.

**Question 76:** Can VHA open planned Community Outpatient Based Clinics with the funding requested for FY 2000? Please identify the source of the funds to be used to open planned Community Outpatient Based Clinics in FY 1999.

**Answer:** An operating principle for VHA from the beginning of the CBOC review and approval process has been that VISNs/facilities fund the establishment of these clinics from within their existing resources. This has been communicated to the field, and all CBOC proposals submitted to Headquarters address the issue of how these new clinics will be funded. Given that mandate, VHA expects that all planned CBOCs for FY 1999 and 2000 can be opened with existing resources.

**Question 77:** How many network managers received exemplary performance reviews in FY 1998? How much merit pay did they receive?

**Answer:** Ten Network Directors received an outstanding performance rating for FY 1998. Two of these received \$16,000 cash awards and five received \$6,800 cash awards for a total of \$66,000 for performance bonuses. The other twelve

Network Directors received an excellent performance rating. Three of these received \$6,800 awards for a total of \$20,400 for performance bonuses.

Four Network Directors received Presidential Rank Awards during FY 1998 and, in accordance with VA policy, were not eligible to receive performance bonuses for the FY 1998 performance period. These Rank Awards were bestowed for achievements over a period of time preceding FY 1998. Two Network Directors received a Distinguished Rank Award with a cash award of \$20,000 and two received a Mentorious Rank Award with a cash award of \$10,000 for a total of \$60,000 for Presidential Rank Awards.

Question 78: Describe the link between the Network "business plans" and VA's Capital Investment strategies and requests for construction funds. How are these plans and strategies coordinated and prioritized at the national level?

Answer: The Networks conduct Capital Asset Planning utilizing the principles in the OMB Capital Asset Program Guide. For proposed investments the three "pesky questions" must be answered. The questions are: (1) does the proposal support core missions of the Department that must be performed by the government; (2) is there no other government or private sector source that can do it better or cheaper; and, (3) have current work processes already been optimized? The network must then identify the primary customers the capital investment would benefit and the specific linkages to VA goals and objectives as well as to the specific Network goals and objectives.

Networks develop their major construction projects in accordance with the planning guidance that is issued from VHA headquarters, in coordination with the field. The guidance reflects priorities established by the Secretary of Veterans Affairs and the Under Secretary for Health. The individual medical facilities establish and refine the scopes for the requested projects. Projects are then submitted to the VISNs for review. The project justification must include an assessment of alternatives to construction, a cost-benefit analysis, and an explanation of how the project ties to the Department's strategic goals. The VISN Director decides which projects are included in the Network's strategic plan which are then be submitted to VHA headquarters.

From the 22 Network strategic plans, VHA compiles a major construction project inventory of proposals that are submitted to the VA Capital Investment Board (VACIB). Projects are reviewed by the VACIB for budget consideration and for the development of the list of top twenty medical facilities for authorization purposes. The VACIB was created to foster a "One VA" approach to the use of capital funds (including construction, information technology, and equipment) and to ensure all major capital investment proposals are based upon sound economic principles and are fully linked to strategic planning, budget, and performance goals. The VACIB is made up of top management from across Department business lines. The VACIB is chaired by the Deputy Secretary and includes the Deputy Under Secretary for Management in the Veterans Benefits Administration (VBA), the Director, Office of Operations Support of the National Cemetery Administration (NCA), the Assistant Secretary for Planning and Analysis, the Assistant Secretary for Information and Technology, and the Assistant Secretary for Financial Management, and has recently added the Assistant Secretary for Congressional Affairs and the General Counsel.

The VACIB supports strategic planning, budgeting, and performance goals by reviewing proposals that represent high risk or national visibility and projects that exceed established dollar thresholds. The Board reviews capital investments and makes recommendations to the Secretary as chair of the VA Resources Board (VARB), on each proposal's inclusion in the VA Capital Plan and the annual budget request for appropriation and authorization purposes. This composition embodies diverse perspectives from within VA that promote dialogue and interaction of top executives.

The major criteria for selecting capital investments including construction funding were prioritized and weighted by the VA Capital Investment Board members. The criteria for weights for FY 2000 included:

- One-VA Customer Service
- Return on Taxpayer Investment
- High Performing Workforce
- Risk Analysis
- Alternatives Analysis

(These weights will be updated for the FY 2001 process.)

This process produced a prioritized list of technically sound proposals that were compiled, scored, and submitted to the VACIB for review and approval. The VACIB then reviewed the list of projects and voted on the strategic mix of projects that would best enable the Department to achieve the highest priority goals and objectives. These results were presented to the VARB for approval. Approved major projects are submitted to OMB as part of the OMB Budget submission for budget consideration and authorization requirements (Public Law 104-262 – Top Twenty Medical Facilities Report.) Substantiated major construction projects are submitted to the Congress in the President's Budget Submission. These projects also require authorization from the House and Senate Veterans Affairs Committees before funds can be appropriated for the project.

Question 79: Is VA "on target" in meeting all of its identified performance goals? If not, in what areas is it falling short?

Answer: In October 1998, VA leaders identified 24 performance goals considered critical to the success of the Department. Some of these deal with program outcomes; others pertain to the management of our programs. The Secretary will be conducting quarterly meetings with key VA leaders to monitor progress toward achieving these performance goals.

Based on available data through the first quarter of FY 1999, the only performance goal the Department is clearly not going to be able to achieve is the average days to complete core rating actions. Rating actions include original compensation claims, original DIC claims, original pension claims, reopened compensation claims, reopened pension claims, routine examinations, and reviews due to hospitalization. The performance goal is to complete core rating actions in an average of 99 days. Performance for the first quarter of FY 1999 places this value at 154 days.

Question 80: Please provide the number of FTE at the Board of Veterans' Appeals who were responsible for providing information and assistance to the General Counsel's Group VII Litigation Unit during FY 1998.

Answer: While no BVA staff worked on a full-time basis with the General Counsel's Group VII regarding matters in litigation before the Court, we estimate that approximately one FTE of BVA staff time was spent on these activities during FY 1998.

Question 81: Please provide a list of the General Counsel opinions drafted at the request of the Board of Veterans Appeals for use in individual cases before the Board for FY 1998 and the number of FTE (including FTE from the Board) who were responsible for drafting such opinions.

Answer: The following ten General Counsel opinions were drafted at the request of the Board of Veterans' Appeals and issued during FY 1998:

VAOPGCPREC 34-97\* November 5, 1997

Subj: Request for Opinion Concerning Application of 38 U. S. C. § 3014(b), XXXXXX

VAOPGCPREC 36-97 December 12, 1997

Subj: Applicability of 38 C.F.R. §§ 4.40, 4.45, and 3.321(b)(1) in Rating Disability Under Diagnostic Code 5293 (Intervertebral Disc Syndrome)

VAOPGCPREC 37-97\* December 16, 1997

Subj: Opinion Request Concerning Attorney Fees of XXXXXXXXXXXXXXXXXXXX, in the Claim of XXXXXX XXXXXXXXXXX, XX, and XXXXX X. XXXX, XXXXXXX, in the Claim of XXXXX X. XXXXX

VAOPGCPREC 38-97\* December 17, 1997

Subj: Failure to Apply Evidentiary Presumption as Basis to Reopen Claim

VAOPGCPREC 40-97 December 31, 1997

Subj: Effective Date of Amendments to 38 U.S.C. § 1151 Made by Pub. L. No. 104-204

VAOPGCPREC 1-98 January 13, 1998

Subj: Effective Date of Pub. L. No. 105-111—Revision of Decisions Based on Clear and Unmistakable Error

VAOPGCPREC 4-98\* April 1, 1998

Subj: Applicability of 38 U.S.C. § 2305 in Claims for Burial Benefits Based upon Service in the Commonwealth Army of the Philippines During World War II

VAOPGCCONCL 5-98\* April 17, 1998

Subj: Request for Opinion Concerning Legal Eligibility for Compensation Benefits for Residuals of Injury Sustained in Connection with a VA-Authorized Program of Vocational Rehabilitation in 1949

VAOPGCCONCL 6-98\* April 17, 1998

Subj: Application of 38 U.S.C. § 1151 to Treatment Provided Pursuant to 38 U.S.C. § 8153

VAOPGCPREC 9-98 August 14, 1998

Subj: Multiple Ratings for Musculoskeletal Disability and Applicability of 38 C.F.R. §§ 4.40, 4.45, and 4.59

\* opinions requested in connection with an individual's case.

The General Counsel writes a broad range of opinions for the entire Department. Each opinion is written by one staff attorney and is subject to review by at least three supervisors. Opinions requested by the Board of Veterans Appeals represent a very small portion of any one attorney's workload. No Board of Veterans Appeals attorneys are involved in the drafting of General Counsel opinions.

Question 82: Please provide a list of the cases in which fees under the Equal Access to Justice Act during FY 1998, were requested indicating for each case:

- a. the amount of the fees paid (if any);
- b. whether the fees were awarded by the Court or paid pursuant to settlement of a pending fee petition; and,

c. whether the underlying litigation was resolved by a single judge or panel decision, a joint petition for remand or otherwise.

Answer: These types of cases arose in two forums. For the U.S. Court of Veterans Appeals (COVA), attached is a printout taken from the General Counsel's case tracking system which represents payments made as the result of attorney representation before COVA. It reflects that 563 applications were received in FY 98; 529 Equal Access to Justice Act (EAJA) applications were closed. The Government paid \$2,059,556.55 for the 529 closed claims.

This is all the readily available information. The case tracking system is not designed to identify whether fees were awarded by the Court or paid pursuant to a settlement, nor whether the litigation was resolved by a single judge or by a panel decision or by a joint petition for remand or otherwise.

All earlier, and FY 98 EAJA cases, have been closed and placed in storage. It would take a significant amount of time and several FTE to recall cases from storage, extract EAJA files from the hundreds of retired boxes of files, and examine the contents of the litigation files to determine the factors requested.

With regard to the VA Board of Contract Appeals, in response to parts a and b, EAJA fees were awarded in the following six cases:

Penn Environmental Control, Inc., VABCA No. 3726E, 98-1BCA ¶ 29,355 - the VA Board of Contract Appeals awarded fees of \$11,774.00.

Adams Construction Co., Inc., VABCA Nos. 4669E, 4900E, 98-1BCA ¶ 29,479 - the VA Board of Contract Appeals awarded fees of \$21,469.25.

Precision Communications, VABCA No. 5346 - the parties to the dispute settled the issue of attorneys fees by VA paying the sum of \$100.00.

All State Boiler Works, Inc., VABCA No. 4537 - the parties to the dispute settled the issue of attorneys fees by VA paying the sum of \$13,076.00.

Fire Security Systems, Inc., VABCA Nos. 3909-3911 - the parties to the dispute settled the issue of attorneys fees by VA paying the sum of \$14,086.00.

United Thermal Industries, Inc., VABCA Nos. 4909-4912 - the parties to the dispute settled the issue of attorneys fees by VA paying the sum of \$20,000.00.

In response to part c, where EAJA fees were awarded by the VA Board of Contract Appeals, there was a panel of three judges.

## Questions from the Honorable Corrine Brown

Question 1: I congratulate you for setting up the Office of Assistant Secretary for Information and Technology. I believe that information technology is the key to VA being able to provide health care and benefits to veterans at the lowest cost. My concern, however, is that you have sufficient staffing for that new office to enable it to be as effective as it needs to be. I note that the former Office of IRM had lost over 25 percent of its employment base over the last five years. Shouldn't you be beefing up your new office with more personnel?

Answer: Establishing the Office of Assistant Secretary for Information and Technology represents a major step toward unifying information technology (IT) solutions to achieve the "One-VA" vision. This vision can be brought about only with substantial investments in IT infrastructure improvements. IT is the engine that will keep VA vital in changing times and enable us to provide fast, easy, seamless service to our nation's veterans. Investments in IT are critical if VA is going to keep our promise to veterans for one-stop, on-time service when and where it is needed. While it is true that we have lost over 25 percent of our employment base over the last five years, we believe that we have about the right number of personnel to support our mission, however, contract dollars will be needed if we are to accomplish some of our crucial goals in support of Clinger-Cohen and VA's mission.

Question 2: Mr. Secretary, in this electronic age, sensitive information is increasingly vulnerable to attack or misuse. I consider this a serious matter. I am to understand that intrusion tests at some VA locations have yielded successful attacks on VA and that the Department has been criticized for its vulnerability. With all the demands for critical infrastructure protection as well as mandates for new operating approaches and workplace flexibility, I would be interested in why you did not request more funding for information security and program management.

Answer: Last year, the Chief Information Officer (CIO) organization was made a separate Assistant Secretary position from that of the Assistant Secretary for Financial Management. This CIO organization was created to focus on information and technology issues. Information security has been identified as a top priority and will receive the emphasis it deserves. Information security has clearly not kept pace with the investments in open networking technology across VA that increases vulnerabilities. The Acting CIO has an agenda that makes an effective information security program a top priority. The Acting CIO has recently brought to my attention this matter. In addition, by policy, each administration head, assistant secretary, and key official is responsible for allocating sufficient funds, personnel, and management support to assure compliance with federal and VA information security requirements within their scope of operations. The Department's CIO has already formed a team to move ahead with a plan to strengthen the Department-wide security program.

## Questions from the Honorable Mike Doyle

**Question 1:** We are obviously dealing with a very restricted medical care budget which falls well below the VA's original request (by almost \$19.3 billion) to the Office of Management and Budget. Does the VA still stand behind its decision to enroll Priority 7 veterans. How much do you estimate it will cost the VA to treat them?

**Answer:** The decision about what priorities to enroll must be made each year several months before the fiscal year begins and is published in the Federal Register. The decision to enroll Priority 7 veterans this FY 1999 was made last summer, based upon an analysis including both an actuarial private sector and VA model. The decision about whether to enroll Priority 7 veterans for next year, FY 2000, will be made this summer. VA has not yet determined whether we will be able to enroll Priority 7 veterans in FY 2000. The supporting analysis to project this costs in FY 2000 has been initiated and will include updated and refined methods in both the private sector model (by an actuary) and VA model (by VA staff).

**Question 2:** Describe the link between the Network "business plans" and VA's Capital Investment strategies and requests for construction funds. How are these plans and strategies coordinated and prioritized at the national level?

**Answer:** The Networks conduct Capital Asset Planning utilizing the principles in the OMB Capital Asset Program Guide. For proposed investments the three "pesky questions" must be answered. The questions are: (1) does the proposal support core missions of the Department that must be performed by the government; (2) is there no other government or private sector source that can do it better or cheaper; and, (3) have current work processes already been optimized? The network must then identify the primary customers the capital investment would benefit and the specific linkages to VA goals and objectives as well as to the specific Network goals and objectives.

Networks develop their major construction projects in accordance with the planning guidance that is issued from VHA headquarters, in coordination with the field. The guidance reflects priorities established by the Secretary of Veterans Affairs and the Under Secretary for Health. The individual medical facilities establish and refine the scopes for the requested projects. Projects are then submitted to the VISNs for review. The project justification must include an assessment of alternatives to construction, a cost-benefit analysis, and an explanation of how the project ties to the Department's strategic goals. The VISN Director decides which projects are included in the Network's strategic plan which are then be submitted to VHA headquarters.

From the 22 Network strategic plans, VHA compiles a major construction project inventory of proposals that are submitted to the VA Capital Investment Board (VACIB). Projects are reviewed by the VACIB for budget consideration and for the development of the list of top twenty medical facilities for authorization purposes. The VACIB was created to foster a "One VA" approach to the use of capital funds (including construction, information technology, and equipment) and to ensure all major capital investment proposals are based upon sound economic principles and are fully linked to strategic planning, budget, and performance goals. The VACIB is made up of top management from across Department business lines. The VACIB is chaired by the Deputy Secretary and includes the Deputy Under Secretary for Management in the Veterans Benefits Administration (VBA), the Director, Office of Operations Support of the National Cemetery Administration (NCA), the Assistant Secretary for Planning and Analysis, the Assistant Secretary for Information and Technology, and the Assistant Secretary for

Financial Management, and has recently added the Assistant Secretary for Congressional Affairs and the General Counsel.

The VACIB supports strategic planning, budgeting, and performance goals by reviewing proposals that represent high risk or national visibility and projects that exceed established dollar thresholds. The Board reviews capital investments and makes recommendations to the Secretary as chair of the VA Resources Board (VARB), on each proposal's inclusion in the VA Capital Plan and the annual budget request for appropriation and authorization purposes. This composition embodies diverse perspectives from within VA that promote dialogue and interaction of top executives.

The major criteria for selecting capital investments including construction funding were prioritized and weighted by the VA Capital Investment Board members. The criteria for weights for FY 2000 included:

- One-VA Customer Service
- Return on Taxpayer Investment
- High Performing Workforce
- Risk Analysis
- Alternatives Analysis

(These weights will be updated for the FY 2001 process.)

This process produced a prioritized list of technically sound proposals that were compiled, scored, and submitted to the VACIB for review and approval. The VACIB then reviewed the list of projects and voted on the strategic mix of projects that would best enable the Department to achieve the highest priority goals and objectives. These results were presented to the VARB for approval. Approved major projects are submitted to OMB as part of the OMB Budget submission for budget consideration and authorization requirements (Public Law 104-262 – Top Twenty Medical Facilities Report.) Substantiated major construction projects are submitted to the Congress in the President's Budget Submission. These projects also require authorization from the House and Senate Veterans Affairs Committees before funds can be appropriated for the project.

Question 3: Is the VA "on target" in meeting all of its identified performance goals? If not, in what areas is it falling short? And what is the VA doing to ensure that the data used to determine whether the performance goals are being met is accurate and valid? What is the VA doing to ensure that this data is being collected and assessed in a standardized manner?

Answer: In October 1998, VA leaders identified 24 performance goals considered critical to the success of the Department. Some of these deal with program outcomes; others pertain to the management of our programs. The Secretary will be conducting quarterly meetings with key VA leaders to monitor progress toward achieving these performance goals.

Based on available data through the first quarter of FY 1999, the only performance goal the Department is clearly not going to be able to achieve is the average days to complete core rating actions. Rating actions include original compensation claims, original DIC claims, original pension claims, reopened compensation claims, reopened pension claims, routine examinations, and reviews due to hospitalization. The performance goal is to complete core rating actions in an average of 99 days. Performance for the first quarter of FY 1999 places this value at 154 days.

The Department of Veterans Affairs is committed to ensuring that those who use VA's reported performance information to make decisions can do so with the

confidence that VA's data are reliable and valid. VA's commitment to an internally sound data verification process, in which data are verified for reliability and validity, goes one step further by expecting that managers also be accountable for ensuring data integrity.

Over the last year, VA has made progress within the Department to begin the process of addressing both the data verification methods used by our three major operating elements as well as data limitations. In that regard, VA has continued to work to develop a cooperative relationship with the IG, communicated the importance of internal controls to program managers, and monitored ongoing efforts within VA to improve data reliability, validity, and integrity.

Department officials have worked closely with the IG on a series of performance audits focused on VA's highest priority performance data. To date, three performance audits have been completed and two others will be finished soon. The first three audits centered on the timeliness of processing compensation and pension claims. The other two are audits of the number of unique patients treated in the VA healthcare system, and the percent of veterans served by a burial option. These audits send a strong message to all VA elements that the Department is serious about the quality of our performance information.

VA is working to ensure data quality by taking steps to validate measurement systems, develop processes for staff and independent consultants to examine methodologies, have models reviewed by expert panels and make suggested recommendations to those models, and obtain independent evaluations from nationally recognized experts to review methods of data collection, statistical analysis, and reporting which would assist VA in its efforts to improve data quality. External reviews are essential in order to help depoliticize issues related to the validity and reliability of data.

Question 4: Given that the VA is estimating that it will fall \$50 million short of the \$675 million collections goal for FY 1999, what steps are being taken within VA to enable the realization of the \$749 million in medical care collections goal for FY2000? What methodology was used to determine the \$749 million goal?

Answer: The signal has been clearly given to the VISN Directors that collections are a vital part of the Medical Care budget. Performance goals and key process measures have been set for each Network and are monitored on a monthly basis. Accomplishment toward this goal is measured as a part of each VISN Director's quarterly performance review. The chart below contains a list of VA revenue initiatives that are currently being undertaken to increase MCCF collections by FY 2000.

Initiative	Description	Timetable
Insurance Identification	Pre-registration involves contacting patients scheduled for outpatient visits to remind the patients of scheduled appointments and to update VISTA records. This practice was first implemented at seven reengineering pilot sites. In FY 97 the seven pilot sites generated \$5.6 million dollars (approx. \$800,000.00 per site) in additional third party revenues just from pre-registration. Due to the success of this pilot, implementation of pre-registration software is now mandatory at all locations.	First Implementation August 1998. Implementation Continues.
Intake Training	Gathering of demographic, employment and insurance information is critical to the success of the third party revenue generation process. A nationwide study of Diagnostic Measures performed in Fall 1997 showed that the intake portion of the revenue generation process is inadequate at the vast majority of VA facilities. The Revenue Office, working with the Employee Education System, has identified a large number of training and performance issues to be addressed, and is working with Network Revenue Teams to provide guidance and training to all VA Intake staff.	Underway Now
Compliance	Compliance will ensure that coding and documentation for billing and medical records purposes are accurate and in conformance with industry standards and will support reasonable charges.	Underway Now

Initiative	Description	Timetable
Medicare Remittance Advice (MRA)	VA is prohibited under current law from billing Medicare for health care services provided to Medicare-eligible veterans. Unlike claims from private hospitals and physicians, VA claims for veterans with Medicare supplemental insurance are not adjudicated by Medicare and are not accompanied with Medicare remittance advice forms when submitted for reimbursement to those insurers. HCFA and VA have entered into an agreement that will enable VA to have Medicare-equivalent adjudication of VA's claims for the cost of non service-connected health care services furnished to all insured Medicare-eligible veterans. The Medicare adjudication of VA claims will be provided by a Medicare Fiscal Intermediary (FI) and Medicare Carrier under contract with HCFA. The Medicare furnished adjudication of VA's claims will be in the form of a Medicare Remittance Advice (MRA) and will be equivalent to the adjudication furnished under the Medicare program to private sector providers of health care services. Note: 70% of VA claims are for veterans over the age of 65 with Medicare supplemental insurance.	Planned for September 1999
Medicare On Line Project	VA facilities can verify a veteran's eligibility for Medicare benefits by using Medicare software. The Medicare Online eligibility program can be accessed by VA staff through a simple telecommunication modem link at a cost of 9 cents per minute.	Underway Now
Utilization Review	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 denied claims with effective training in effective techniques. With effort, UR staff recovered as much as \$400,000 per medical center in previously denied claims. UR training provided to Revenue Teams in March 98, National UR Conference held April '98 to provide education and training to field staff. Monthly conference calls and training sessions continue.	Underway Now
Benefit Offset	An IG audit determined that by referring delinquent patient copayment and means test debt for 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.	Underway Now
HMO Point of Service Contracts	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.	Underway Now
Revenue Teams	At the direction of the Under Secretary of Health, the CNO and CFO developed the Network Revenue Team concept. Each VISN established a team of experts to assess medical care collection activities with in the VISN and make needed changes to: <ol style="list-style-type: none"><li>1. assure the VISN reaches its FY 98 collection goal;</li><li>2. improve processes; and,</li><li>3. determine future needs in the collection process</li></ol> Cost recovery consultants are assisting teams as needed with training and follow-up	Underway Now
Reasonable Charges	Reasonable charges are representative of provider charges in the market of each VAMC, and should result in payment from third party insurers at the prevailing payment rate. DRG based per diems will be used to charge for inpatient facility services, procedure case based charges for outpatient facility services and procedure charges for clinician services. These industry compatible charge formats will allow processing by payer automated processing systems and timely payment. Reasonable charges implementation will occur after regulatory approval is received.	September 1999
Third party delinquent claims	A nationwide fixed fee contract for MCCR delinquent third party claims over 90 days for inpatient health care services provided veterans will help increase delinquent collections. Cost is \$4.75 for each case referred. Each facility individually pays contractor for cases referred.	Underway Now
Third Party EDI	A national solution is being developed for electronic billing of health care payers using ANSI X12 and other national standards as mandated in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). EDI will automate submission and receipt of billing, payment, and related information through computer software modules to VA Integrated Billing and Accounts Receivables software packages. The cross-industry average is \$5* saved for every paper document	June - July 1999

Initiative	Description	Timetable
	converted <sup>The EDI Group, Ltd.</sup> VA's savings are projected to be less than this average to start. One reason is that the full-cycle-use of EDI in Health Care billing and collection is still emerging, meaning it has not been widely implemented throughout the Health Care industry. Another factor is the new frontier of implementing national standard transactions as set forth under HIPAA. Software functional requirements are under development.	
Clinician Involvement Learning Maps	Clinician understanding of the importance of their role in revenue generation is critical to the success of the collection process. Several VISN Clinical managers are working with the Revenue office to develop materials for presentation to clinicians on their role and responsibilities. Two PowerPoint presentations developed by Dr. Carter Mecher and Dr. Paul Billings, have been distributed to Network Revenue teams. The Revenue Office and EES are considering the development of a Learning Map program to help all staff understand the revenue process and their roles in relation to it.	Map Being Tested April 1999
Fee Basis	The fee basis program allows certain veterans to be treated by non-VA physicians at VA expense. Once a veteran is authorized fee basis care and receives treatment from a private physician or other medical professional, the bills for that care are submitted to the VA facility authorizing such care. Bills received by VA for fee basis patients are generally submitted on the standard UB-92 or HCFA 1500 forms. In most instances those bills include information on other insurance under which a veteran is covered. By utilizing those bills insurance information can be obtained that was not previously identified during the patient registration process. Once identified back billing for NSC care provided can be initiated as well as future billing for all other NSC care rendered.	Implementation in Progress

Collections estimates are derived by looking at historical collections in conjunction with a forecasting model developed by an economist at the Management Decision and Research Center (MDRC) of the VA Health Services Research & Development Service (HSR&D). The forecasting model for the MCCF collections projects forward based on workload, insurance and demographic trends.

The forecast model is used to establish maximum potential at the national level. The forecast model is based on inpatient and outpatient workload using linear trends based on historical data for the following factors:

- Veteran population by geographic area, age group, eligibility, and bed service
- Percentage of VHA users with private health insurance and Medicare Supplemental insurance
- Inpatient and outpatient utilization within age groups
- HMO market penetration
- MCCF billing rates

The assumptions assumed that VHA enrollments continue to grow and utilization continues to change through the Year 2002 as they have in the recent past. HMO enrollment is calculated as a percentage of the total population in each VISN. MCCF billing rates were established by using a simple trend by bed section based FY 1996 through FY 1998 rates, and assumed Medicare rates would continue to grow at 3 percent per year.

Initially a drop in collections is anticipated as insurance companies and the medical centers make adjustments to the changes in the billing formats resulting from the implementation of reasonable charges. Longer term, VA's revenues should increase, as VA's bills will reflect the market value of the services provided and conform to industry standard. Once VHA has six months to a year experience with "reasonable charges," estimates using reasonable charges will be incorporated into the forecast model.

Question 5: During the 2/11/99 hearing Under Secretary Kizer stated that there would be a reduction of 7,000 *positions* in FY 2000. Undersecretary Kizer went on to state that these reductions would largely be absorbed in the support personnel and administrative sectors, and that further details would not be available until information was gathered from the field sometime later this summer. This process appears to be *putting the horse* in front of the cart—What information/plans were used to arrive at the 7,000 position figure? Was this determination accepted unconditionally? What effort was made—or will be made—to reduce this figure?

Answer: The estimated FTE reduction is associated with the anticipated management efficiency resource savings that will be required to offset the increased cost of uncontrollable inflation and payroll (including payraises) and the earmarking of funds for the evaluation and treatment of Hepatitis C patients, enhancement of extended care programs and extension of VA's homeless effort to all VA medical centers. VISNs will need to continue their efforts in reaching their performance goals of efficiency and quality. Because of VHA's decentralized decision structure, the specific management initiatives will be decided by the VISNs. This will be accomplished in large measure by continuing to improve clinical processes. In part, this entails a shift to more appropriate care settings, including the shift of excess acute inpatient resources to expand and enhance outpatient and long-term care services for veterans. Another part relates to care management, prevention, and rational use of therapies. Continuing efforts to re-engineer our health delivery systems and our commercial practice initiatives (including a new initiative on inventory management) will also contribute additional savings. As a result of these management efficiencies we have, in the past, been able to increase total patients and outpatient visits and improve our customer satisfaction scores and quality of care performance.

Beyond the 6,949 FTE reduction associated with management efficiencies under current legislation, 1,580 FTE are estimated to be reduced through the absorption of the cost associated with the emergency care legislative proposal. The budgeted FTE reductions are estimates. Not all management efficiencies impact FTE and the type and amount of employment reduced will be ultimately determined by the VISNs.

Question 6: What is the National Cemetery Administration doing to ensure that locations/geographic areas identified as most in need of burial space for veterans – specifically Pittsburgh – in the Department of Veterans Affairs 1987 report will receive appropriate planning, construction, and funding consideration?

Answer: By the turn of the century, six national cemeteries will be operational from the 1987 and 1994 Reports to Congress identifying areas in greatest need for a national cemetery. Four of these new national cemeteries are currently under construction in the areas of Chicago, Illinois; Dallas/Ft. Worth, Texas; Saratoga, New York; and Cleveland, Ohio. This growth is unprecedented since the Civil War.

After these four new cemeteries are open later this year, VA plans to evaluate the need for establishment of additional new national cemeteries in the other remaining geographic areas identified in the two Reports, which include the Pittsburgh area. Funding for planning new national cemeteries will be determined within the framework of VA's strategic planning and budgeting process. The seven areas identified as being in greatest need from the combined listings of the 1987 report, and subsequent 1994 update, still remaining are identified below in alphabetical order:

Atlanta, GA  
 Detroit, MI  
 Miami, FL  
 Oklahoma City/Lawton (Fort Sill), OK  
 Pittsburgh, PA  
 Sacramento, CA  
 St. Louis, MO

Attachment to Hon. Lane Evans Question #56

APPENDIX B  
 TABLE # 3  
 SCI WAITING TIME FOR BOTH INPATIENT AND OUTPATIENT (FY 1986 FY 1987)

MSN	STATION	FY 86 ACUTE CARE ADMISSION WAITING TIME AS OF 9-30-86	Baseline FY 86	FY 87 ACUTE CARE ADMISSION WAITING TIME AS OF 9-30-87	Goal Met FY 86/87	FY 86 WAITING TIME FOR ROUTINE APPT IN SCI CLINIC AS OF 9-30-86	Baseline FY 86	FY 87 WAITING TIME FOR ROUTINE APPT IN SCI CLINIC AS OF 9-30-87	Goal Met For Sep87
1	Brockton	1	Yes	1	Yes	5	Yes	5	Yes
3	Bronx	1	Yes	1	Yes	1	Yes	1	Yes
3	Castle Point	7	no	7	Yes	2	Yes	1	Yes
3	East Orange	10	no	7	no	2	Yes	3	Yes
6	Hampton	n/a	n/a	n/a	n/a	7	Yes	7	Yes
6	Richmond	1	Yes	1	Yes	2	Yes	4	Yes
7	Augusta	7	no	1	Yes	3	Yes	3	Yes
6	Miami	1	Yes	1	Yes	6	Yes	1	Yes
6	San Juen	7	no	1	Yes	28	no	1	Yes
6	Tampa	5	no	1	Yes	5	Yes	3	Yes
9	Memphis	1	Yes	1	Yes	1	Yes	1	Yes
10	Cleveland	14	no	1	Yes	5	Yes	7	Yes
12	Hines	1	Yes	1	Yes	7	Yes	7	Yes
12	Milwaukee	2	no	1	Yes	14	no	2	Yes
15	St Louis	1	Yes	1	Yes	3	Yes	6	Yes
16	Houston	3	no	1	Yes	3	Yes	1	Yes
17	Dallas	20	no	1	Yes	30	no	1	Yes
17	San Antonio	7	no	1	Yes	2	Yes	1	Yes
18	Albuquerque	1	Yes	1	Yes	2	Yes	1	Yes
20	Seattle	1	Yes	1	Yes	1	Yes	1	Yes
21	Palo Alto	3	no	1	Yes	1	Yes	5	Yes
22	Long Beach	3	no	1	Yes	7	Yes	7	Yes
22	San Diego	4	no	2.5	no	4	Yes	3	Yes
	Percentage of Achieving Goal	N/A	41% met	N/A	81%	N/A	87% met	N/A	100%

Acute care goal is same day. Source: FY 86/87 Survey of SCI Centers B - 1 Output goal is appointment within 7 days of referral.

APPENDIX B

TABLE # 4A  
INPATIENT BLIND REHABILITATION WAITING TIME

Months	A	B	C	D	E
	FY 1988 Total Apps. for all BRCs	Avg. Wait. time in weeks	FY 1987 Total Apps. for all BRCs	Avg. Wait. time in weeks	Change in Avg. Waiting Time in Weeks (FY88 vs. FY87)
Oct.	1349	28	1586	28	3
Nov.	1387	31	1829	33	2
Dec.	1377	27	1597	33	6
Jan.	1415	35	1383	31	-4
Feb.	1487	25	1475	32	7
Mar.	1573	28	1487	33	5
Apr.	1577	28	1463	34	5
May	1614	28	1487	34	6
Jun.	1598	25	1416	33	8
Jul.	1588	28	1443	27	1
Aug.	1588	25	1448	28	3
Sept.	1628	30	1430	32	2

# of Blinded veterans treated for FY 1988 = 1,384  
# of Blinded veterans treated for FY 1987 = 1,634

B - 2

E = D-B

Negative # represents a decrease in the waiting time

TABLE # 4B  
BLIND REHABILITATION OUTPATIENT SERVICES (BROS)

BROS Program	FY 1987 Total Vets Served	FY 1987 Total Obligated	FY 1987 Percent Obligated
VAMC Seattle	76	11	14.5
VAMC Knoxville	87	22	25.3
VAMC Dallas	77	7	9.1
VAOPC Boston	35	1	2.9
VAMC Gainesville	86	11	12.8
VAMC Baltimore	73	2	2.7
VAMC Bay Pines	80	10	12.5
VAMC Albuquerque	69	5	7.3
VAMC Cleveland	44	9	20.5
VAMC West Haven	57	29	50.9
VAMC Phoenix	90	2	2.2
VAMC San Juan	76	7	9.2
VAMC Portland	58	12	20.7
OPC Los Angeles			
Overall Total	908	128	

Vacancies:

VAMC Indianapolis - vacant 808, position relocated to VAMC Ann Arbor in July, 1987.  
 OPC Los Angeles - vacant since November, 1988.  
 OPC Los Angeles - vacant since June, 1987 and resigned October, 1987.  
 Boston - maternity leave since June, 1987 and resigned October, 1987.

The BROS positions were not all hired and operational at the same time, so there is no comparable data for FY 96.  
 Total Obligated - number of veterans who did not require admission to Inpatient Blind Rehab. Center program.

APPENDIX B

TABLE #5  
TBI WAITING TIME BY VISN AND BY TBI CENTER  
(BOTH INPATIENT AND OUTPATIENT FY 1996 AND FY 1997)

VISN#	VA FACILITY	INPATIENT DAYS		OUTPATIENT DAYS		COMMENTS		
		A FY 1996	B FY 1997	C CHANGE IN DAYS	D FY 1996		E FY 1997	F CHANGE IN DAYS
1	Boston	4	2	-2	7	7	0	
2	Albany	4	3	-1	7	1	-4	
3	Lynn, Norquet	3	1	-2	0	0	0	(1997- Lynn removed from TBI network)
4	Pittsburgh	N/A	N/A	N/A	10	7	-3	(This VISN has no Inpatient TBI beds)
5	Meridenburg	0	0	0	0	0	0	(Long term placement using Dueschler)
6	Richmond	2	1	-1	7	0	-7	
7	Tuscaloosa	17	3	-14	0	7	7	
8	Bay Pines, Tampa, San Jose	4	2	-2	7	3	-4	
9	Memphis	3	N/A	N/A	0	N/A	N/A	(Program discontinued)
10	-----	N/A	N/A	N/A	N/A	N/A	N/A	(No program established)
11	-----	N/A	N/A	N/A	N/A	N/A	N/A	(No program established)
13	Chicago (Home)	3	5.2	2.2	21	10	-11	(No Case Manager assigned to TBI)
13	St. Cloud, Minneapolis	3	2	-1	21	14	-7	
14	Kennett	1	0	-1	0	0	0	
15	-----	N/A	N/A	N/A	N/A	N/A	N/A	(No program established)
16	Houston	3	2	-1	0	14	14	
17	-----	N/A	N/A	N/A	N/A	N/A	N/A	(No program established)
18	Albuquerque	0	1	1	7	1	-4	
19	Denver	4	2	-2	7	7	0	
20	Seattle	0	0	0	21	7	-14	
21	Palo Alto	3	2	-1	0	7	7	
22	W. Los Angeles, Long Beach	2	0	-2	0	0	0	

C = B-A  
F = E-D  
Source: FY 96 FY 97 Survey of TBI Centers  
B - 4  
Negative numbers indicate improvement  
Positive numbers indicate waiting time has increased

APPENDIX - B

TABLE #A DELAYED PROSTHETIC ORDERS  
 CUMULATIVE TOTAL  
 FY 1986 AND FY 1987

VEN#	TOTAL ORDERS RECEIVED				TOTAL DELAYED ORDERS							
	A	B	C		D	E	F	G	H			
	FY 86	FY 87	FY 86/FY 87	% Change	FY 86	FY 87	FY 86	FY 87	FY 86	FY 87	FY 86/FY 87	% of Change
1	89,918	67,835	25.3%	2,325	3.3%	590	0.7%	590	0.7%			-2.8%
2	37,563	43,377	15.4%	388	1.0%	139	0.3%	139	0.3%			-0.7%
3	63,647	68,121	38.5%	545	0.9%	0	0.0%	0	0.0%			-0.9%
4	81,486	78,156	27.1%	549	0.9%	371	0.5%	371	0.5%			-0.4%
5	32,260	53,419	85.6%	228	0.7%	593	1.1%	593	1.1%			0.4%
6	111,223	133,261	19.8%	2,231	2.0%	1,533	1.2%	1,533	1.2%			-0.8%
7	97,428	114,329	17.3%	1,852	1.7%	666	0.6%	666	0.6%			-0.9%
8	136,283	173,278	25.3%	738	0.5%	872	0.5%	872	0.5%			0.0%
9	93,928	104,912	11.7%	1,028	1.1%	647	0.8%	647	0.8%			-0.5%
10	38,987	44,817	14.5%	322	0.8%	140	0.3%	140	0.3%			-0.5%
11	61,547	69,529	13.0%	586	1.0%	255	0.4%	255	0.4%			-0.8%
12	93,367	102,375	9.8%	442	0.5%	104	0.1%	104	0.1%			-0.4%
13	57,068	58,813	3.1%	1,166	2.0%	109	0.2%	109	0.2%			-1.8%
14	32,869	36,867	12.8%	151	0.5%	488	1.3%	488	1.3%			0.8%
15	71,304	103,895	45.7%	947	1.3%	540	0.5%	540	0.5%			-0.8%
16	175,740	215,403	22.8%	992	0.8%	562	0.3%	562	0.3%			-0.3%
17	82,808	83,733	33.3%	584	0.9%	1,325	1.8%	1,325	1.8%			0.7%
18	56,500	70,075	24.0%	455	0.8%	781	1.1%	781	1.1%			0.3%
19	35,899	36,647	2.1%	823	1.7%	590	1.6%	590	1.6%			-0.1%
20	73,140	83,410	14.0%	1,308	1.8%	313	0.4%	313	0.4%			-1.4%
21	82,962	80,174	27.9%	1,129	1.8%	798	1.0%	798	1.0%			-0.8%
22	80,431	78,148	-2.8%	1,725	2.1%	2,184	2.8%	2,184	2.8%			0.7%
<b>TOTAL</b>	<b>1,697,872</b>	<b>1,940,194</b>	<b>29.7%</b>	<b>20,130</b>	<b>1.3%</b>	<b>13,778</b>	<b>0.7%</b>	<b>13,778</b>	<b>0.7%</b>			<b>-0.8%</b>

Source: Monthly Delayed Prosthetic Order Report  
 B - 6

TABLE #6B DELAYED PROSTHETIC ORDERS - FY 1986 AND FY 1987

STATION #	TOTAL ORDERS RECEIVED				TOTAL DELAYED ORDERS											
	A		B		C		D		E		F		G		H	
	FY 86	FY 87	FY 86	FY 87	FY 86	% Change	FY 86	% Delayed	FY 86	% Delayed	FY 87	% Delayed	FY 87	% Delayed	FY 86 / FY 87	% of Change
462	6553	12038	40.7%	82	1.0%	91	0.7%									-0.3%
465	7667	25.8%	9	0.1%	59	0.6%										0.7%
518	2161	46.0%	23	1.6%	52	2.4%										0.8%
523	18889	20057	6.2%	1202	6.4%	72	0.4%									-6.0%
525	12117	16940	39.8%	734	6.1%	70	0.4%									-5.7%
608	4183	5069	21.2%	112	2.7%	12	0.2%									-2.5%
631	1766	2435	37.9%	25	1.4%	0	0.0%									-1.4%
650	8471	18.6%	23	0.3%	37	0.4%										0.1%
68088844	9715	12797	31.7%	115	1.2%	197	1.5%									0.3%
	68,818	87,838	26.3%	2,328	3.3%	680	0.7%									-3.6%
TOTAL																
500	9901	12247	25.0%	25	0.3%	26	0.2%									-0.1%
514	1939	2235	15.3%	87	4.5%	0	0.0%									-4.5%
52852844	12148	12564	3.6%	26	0.2%	0	0.0%									-0.2%
532	542	667	23.1%	0	0.0%	6	0.9%									0.9%
670	13153	15644	18.9%	249	1.9%	107	0.7%									-1.2%
	37,683	43,377	16.4%	316	1.9%	139	0.3%									-4.7%
TOTAL																
526	10366	11430	10.3%	0	0.0%	0	0.0%									0.0%
527	8108	10606	33.3%	0	0.0%	0	0.0%									0.0%
533	3924	7039	79.4%	6	0.2%	0	0.0%									-0.2%
561/604	13967	19710	41.1%	423	3.0%	0	0.0%									-3.0%
620	1907	6059	235.3%	101	5.6%	0	0.0%									-5.6%
630	17837	19067	6.9%	0	0.0%	0	0.0%									0.0%
632	7638	14008	83.4%	15	0.2%	0	0.0%									-0.2%
	62,647	86,121	28.8%	646	8.9%	6	0.9%									-4.9%
TOTAL																

\*FY 97 Figures reflect 11 months of data

Source: FY 1986 and FY 1997 Monthly Delayed Prosthetic Order Report B - 6

TABLE #6B DELAYED PROSTHETIC ORDERS - FY 1996 AND FY 1997

STATION #	TOTAL ORDERS RECEIVED				TOTAL DELAYED ORDERS							
	A		C		D	E	F	G	H			
	FY 96	FY 97	FYMP197	% Change						FY 96	FY 97	FY 96 / FY 97
480 WILMINGTON, DE	6548	8374	27.9%	27.9%	125	1.9%	5	0.1%	-1.8%			
503 ALTOONA, PA	1725	2604	61.6%	38.7%	0	0.0%	22	0.6%	0.6%			
528 BUTLER, PA	2467	3447	38.7%	0	0	0.0%	0	0.0%	0.0%			
540 CLARKSBURG, WV	4635	8178	75.4%	0	0	0.0%	0	0.0%	0.0%			
542 COATESVILLE, PA	1143	1900	31.2%	0	0	0.0%	0	0.0%	0.0%			
562 ERIE, PA	2315	2980	28.2%	22	1.0%	6	0.3%	-0.7%				
565 LEBANON, PA	9659	9053	-6.3%	22	0.2%	2	0.0%	-0.2%				
642 PHILADELPHIA, PA	13368	17527	30.9%	244	1.8%	254	1.9%	-0.5%				
645640 PITTSBURGH H.C. SYSTEM	6876	10019	45.7%	0	0.0%	0	0.0%	0.0%				
683 WILKES-BARRE, PA	12717	14314	12.6%	136	1.1%	100	0.7%	-0.4%				
<b>TOTAL</b>	<b>81,448</b>	<b>78,168</b>	<b>37.1%</b>	<b>848</b>	<b>8.8%</b>	<b>371</b>	<b>6.3%</b>	<b>-6.4%</b>				
51251240A MARYLAND H.C. SYSTEM	12030	20792	72.8%	23	0.2%	177	0.6%	1.5%				
613 MARTINSBURG, WV	4895	7009	48.3%	83	1.3%	15	0.2%	-1.1%				
688 WASHINGTON, DC	15535	25618	64.9%	140	0.9%	401	1.6%	0.7%				
<b>TOTAL</b>	<b>32,260</b>	<b>83,419</b>	<b>64.8%</b>	<b>228</b>	<b>6.7%</b>	<b>683</b>	<b>1.1%</b>	<b>6.4%</b>				
517 BECKLEY, WV	5598	9389	67.4%	0	0.0%	0	0.0%	0.0%				
558 DURHAM, NC	11119	13649	22.6%	0	0.0%	1	0.0%	0.0%				
565 FAYETTEVILLE, NC	9600	8983	-6.4%	38	0.4%	0	0.0%	-0.4%				
590 HAMPTON, VA	10520	11458	8.7%	672	6.4%	310	2.7%	-5.7%				
637 ASHEVILLE, NC	9214	8640	-6.1%	121	1.3%	208	2.1%	0.8%				
652 RICHMOND, VA	31580	30715	-2.8%	702	2.2%	89	0.2%	-2.0%				
658 SALEM, VA	22830	28218	23.6%	389	1.7%	823	3.3%	1.8%				
659 SAUSBURY, NC	10784	12873	12.0%	310	2.9%	1	0.0%	-2.9%				
<b>TOTAL</b>	<b>111,213</b>	<b>133,281</b>	<b>19.8%</b>	<b>1,231</b>	<b>2.6%</b>	<b>1833</b>	<b>1.3%</b>	<b>-4.3%</b>				

\*FY 97 Figures reflect 11 months of data  
 Source: FY 1996 and FY 1997 Monthly Delayed Prosthetic Order Report B-7

TABLE #6B DELAYED PROSTHETIC ORDERS - FY 1996 AND FY 1997

STATION #	TOTAL ORDERS RECEIVED				TOTAL DELAYED ORDERS							
	A	B	C	D	E	F	G	H	FY 96 / FY 97 % of Change			
	FY 96	FY 97	FY 96 / FY 97 % Change	FY 96	% Delayed	FY 97	% Delayed	FY 97		% Delayed		
508 ATLANTA, GA	21200	29313	24.1%	243	1.1%	203	0.8%	0.8%	-0.3%			
509 AUGUSTA, GA	12113	16654	58.6%	281	2.3%	0	0.0%	0.0%	-2.3%			
521 BIRMINGHAM, AL	14404	14293	-1.0%	197	1.4%	27	0.2%	0.2%	-1.2%			
534 CHARLESTON, SC	11058	11540	4.4%	695	6.3%	311	2.7%	3.0%	-3.6%			
544 COLUMBIA, SC	9857	13274	37.5%	185	1.9%	308	2.3%	2.3%	0.4%			
557 DUBLIN, GA	6529	6812	4.3%	14	0.2%	16	0.2%	0.2%	0.0%			
6194690 CENTRAL ALABAMA H.C.S.	20025	19433	-3.0%	37	0.2%	0	0.0%	0.0%	-0.2%			
679 TUSCALOOSA, AL	2240	3140	40.2%	0	0.0%	3	0.1%	0.1%	0.1%			
<b>TOTAL</b>	<b>87,428</b>	<b>114,339</b>	<b>17.3%</b>	<b>1,852</b>	<b>1.7%</b>	<b>886</b>	<b>0.8%</b>	<b>0.8%</b>	<b>-0.8%</b>			
518 BAY PINES, FL	17810	23200	31.7%	0	0.0%	0	0.0%	0.0%	0.0%			
546 MIAMI, FL	14859	18993	27.8%	6	0.0%	1	0.0%	0.0%	0.0%			
546 WEST PALM BEACH, FL	14223	23470	65.0%	259	1.8%	117	0.5%	0.5%	-1.3%			
573 GAINESVILLE, FL	25238	25563	1.3%	0	0.0%	168	0.6%	0.6%	0.6%			
584 LAKE CITY, FL	5401	6690	27.8%	76	1.4%	0	0.0%	0.0%	-1.4%			
672 SAN JUAN, PR	19373	30498	57.4%	398	2.1%	415	1.4%	1.4%	-0.7%			
673 TAMPA, FL	41581	44694	7.5%	0	0.0%	173	0.4%	0.4%	0.4%			
<b>TOTAL</b>	<b>138,383</b>	<b>173,378</b>	<b>24.3%</b>	<b>738</b>	<b>0.5%</b>	<b>872</b>	<b>0.4%</b>	<b>0.4%</b>	<b>0.0%</b>			
561 HUNTINGTON, WV	8712	8378	24.6%	98	1.5%	11	0.1%	0.1%	-1.4%			
586 LEXINGTON, KY	4463	5643	30.9%	22	0.5%	11	0.2%	0.2%	-0.3%			
603 LOUISVILLE, KY	8993	10448	18.2%	788	8.7%	0	0.0%	0.0%	-8.7%			
614 MEMPHIS, TN	48011	47898	0.2%	0	0.0%	0	0.0%	0.0%	0.0%			
621 MOUNTAIN HOME, TN	10351	13341	28.9%	54	0.5%	564	4.2%	4.2%	3.7%			
622 MURFREESBORO, TN	4811	6952	50.8%	1	0.0%	0	0.0%	0.0%	0.0%			
626 NASHVILLE, TN	10785	12652	11.7%	67	0.6%	61	0.5%	0.5%	-0.1%			
<b>TOTAL</b>	<b>93,928</b>	<b>104,912</b>	<b>11.7%</b>	<b>1,028</b>	<b>1.1%</b>	<b>647</b>	<b>0.6%</b>	<b>0.6%</b>	<b>-0.6%</b>			

\*FY 97 Figures reflect 11 months of data  
 Source: FY 1996 and FY 1997 Monthly Delayed Prosthetic Order Report  
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TABLE 48B DELAYED PROSTHETIC ORDERS - FY 1986 AND FY 1987

STATION #	TOTAL ORDERS RECEIVED				TOTAL DELAYED ORDERS									
	A		B		C		D		E		F		G	
	FY 86	FY 87	FY 87	% Change	FY 87	% Change	FY 86	% Delayed	FY 86	% Delayed	FY 87	% Delayed	FY 87	% of Change
538 CHILlicothe, OH	428	6018	38.8%	23	0.5%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	-0.5%
538 Cincinnati, OH	11675	11661	-1.6%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0.0%
541 CLEVELAND, OH	12801	13003	4.0%	75	0.6%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	-0.6%
562 DAYTON, OH	5688	5648	-4.9%	128	2.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	-2.2%
757 COLUMBUS, OH	4591	7888	74.0%	88	2.1%	140	1.6%	140	1.6%	140	1.6%	140	1.6%	-0.3%
<b>TOTAL</b>	<b>28,987</b>	<b>44,817</b>	<b>14.8%</b>	<b>322</b>	<b>0.8%</b>	<b>148</b>	<b>0.2%</b>	<b>148</b>	<b>0.2%</b>	<b>148</b>	<b>0.2%</b>	<b>148</b>	<b>0.2%</b>	<b>-4.5%</b>
508 ANN ARBOR, MI	22274	21840	-1.9%	128	0.6%	25	0.1%	25	0.1%	25	0.1%	25	0.1%	-0.5%
515 BATTLE CREEK, MI	3753	5559	48.1%	12	0.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	-0.3%
650 DANVILLE, IL	5408	8750	61.8%	118	2.2%	68	0.8%	68	0.8%	68	0.8%	68	0.8%	-1.4%
553 DETROIT, MI	7179	10613	47.8%	0	0.0%	10	0.1%	10	0.1%	10	0.1%	10	0.1%	0.1%
583 INDIANAPOLIS, IN *	15419	13775	-10.7%	252	1.6%	142	1.0%	142	1.0%	142	1.0%	142	1.0%	-0.6%
61061044 NORTHERN INDIANA H.C.S.	4014	4526	12.8%	85	2.1%	10	0.2%	10	0.2%	10	0.2%	10	0.2%	-1.6%
655 BAGINAW, MI	3488	4488	27.8%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0.0%
<b>TOTAL</b>	<b>61,847</b>	<b>89,828</b>	<b>12.8%</b>	<b>888</b>	<b>1.6%</b>	<b>288</b>	<b>0.4%</b>	<b>288</b>	<b>0.4%</b>	<b>288</b>	<b>0.4%</b>	<b>288</b>	<b>0.4%</b>	<b>-4.8%</b>
536 CHICAGO (S.I.), IL	7618	6083	-7.3%	15	0.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	-0.2%
537 CHICAGO (M8), IL	13220	15261	15.7%	82	0.5%	43	0.3%	43	0.3%	43	0.3%	43	0.3%	-0.2%
558 NORTH CHICAGO, IL	4828	6774	40.1%	0	0.0%	10	0.1%	10	0.1%	10	0.1%	10	0.1%	0.1%
578 HINES, IL	32450	38583	12.8%	148	0.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	-0.6%
565 IRON MOUNTAIN, MI	1851	2465	31.9%	5	0.3%	38	1.6%	38	1.6%	38	1.6%	38	1.6%	1.2%
607 MADISON, WI	6627	8063	30.8%	175	2.5%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	-2.5%
678 TOMAH, WI	2608	3028	12.3%	35	1.3%	12	0.4%	12	0.4%	12	0.4%	12	0.4%	-0.8%
685 MELWAUSEE, WI	23871	20888	-12.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0.0%
<b>TOTAL</b>	<b>62,387</b>	<b>162,276</b>	<b>9.6%</b>	<b>448</b>	<b>0.6%</b>	<b>164</b>	<b>0.1%</b>	<b>164</b>	<b>0.1%</b>	<b>164</b>	<b>0.1%</b>	<b>164</b>	<b>0.1%</b>	<b>-4.1%</b>

\*FY 87 Figures reflect 11 months of data

Source: FY 1986 and FY 1987 Monthly Delayed Prosthetic Order Report B - 5

APPENDIX - B

TABLE #48 DELAYED PROSTHETIC ORDERS - FY 1986 AND FY 1987

STATION #	TOTAL ORDERS RECEIVED				TOTAL DELAYED ORDERS											
	A		B		C		D		E		F		G		H	
	FY 86	FY 87	FY 86/FY 87 % Change	FY 86/FY 87 % Change	FY 86	FY 87	FY 86 % Delayed	FY 87 % Delayed	FY 86	FY 87	FY 86 % Delayed	FY 87 % Delayed	FY 86 % Delayed	FY 87 % Delayed	FY 86 % of Change	FY 87 % of Change
437	8049	8723	8.4%	8.4%	80	91	1.1%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
438	8413	7512	17.1%	17.1%	0	3	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
966079	8754	8997	7.5%	7.5%	52	2	0.6%	0.0%	2	0.0%	0.0%	0.0%	0.0%	0.0%	-0.5%	-0.5%
618	32978	32568	1.2%	1.2%	1024	13	3.1%	0.0%	13	0.0%	0.0%	0.0%	0.0%	0.0%	-3.1%	-3.1%
656	874	1813	118.9%	118.9%	0	0	0.0%	0.0%	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>TOTAL</b>	<b>87,888</b>	<b>88,813</b>	<b>3.1%</b>	<b>3.1%</b>	<b>1,166</b>	<b>198</b>	<b>2.6%</b>	<b>6.2%</b>	<b>198</b>	<b>6.2%</b>	<b>1.9%</b>	<b>6.2%</b>	<b>6.2%</b>	<b>6.2%</b>	<b>-1.8%</b>	<b>-1.8%</b>
555	10544	12101	14.8%	14.8%	19	174	0.2%	1.4%	174	1.4%	0.2%	1.4%	1.4%	1.2%	1.2%	1.2%
574	561	1002	78.6%	78.6%	7	34	1.2%	3.4%	34	3.4%	1.2%	3.4%	3.4%	2.2%	2.2%	2.2%
594	6329	7017	10.9%	10.9%	26	103	0.4%	1.5%	103	1.5%	0.4%	1.5%	1.5%	1.1%	1.1%	1.1%
592	3528	3656	8.4%	8.4%	84	135	2.4%	3.5%	135	3.5%	2.4%	3.5%	3.5%	1.1%	1.1%	1.1%
*597	2091	2441	16.7%	16.7%	11	0	0.5%	0.0%	0	0.0%	0.5%	0.0%	0.0%	0.0%	-0.5%	-0.5%
636	9638	10450	8.4%	8.4%	4	22	0.0%	0.2%	22	0.2%	0.0%	0.2%	0.2%	0.2%	0.2%	0.2%
<b>TOTAL</b>	<b>32,889</b>	<b>36,887</b>	<b>12.2%</b>	<b>12.2%</b>	<b>151</b>	<b>488</b>	<b>0.5%</b>	<b>1.3%</b>	<b>488</b>	<b>1.3%</b>	<b>0.5%</b>	<b>1.3%</b>	<b>1.3%</b>	<b>0.8%</b>	<b>0.8%</b>	<b>0.8%</b>
462	7930	13294	67.8%	67.8%	56	0	0.7%	0.0%	0	0.0%	0.7%	0.0%	0.0%	0.0%	-0.7%	-0.7%
543	6535	11365	73.9%	73.9%	53	7	0.8%	0.1%	7	0.1%	0.8%	0.1%	0.1%	0.1%	-0.7%	-0.7%
598	19850	24492	22.3%	22.3%	100	418	0.5%	1.7%	418	1.7%	0.5%	1.7%	1.7%	1.2%	1.2%	1.2%
608	6248	9415	50.7%	50.7%	0	8	0.0%	0.1%	8	0.1%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%
647	2688	3105	15.2%	15.2%	0	35	0.0%	1.1%	35	1.1%	0.0%	1.1%	1.1%	1.1%	1.1%	1.1%
657	20939	31274	48.4%	48.4%	390	66	1.9%	0.2%	66	0.2%	1.9%	0.2%	0.2%	0.2%	-1.7%	-1.7%
677	2288	2648	15.7%	15.7%	2	5	0.0%	0.2%	5	0.2%	0.0%	0.2%	0.2%	0.2%	0.2%	0.2%
688	4717	8300	76.0%	76.0%	346	0	7.3%	0.0%	0	0.0%	7.3%	0.0%	0.0%	0.0%	-7.3%	-7.3%
<b>TOTAL</b>	<b>71,384</b>	<b>103,896</b>	<b>46.7%</b>	<b>46.7%</b>	<b>847</b>	<b>648</b>	<b>1.3%</b>	<b>6.6%</b>	<b>648</b>	<b>6.6%</b>	<b>1.3%</b>	<b>6.6%</b>	<b>6.6%</b>	<b>6.6%</b>	<b>-8.8%</b>	<b>-8.8%</b>

\*FY 87 Figures reflect 11 months of data

Sources: FY 1986 and FY 1987 Monthly Delayed Prosthetic Order Report B - 10

TABLE #8B DELAYED PROSTHETIC ORDERS - FY 1986 AND FY 1987

STATION #	TOTAL ORDERS RECEIVED				TOTAL DELAYED ORDERS							
	A	B	C		D	E	F	G	H			
	FY 86	FY 87	FY 86/FY 87 % Change		FY 86	FY 86 % Delayed	FY 87	FY 87 % Delayed	FY 86 / FY 87 % of Change	FY 87 % of Change		
502 ALEXANDRIA, LA	12461	21470	72.4%		0	0.0%	0	0.0%		0.0%		
520 BALDVI, MS	14563	16653	15.8%		0	0.0%	0	0.0%		0.0%		
564 FAYETTEVILLE, AR	4519	5442	20.4%		0	0.0%	0	0.0%		0.0%		
500 HOUSTON, TX	26550	31059	17.0%	46	0.2%	0	0.0%			-0.2%		
506 JACKSON, MS	10271	15565	51.5%	113	1.1%	72	0.5%			-0.6%		
598 LITTLE ROCK, AR	66539	78145	14.4%	210	0.3%	45	0.1%			-0.2%		
623 MUSKOGEE, OK	8785	8402	-2.2%	9	0.1%	0	0.0%			-0.1%		
629 NEW ORLEANS, LA	13659	13464	-1.4%	0	0.0%	0	0.0%			0.0%		
635 OKLAHOMA CITY, OK	16628	16667	0.2%	452	2.6%	323	1.8%			-1.0%		
867 SHREVEPORT, LA	3370	6977	107.0%	182	5.4%	122	1.7%			-3.7%		
<b>TOTAL</b>	<b>178,748</b>	<b>218,483</b>	<b>23.8%</b>	<b>892</b>	<b>0.8%</b>	<b>842</b>	<b>0.3%</b>			<b>-4.3%</b>		
522/540 NORTH TEXAS H.C.S.	20359	29281	45.8%	39	0.2%	154	0.5%			0.3%		
671/671A4 SOUTH TEXAS VETS H.C.S.	20468	25669	26.1%	0	0.0%	59	0.2%			0.2%		
674/674A4A CENTRAL TEXAS H.C.S.	21983	28643	30.3%	555	2.5%	1112	3.8%			1.4%		
<b>TOTAL</b>	<b>63,888</b>	<b>83,733</b>	<b>31.2%</b>	<b>884</b>	<b>0.8%</b>	<b>1325</b>	<b>1.8%</b>			<b>6.7%</b>		
501 ALBUQUERQUE, NM	16549	20280	22.4%	100	0.8%	154	0.8%			0.2%		
504 AMARILLO, TX	6151	7015	14.0%	0	0.0%	0	0.0%			0.0%		
519 BIG SPRING, TX	2088	2221	6.4%	4	0.2%	0	0.0%			-0.2%		
644 PHOENIX, AZ	10447	13078	32.6%	324	3.1%	238	1.7%			-1.4%		
649 PRESCOTT, AZ	4077	5349	31.2%	0	0.0%	0	0.0%			0.0%		
678 TUCSON, AZ	14489	18223	25.8%	27	0.2%	231	1.3%			1.1%		
756 EL PASO, TX	2700	3131	16.0%	0	0.0%	158	5.0%			3.0%		
<b>TOTAL</b>	<b>61,006</b>	<b>76,876</b>	<b>24.6%</b>	<b>485</b>	<b>0.8%</b>	<b>781</b>	<b>1.1%</b>			<b>0.3%</b>		

Source: FY 1986 and FY 1987 Monthly Delayed Prosthetic Order Report  
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\*FY 87 Figures reflect  
11 months of data

TABLE #6B DELAYED PROSTHETIC ORDERS - FY 1996 AND FY 1997

STATION #	TOTAL ORDERS RECEIVED				TOTAL DELAYED ORDERS											
	A		B		C		D		E		F		G		H	
	FY 96	FY 97	FY 96	FY 97	FY 96	% Change	FY 96	% Delayed	FY 96	% Delayed	FY 97	% Delayed	FY 96	% Delayed	FY 97	% of Change
436	9076	9408			3.6%		29	0.3%			0	0.0%				0.3%
442	4595	4510			-1.8%		135	2.9%			35	1.2%				-1.7%
554	5474	5789			5.8%		426	7.8%			211	3.8%				-4.2%
567	859	859			0.0%		0	0.0%			0	0.0%				0.0%
575	1976	2190			10.6%		26	1.3%			0	0.0%				-1.3%
617	941	1076			14.3%		0	0.0%			0	0.0%				0.0%
660	11068	10740			-4.0%		7	0.1%			257	2.4%				2.3%
666	1306	2079			58.9%		0	0.0%			67	3.2%				3.2%
<b>TOTAL</b>	<b>36,889</b>	<b>36,647</b>			<b>1.1%</b>		<b>633</b>	<b>1.7%</b>			<b>890</b>	<b>1.8%</b>				<b>-4.1%</b>
463	2895	3067			10.4%		6	0.2%			0	0.0%				-0.2%
531	7485	8940			19.4%		15	0.2%			44	0.5%				0.3%
648	17023	19322			13.5%		81	0.5%			125	0.8%				0.1%
653	4460	6885			54.6%		69	1.5%			0	0.0%				-1.5%
663/605	31968	34433			7.7%		1052	3.3%			105	0.3%				-3.0%
668	4832	5938			20.4%		55	1.1%			32	0.5%				-0.6%
667	2068	2254			9.0%		29	1.4%			6	0.3%				-1.1%
682	2399	2531			5.5%		1	0.0%			1	0.0%				0.0%
<b>TOTAL</b>	<b>73,140</b>	<b>83,410</b>			<b>14.0%</b>		<b>1,308</b>	<b>1.8%</b>			<b>313</b>	<b>0.4%</b>				<b>-1.4%</b>
456	3573	4155			16.3%		0	0.0%			0	0.0%				0.0%
570	7104	10894			53.2%		103	1.4%			0	0.0%				-1.4%
612	12854	15030			18.6%		67	0.5%			128	0.9%				0.4%
358	115	28			-75.7%		0	0.0%			0	0.0%				0.0%
640/569	28222	22428			-13.6%		103	0.5%			350	1.5%				1.0%
654	4965	10773			118.6%		367	7.5%			233	2.2%				-5.3%
662	13689	15676			16.0%		468	3.0%			85	0.5%				-3.1%
<b>TOTAL</b>	<b>62,862</b>	<b>80,174</b>			<b>27.5%</b>		<b>1,128</b>	<b>1.8%</b>			<b>786</b>	<b>1.0%</b>				<b>-4.8%</b>

\*FY 97 Figures reflect 11 months of data  
 Source: FY 1996 and FY 1997 Monthly Delayed Prosthetic Order Report  
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TABLE #88 DELAYED PROSTHETIC ORDERS - FY 1986 AND FY 1987

	TOTAL COURSES RECEIVED				TOTAL DELAYED COURSES											
	A		B		C		D		E		F		G		H	
	FY 86	FY 87	FY 87	% Change	FY 87	% Change	FY 86	% Delayed	FY 86	% Delayed	FY 87	% Delayed	FY 87	% Delayed	FY 86 / FY 87	% of Change
803 LAS VEGAS, NV	3078	5843		41.8%	207	5.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%		-5.2%
800 LONG BEACH, CA	2892	2214		5.2%	139	0.7%	0	0.0%	0	0.0%	0	0.0%	0	0.0%		-0.7%
805 LOMA LINDA, CA	11468	11288		-1.1%	288	2.8%	1905	16.9%	1905	16.9%	1905	16.9%	1905	16.9%		14.3%
804 SAN DIEGO, CA	18177	17083		11.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%		0.0%
885/782 SOUTHERN CA H.C.S.	6355	6023		-5.2%	188	4.8%	38	1.4%	38	1.4%	38	1.4%	38	1.4%		-2.0%
801 WEST LOS ANGELES, CA	18510	18018		-13.5%	854	4.8%	183	1.2%	183	1.2%	183	1.2%	183	1.2%		-3.8%
<b>TOTAL</b>	<b>88,831</b>	<b>78,148</b>		<b>-2.8%</b>	<b>1,728</b>	<b>2.1%</b>	<b>2184</b>	<b>2.5%</b>	<b>2184</b>	<b>2.5%</b>	<b>2178</b>	<b>2.5%</b>	<b>2178</b>	<b>2.5%</b>		<b>0.7%</b>
	<b>1,887,873</b>	<b>1,540,184</b>		<b>20.7%</b>	<b>28,138</b>	<b>1.5%</b>	<b>13,778</b>	<b>0.7%</b>	<b>13,778</b>	<b>0.7%</b>	<b>13,778</b>	<b>0.7%</b>	<b>13,778</b>	<b>0.7%</b>		<b>-4.8%</b>

\*FY 87 Figures reflect 11 months of data

Source: FY 1986 and FY 1987 Monthly Delayed Prosthetic Order Report

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TABLE 7A

Timeliness of Access to Outpatient Services Among Seriously Mentally Ill Veterans during the First Six Months Following Discharge, 10/1/95 through 3/31/96, 10/1/96 through 3/31/97, and change, by VISN.

VISN	OUTPATIENT GENERAL PSYCHIATRY						Change	Days to 1st OP Stop in 6 mos. After DC (PT 1996)	Days to 1st OP Stop in 6 mos. After DC (PT 1997)	Change
	Any Psych. Outpatient Stop in 30 days After DC (PT 1996)	Any Psych. Outpatient Stop in 30 days After DC (PT 1997)	Change	Days to 1st OP Stop in 6 mos. After DC (PT 1996)	Days to 1st OP Stop in 6 mos. After DC (PT 1997)	Change				
1	59.2%	60.0%	0.8%	27.65	25.63	-2.02				
2	57.8%	62.9%	5.1%	31.76	25.74	-6.02				
3	56.5%	50.4%	-6.1%	31.76	31.06	-0.70				
4	52.4%	52.4%	0.0%	35.38	33.98	-1.40				
5	50.7%	62.0%	11.3%	35.65	24.67	-10.98				
6	44.8% X	44.2% X	-0.6%	38.12 X	37.59 X	-0.53				
7	42.9% X	47.1%	4.2%	40.17 X	35.83 X	-4.34				
8	53.3%	50.9%	-2.4%	33.38	34.49	1.11				
9	49.4%	44.1% X	-5.3%	34.81	36.40 X	1.59				
10	50.6%	56.2%	5.6%	33.87	31.47	-2.40				
11	51.4%	52.2%	0.8%	34.75	32.74	-2.01				
12	51.4%	48.8%	-2.6%	34.19	33.37	-0.82				
13	50.8%	59.1%	8.3%	33.37	27.36	-6.01				
14	49.4%	48.4%	-1.0%	36.06	34.15	-1.91				
15	59.6%	63.1%	3.5%	30.85	26.27	-4.58				
16	45.8% X	48.3%	2.5%	36.85 X	34.87	-1.98				
17	51.4%	46.5% X	-4.9%	34.08	34.17	0.09				
18	52.9%	53.0%	0.1%	32.95	29.92	-3.03				
19	47.8%	45.6% X	-2.2%	34.78	37.26 X	2.48				
20	48.9%	48.9%	0.0%	34.71	32.31	-2.40				
21	58.5%	57.6%	-0.9%	28.30	27.64	-0.66				
22	59.9%	57.9%	-2.0%	27.83	29.00	1.17				
Average	52.1%	52.7%	0.6%	33.69	31.63	-2.06				
S.D.	4.7%	6.0%	3.05	3.05	3.94	0.89				
C.V.	0.09	0.11	0.09	0.09	0.12	0.12				

VISNs or facilities marked by an "X" are over 1 Standard Deviation (S.D.) from the mean in an undesirable direction.

Note: Risk adjusted for differences in patient characteristics, distance of residence from VA, diagnosis, etc.

Source: Patient Treatment File and Staff Outpatient File

## APPENDIX - B

TABLE 7B

Timeliness of Access to Outpatient Services Among Seriously Mentally Ill Veterans During the First Six Months Following Discharge, 10/1/95 through 3/31/96, 10/1/96 through 3/31/97, and change, by Facility.

STATION #	OUTPATIENT SMI, GENERAL PSYCHIATRY				Change	Days to 1st OP Stop in 6 mos. After DC (FY 1996)	Days to 1st OP Stop in 6 mos. After DC (FY 1997)	Change
	Any Psych. Outpatient Stop in 30 days After DC (FY 1996)	Any Psych. Outpatient Stop in 30 days After DC (FY 1997)	Change	Change				
402	40.3%	44.4%	4.1%	38.48	36.30	-2.18		
405	58.0%	60.7%	2.7%	26.83	23.11	-3.72		
518	37.0%	61.8%	4.8%	26.14	23.48	-2.66		
523	62.7%	64.0%	1.3%	23.95	23.18	-0.77		
525	64.0%	66.3%	2.3%	26.53	22.99	-3.54		
608	50.2%	N/A	N/A	33.72	N/A	N/A		
631	53.8%	53.1%	-0.7%	30.36	29.83	-0.53		
650	58.6%	70.3%	11.7%	27.12	22.53	-4.59		
689	64.3%	72.0%	7.7%	20.67	14.12	-6.55		
TOTAL	59.2%	60.0%	0.8%	27.65	25.63	-2.02		
STATION #								
500	53.2%	72.4%	19.2%	30.63	15.94	-14.69		
514	59.9%	62.6%	2.7%	32.60	27.53	-5.07		
528	56.5%	59.8%	3.3%	31.14	28.89	-2.25		
532	60.8%	70.8%	10.0%	23.16	19.04	-4.12		
670	54.1%	57.8%	3.7%	37.43	31.96	-5.47		
TOTAL	57.8%	62.9%	5.1%	31.76	25.74	-6.02		
STATION #								
526	66.8%	66.2%	-0.6%	20.24	18.41	-1.83		
527	62.8%	50.7%	-12.1%	23.49	29.16	5.67		
561	42.4%	37.2%	-5.2%	37.25	34.16	-3.09		
604	50.2%	N/A	N/A	37.00	N/A	N/A		
620	59.6%	62.1%	2.5%	27.59	21.61	-5.98		
630	56.2%	53.4%	-2.8%	34.02	31.39	-2.63		
632	50.7%	52.4%	1.7%	35.48	33.22	-2.26		
TOTAL	56.5%	50.4%	-6.1%	31.76	31.06	-0.70		

Source: Patient Treatment File and Staff Outpatient File

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APPENDIX - B

TABLE 7B

Timeliness of Access to Outpatient Services Among Seriously Mentally Ill Veterans During the First Six Months Following Discharge, 10/1/95 through 3/31/96, 10/1/96 through 3/31/97, and change, by Facility.

STATION #	OUTPATIENT SMIL GENERAL PSYCHIATRY				Change	Days to 1st OP Stop in 6 mos. After DC (FY 1996)	Days to 1st OP Stop in 6 mos. After DC (FY 1997)	Change
	Any Psych. Outpatient Stop in 30 days After DC (FY 1996)	Any Psych. Outpatient Stop in 30 days After DC (FY 1997)	Change	Days to 1st OP Stop in 6 mos. After DC (FY 1996)				
<b>MASS.</b>								
460	43.2%	43.2%	N/A	42.79	X	N/A	N/A	N/A
529	50.2%	50.2%	N/A	33.72		N/A	N/A	N/A
540	55.3%	61.6%	6.3%	31.06		30.15	30.15	-0.91
542	54.6%	57.3%	2.7%	30.34		29.44	29.44	-0.90
595	44.1%	47.6%	3.5%	40.05		39.59	39.59	-0.46
642	56.2%	60.2%	4.0%	30.42		27.84	27.84	-2.58
645	47.6%	32.8%	X	38.34		43.32	43.32	4.98
646	58.1%	58.1%	N/A	N/A		29.49	29.49	N/A
693	47.7%	48.4%	0.7%	35.57		37.06	37.06	1.49
<b>TOTAL</b>	<b>52.4%</b>	<b>52.4%</b>	<b>0.0%</b>	<b>35.38</b>		<b>33.98</b>	<b>33.98</b>	<b>-1.40</b>
<b>MISSOURI</b>								
<b>TOTAL</b>	<b>57.3%</b>	<b>66.8%</b>	<b>9.5%</b>	<b>30.32</b>		<b>20.06</b>	<b>20.06</b>	<b>-10.26</b>
512	37.5%	51.3%	13.8%	38.50		35.19	35.19	-3.31
641	20.9%	20.9%	N/A	60.42	X	N/A	N/A	N/A
688	53.1%	67.3%	14.2%	32.15		20.71	20.71	-11.44
<b>TOTAL</b>	<b>50.7%</b>	<b>62.0%</b>	<b>11.3%</b>	<b>35.65</b>		<b>24.67</b>	<b>24.67</b>	<b>-10.98</b>
<b>NORTH CAROLINA</b>								
558	31.0%	38.4%	X	45.39	X	40.52	40.52	-4.87
565	39.4%	46.3%	6.9%	48.24	X	35.31	35.31	-12.93
590	51.0%	55.7%	4.7%	29.70		31.28	31.28	1.58
637	33.6%	45.2%	11.6%	49.13	X	40.49	40.49	-8.64
652	30.5%	40.3%	X	42.62	X	40.71	40.71	-1.91
658	52.3%	47.7%	-4.6%	33.21		33.24	33.24	0.03
659	47.9%	50.7%	2.8%	34.37		32.48	32.48	-1.89
<b>TOTAL</b>	<b>44.8%</b>	<b>44.2%</b>	<b>-0.6%</b>	<b>38.12</b>	<b>X</b>	<b>37.59</b>	<b>37.59</b>	<b>-0.53</b>

Source: Patient Treatment File and Staff Outpatient File

TABLE 7B

Timeliness of Access to Outpatient Services Among Seriously Mentally Ill Veterans During the First Six Months Following Discharge, 10/1/95 through 3/31/96, 10/1/96 through 3/31/97, and change, by Facility.

STATION #	OUTPATIENT SMIL GENERAL PSYCHIATRY				Change	Days to 1st OP Stop in 6 mos. After DC (FY 1996)	Days to 1st OP Stop in 6 mos. After DC (FY 1997)	Change
	Any Psych. Outpatient Stop in 30 days After DC (FY 1996)	Any Psych. Outpatient Stop in 30 days After DC (FY 1997)	Change	Change				
508	53.0%	58.6%	5.6%	29.39	-0.59	29.39	-0.59	
509	48.1%	48.6%	0.5%	33.82	-1.38	33.82	-1.38	
521	50.2%	N/A	N/A	N/A	N/A	N/A	N/A	
534	50.1%	68.9%	18.8%	20.63	-12.13	20.63	-12.13	
544	40.4%	53.1%	12.7%	42.21	-3.35	35.35	-6.86	
557	39.9%	63.8%	23.9%	41.55	-15.66	25.89	-15.66	
619	41.4%	41.4% X	N/A	36.64	N/A	36.64	N/A	
679	42.8%	52.6%	9.8%	37.92	-7.92	30.00	-7.92	
680	31.7% X	38.3% X	6.6%	46.23 X	-4.47	41.78 X	-4.47	
TOTAL	42.9% X	47.1% X	4.2%	40.17 X	-4.34	35.83 X	-4.34	
STATION #								
516	48.3%	55.7%	7.4%	33.90	-2.04	31.86	-2.04	
546	47.8%	48.3%	0.7%	33.41	3.41	36.82	3.41	
548	N/A	57.9%	N/A	30.76	N/A	30.76	N/A	
573	49.7%	54.0%	4.3%	38.80	-8.93	29.87	-8.93	
594	38.2% X	41.2% X	3.0%	36.92	2.17	39.09 X	2.17	
672	44.0%	49.2%	5.2%	16.81	54.90 X	54.90 X	38.09	
673	57.5%	61.3%	3.8%	29.48	-2.80	26.68	-2.80	
TOTAL	53.3%	50.9%	-2.4%	33.38	1.11	34.49	1.11	
STATION #								
581	47.9%	57.5%	9.6%	36.11	-7.22	28.89	-7.22	
596	41.3%	43.7% X	2.4%	34.32	-4.72	29.60	-4.72	
603	42.0%	38.8% X	-3.2%	33.82	1.40	37.22	1.40	
614	55.6%	51.7%	-3.9%	29.41	1.11	30.32	1.11	
621	54.5%	52.1%	-2.4%	30.41	34.56	34.56	4.55	
622	48.1%	52.8%	4.7%	15.55	-2.15	33.40	-2.15	
626	48.1%	40.7% X	-7.3%	41.17	-1.18	39.99 X	-1.18	
TOTAL	49.4%	44.1% X	-5.3%	34.81	1.59	36.40 X	1.59	

Source: Patient Treatment File and Staff Outpatient File  
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TABLE 7B

Timeliness of Access to Outpatient Services Among Seriously Mentally Ill Veterans During the First Six Months Following Discharge, 10/1/95 through 3/31/96, 10/1/96 through 3/31/97, and change, by Facility.

STATION #	OUTPATIENT SVCS, GENERAL PSYCHIATRY										Change	
	Any Psych. Outpatient Stop in 30 days After DC (FY 1996)	Any Psych. Outpatient Stop in 30 days After DC (FY 1997)	Change	Days to 1st OP Stop in 6 mos. After DC (FY 1996)	Days to 1st OP Stop in 6 mos. After DC (FY 1997)	Change	Any Psych. Outpatient Stop in 30 days After DC (FY 1996)	Any Psych. Outpatient Stop in 30 days After DC (FY 1997)	Change	Days to 1st OP Stop in 6 mos. After DC (FY 1996)		Days to 1st OP Stop in 6 mos. After DC (FY 1997)
538	46.7%	58.2%	11.5%	36.51	33.57	-2.94						
539	35.0% X	54.6%	19.6%	43.47 X	28.20	-15.27						
541	36.8%	62.6%	5.8%	25.58	27.04	1.46						
552	50.4%	58.3%	7.9%	35.52	26.01	-9.51						
TOTAL	50.6%	56.2%	5.6%	33.87	31.47	-2.40						
506	58.1%	55.9%	-2.2%	26.69	28.82	2.13						
515	48.0%	56.8%	8.8%	34.09	30.56	-3.53						
550	57.5%	64.3%	6.8%	30.67	26.63	-4.04						
553	42.0%	43.5% X	1.5%	41.90 X	36.65	-5.25						
583	56.9%	65.7%	8.8%	31.83	21.62	-10.21						
610	48.7%	59.4%	10.7%	33.64	29.55	-4.09						
TOTAL	51.4%	52.2%	0.8%	34.75	32.74	-2.01						
535	43.8%	43.6% X	-0.2%	39.80	37.90 X	-1.90						
537	34.7%	58.9%	4.2%	32.31	25.39	-6.92						
556	36.6%	63.9%	7.3%	26.79	22.04	-4.75						
578	41.8%	41.2% X	-0.6%	38.18	38.85 X	0.67						
585	50.2%	N/A	N/A	33.72	N/A	N/A						
607	58.3%	56.3%	-2.0%	31.08	26.93	-4.15						
676	44.0%	44.8%	2.8%	38.74	35.55	-3.19						
693	68.2%	56.3%	-11.9%	23.06	32.74	9.68						
TOTAL	51.4%	48.8%	-2.6%	34.19	33.37	-0.82						

Source: Patient Treatment File and Staff Outpatient File

APPENDIX - B

TABLE 7B

Timeliness of Access to Outpatient Services Among Seriously Mentally Ill Veterans During the First Six Months Following Discharge, 10/1/95 through 3/31/96, 10/1/96 through 3/31/97, and change, by Facility.

STATION #	OUTPATIENT SMI, GENERAL PSYCHIATRY				Change	Drops to 1st OP Stop in 6 mos. After DC (FY 1996)	Drops to 1st OP Stop in 6 mos. After DC (FY 1997)	Change
	Any Psych. Outpatient Stop in 30 days After DC (FY 1996)	Any Psych. Outpatient Stop in 30 days After DC (FY 1997)	Change	Change				
437	FARGO	37.6% X	50.3%	12.7%	41.52	31.76	-9.76	
438	SIoux FALLS	42.0%	64.3%	22.3%	38.45	17.77	-20.68	
568	FORT MEADE†	44.4%	57.6%	13.2%	36.97	29.42	-7.55	
579	HOT SPRINGS†	71.9%		N/A	22.03		N/A	
618	MINNEAPOLIS	50.2%	61.1%	10.9%	32.07	26.27	-5.80	
656	ST CLOUD	55.0%	72.8%	17.8%	27.56	19.39	-8.17	
	TOTAL	50.8%	59.1%	8.3%	33.37	27.36	-6.01	
STATION #								
555	DIES MOINES†	22.6% X	41.8% X	19.2%	58.10 X	32.97	-25.13	
574	GRAND ISLAND†	50.2%		N/A	33.72		N/A	
584	IOWA CITY	42.7%	41.9% X	-0.8%	39.11	39.34 X	0.23	
592	KNOXVILLE IAT	49.1%	52.4%	3.3%	33.72	28.70	-5.02	
597	LINCOLN†	52.8%	55.5%	2.7%	36.71	33.51	-3.20	
636	OMAHA	51.8%	57.6%	5.8%	30.92	30.44	-0.48	
	TOTAL	49.4%	48.4%	-1.0%	36.06	34.15	-1.91	
STATION #								
452	WICHITA	50.3%	53.5%	3.2%	38.27	31.40	-6.87	
543	COLUMBIA MO	54.1%	62.1%	8.0%	26.88	21.38	-5.50	
589	KANSAS CITY	64.2%	74.1%	9.9%	17.13	18.63	1.50	
647	POPLAR BLUFF	33.6% X	40.6% X	7.0%	43.97 X	37.61 X	-6.36	
657	ST LOUIS-John Co	56.2%	60.7%	4.5%	31.74	28.29	-3.45	
677	TOPEKA	61.7%	66.4%	4.7%	26.91	23.42	-3.49	
686	LEAVENWORTH	68.9%	81.7%	12.8%	26.73	16.13	-10.60	
	TOTAL	59.6%	63.1%	3.5%	30.85	26.27	-4.58	

Source: Patient Treatment File and Staff Outpatient File

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APPENDIX - B

TABLE 7B

Timeliness of Access to Outpatient Services Among Seriously Mentally Ill Veterans During the First Six Months Following Discharge, 10/1/95 through 3/31/96, 10/1/96 through 3/31/97, and change, by Facility.

STATION #	OUTPATIENT SMI, GENERAL PSYCHIATRY				Change	Days to 1st OP Stop in 6 mos After DC (FY 1996)	Days to 1st OP Stop in 6 mos After DC (FY 1997)	Change
	Any Psych. Outpatient Stop in 30 days After DC (FY 1996)	Any Psych. Outpatient Stop in 30 days After DC (FY 1997)	Any Psych. Outpatient Stop in 6 mos After DC (FY 1996)	Any Psych. Outpatient Stop in 6 mos After DC (FY 1997)				
502	ALEXANDRIA	45.1%	61.2%	16.1%	36.35	26.76	-9.79	
520	BILOXI		31.0%	N/A		30.38	N/A	
564	FAYETTEVILLE AR	30.1% X	42.2% X	12.1%	45.33 X	38.74 X	-6.59	
590	HOUSTON	41.3%	49.7%	8.4%	38.42	33.25	-5.17	
586	JACKSON	41.5%	46.4%	4.9%	39.15	37.08	-2.07	
598	LITTLE ROCK	48.9%	57.9%	9.0%	33.83	26.67	-7.16	
629	NEW ORLEANS	56.6%	57.2%	0.6%	27.98	30.13	2.15	
635	OKLAHOMA CITY	37.2% X	42.0% X	4.8%	41.79 X	40.62 X	-1.17	
667	SHREVEPORT		58.7%	N/A		30.18	N/A	
	TOTAL	45.8% X	48.3%	2.5%	36.85 X	34.87	-1.98	
549	DALLAS	55.2%	59.2%	4.0%	24.37	25.00	0.63	
591	KERRVILLE	50.2%		N/A	33.72	N/A	N/A	
671	SAN ANTONIO	50.1%	36.4% X	-13.7%	36.10	40.61 X	4.51	
674	TEMPLE	48.1%	55.8%	7.7%	34.78	28.43	-6.35	
685	WACOT	25.3% X		N/A	59.17 X		N/A	
	TOTAL	51.4%	46.5% X	-4.9%	34.08	34.17	0.09	
501	ALBUQUERQUE	51.8%	55.4%	3.6%	26.99	28.63	1.64	
504	AMARILLO	50.2%		N/A	33.72		N/A	
519	BIG SPRING	41.6%	39.0% X	-2.6%	38.16	38.15 X	-0.01	
644	PHOENIX	49.5%	58.2%	8.7%	36.01	26.06	-9.95	
649	PRESCOTT	50.2%		N/A	33.72		N/A	
678	TUCSON	66.6%	63.5%	-3.1%	24.14	22.41	-0.73	
	TOTAL	52.9%	53.0%	0.1%	32.95	29.92	-3.03	

Source: Patient Treatment File and Staff Outpatient File  
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## APPENDIX - B

TABLE 7B

Timeliness of Access to Outpatient Services Among Seriously Mentally Ill Veterans During the First Six Months Following Discharge, 10/1/95 through 3/31/96, 10/1/96 through 3/31/97, and change, by Facility.

STATION #	OUTPATIENT SMI, GENERAL PSYCHIATRY				Change	Days to 1st OP Stop in 6 mos After DC (FY 1996)	Days to 1st OP Stop in 6 mos After DC (FY 1997)	Change
	Any Psych. Outpatient Stop in 30 days After DC (FY 1996)	Any Psych. Outpatient Stop in 30 days After DC (FY 1997)	Change	Days to 1st OP Stop in 6 mos After DC (FY 1996)				
436	43.6%	41.8% X	-1.8%	43.65 X	44.33 X	0.68		
442	50.1%	N/A	N/A	33.72	23.55	1.31		
554	58.8%	56.4%	-2.4%	24.24	38.07 X	3.52		
567	44.6%	43.4%	0.8%	34.55	29.57	-1.63		
575	51.7%	67.9%	12.7%	33.20	33.96	1.82		
660	39.8% X	45.2%	5.4%	33.14	47.77 X	-8.64		
666	28.5% X	41.3% X	12.8%	56.41 X	37.26 X	2.48		
TOTAL	47.8%	45.6% X	-2.1%	34.78	37.26 X	2.48		
STATION #								
531	47.1%	60.1%	13.0%	29.23	23.41	-5.82		
648	48.6%	60.7%	11.6%	29.53	24.13	-5.40		
653	38.1% X	45.3%	7.2%	41.80	33.71	-8.08		
663	51.7%	49.5%	-3.2%	31.19	31.93	0.74		
668	50.2%	N/A	N/A	33.72	33.93	N/A		
687	38.1% X	47.3%	9.2%	48.03 X	33.93	-12.12		
TOTAL	48.9%	48.9%	0.0%	34.71	32.31	-2.40		

Source: Patient Treatment File and Staff Outpatient File  
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TABLE 7C

Timeliness of Access to Outpatient Services Among Veterans Discharged from Inpatient Substance Abuse Programs During the First Six Months Following Discharge, 10/1/95 through 3/31/97, and changes, by VISN.

VISN	Any SA				Outpatient				Days to			
	Opportunistic Stop in 30 days After DC (FY 1996)	Stop in 30 days After DC (FY 1997)	Change	Days to 1st OP Stop in 6 mos. After DC (FY 1996)	Days to 1st OP Stop in 6 mos. After DC (FY 1997)	Change	Days to 1st OP Stop in 6 mos. After DC (FY 1996)	Days to 1st OP Stop in 6 mos. After DC (FY 1997)	Change			
1	37.0%	37.1%	0.1%	34.80 X	34.93	0.13	21.78	21.78	-3.75			
2	42.6%	49.9%	7.3%	25.53	25.53	0.00	42.16 X	42.16 X	7.14			
3	31.5%	27.6% X	-3.9%	30.8%	35.02 X	-3.9%	39.62 X	39.62 X	5.94			
4	30.8%	30.8%	0.0%	25.83	25.83	0.00	33.09	33.09	7.26			
5	38.1%	35.4%	-2.7%	26.39	26.39	0.00	25.10	25.10	-1.29			
6	30.7%	38.6%	7.9%	25.53	25.53	0.00	16.48	16.48	-6.05			
7	39.4%	55.0%	15.6%	20.21	20.21	0.00	13.63	13.63	-6.58			
8	45.2%	53.0%	7.8%	28.07	28.07	0.00	28.48	28.48	0.41			
9	35.9%	40.5%	4.6%	23.91	23.91	0.00	19.57	19.57	-4.34			
10	45.3%	58.3%	13.0%	32.15	32.15	0.00	31.62	31.62	-0.53			
11	25.4% X	24.6% X	-0.8%	31.03 X	31.03 X	0.00	29.90	29.90	-1.13			
12	28.9% X	36.3%	7.4%	30.93	30.93	0.00	24.62	24.62	-6.31			
13	36.2%	49.3%	13.1%	32.58	32.58	0.00	23.52	23.52	-9.06			
14	37.3%	53.3%	16.0%	24.48	24.48	0.00	44.95 X	44.95 X	20.47			
15	35.1%	19.3% X	-15.8%	19.95	19.95	0.00	23.17	23.17	3.22			
16	45.1%	45.7%	0.6%	29.40	29.40	0.00	22.60	22.60	-6.80			
17	36.4%	45.3%	8.9%	33.80 X	33.80 X	0.00	38.14 X	38.14 X	4.34			
18	27.9% X	20.2% X	-7.7%	28.10	28.10	0.00	26.44	26.44	-1.66			
19	37.2%	35.6%	-1.6%	16.34	16.34	0.00	20.39	20.39	4.05			
20	55.4%	54.2%	-1.2%	21.70	21.70	0.00	26.48	26.48	4.78			
21	38.3%	41.8%	3.5%	21.66	21.66	0.00	19.13	19.13	-2.53			
22	48.6%	46.4%	-2.2%	27.28	27.28	0.00	27.54	27.54	0.26			
Average	37.6%	40.8%	3.2%	5.38	5.38	0.00	8.24	8.24	0.00			
S.D.	7.1%	11.2%	4.1%	0.20	0.20	0.00	0.30	0.30	0.00			
C.V.	0.19	0.27	0.08									

VISNs or facilities marked by an "X" are over 1 Standard Deviation (S.D.) from the mean in an undesirable direction.  
 Note: Risk adjusted for differences in patient characteristics, distance of residence from VA, diagnosis, etc.  
 Source: Patient Treatment File and Staff Outpatient File

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TABLE 7D

Timeliness of Access to Outpatient Services Among Veterans Discharged from Substance Abuse Programs During the First Six Months Following Discharge, 10/1/95 through 3/31/97, and change, by Facility.

STATION #	OUTPATIENT SUBSTANCE ABUSE				Change	Days to 1st OP Stop in 6 mos. After DC (FY 1996)	Days to 1st OP Stop in 6 mos. After DC (FY 1997)	Change
	Any SA Outpatient Stop in 30 days After DC (FY 1996)	Any SA Outpatient Stop in 30 days After DC (FY 1997)	Change	Change				
402	65.0%	48.4%	-16.6%	26.22	28.58	2.36	N/A	
518	42.3%	37.65	N/A	37.89	44.63 X	6.74	N/A	
523	45.3%	34.2%	-11.1%	37.89	40.93 X	-3.70	N/A	
525	32.5%	25.6%	-6.8%	46.63 X	30.65	N/A	N/A	
608	60.4%	N/A	N/A	30.65	45.52 X	5.37	N/A	
631	32.0%	21.3% X	-10.7%	40.15	16.71	-24.67	N/A	
689	31.6%	60.6%	29.1%	41.39	34.93	-7.46	N/A	
TOTAL	37.0%	37.1%	0.1%	34.80 X	34.93	0.13	N/A	
500	24.2%	N/A	N/A	48.98 X	N/A	N/A	N/A	
514	51.3%	N/A	N/A	23.35	N/A	N/A	N/A	
528	47.8%	42.5%	-5.3%	28.75	23.66	-5.09	N/A	
532	46.1%	55.1%	9.0%	28.33	16.85	-11.48	N/A	
TOTAL	42.6%	49.9%	7.3%	25.53	21.78	-3.75	N/A	
526	50.3%	47.5%	-2.8%	35.66	24.44	-11.22	N/A	
537	36.0%	27.8%	-8.2%	39.31	38.50	-0.81	N/A	
561	25.9%	42.2%	16.3%	37.95	18.10	-19.85	N/A	
604	45.6%	N/A	N/A	25.67	N/A	N/A	N/A	
620	18.3% X	10.6% X	-7.7%	58.15 X	67.00 X	8.84	N/A	
630	33.7%	26.9%	-6.8%	39.28	39.87	0.58	N/A	
632	33.4%	26.5%	-6.9%	34.84	39.03	4.19	N/A	
TOTAL	31.5%	27.6% X	-3.9%	35.02 X	42.16 X	7.14	N/A	

Source: Patient Treatment File and Staff Outpatient File  
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TABLE 7D

Timeliness of Access to Outpatient Services Among Veterans Discharged from Substance Abuse Programs During the First Six Months Following Discharge, 10/1/95 through 3/31/96, 10/1/96 through 3/31/97, and change, by Facility.

STATION #	OUTPATIENT SUBSTANCE ABUSE				Days to 1st OP Stop in 6 mos. After DC (PT 1996)	Days to 1st OP Stop in 6 mos. After DC (PT 1997)	Change
	Any SA Outpatient Stop in 30 days After DC (PT 1996)	Any SA Outpatient Stop in 30 days After DC (PT 1997)	Change				
460 WILMINGTON	N/A	N/A	N/A	15.23	N/A	N/A	
529 BUTLER	56.9%	64.8%	N/A	18.72	N/A	N/A	
540 CLARKSBURG	37.7%	30.1%	-7.1%	30.51	37.15	6.64	
542 COATESVILLE	18.3% X	30.6%	12.2%	56.56 X	28.05	-28.51	
595 LEBANON	41.6%	38.2%	-3.4%	29.89	30.49	0.60	
642 PHILADELPHIA	28.6%	29.5%	1.0%	41.98	37.76	-4.23	
645 PITTSBURGH-HIGHL	44.0%	N/A	N/A	33.94	N/A	N/A	
693 WILKES BARRE	13.1% X	18.0% X	4.9%	60.58 X	53.07 X	-7.50	
TOTAL	30.8%	30.8%	0.0%	33.68 X	39.62 X	5.94	
STATION #							
512 BALTIMORE†	46.7%	39.6%	-7.0%	27.08	27.58	0.50	
613 MARTINSBURG	21.8% X	24.7%	2.9%	47.72 X	40.80 X	-6.92	
641 PERRY POINT	42.0%	N/A	N/A	23.11	N/A	N/A	
688 WASHINGTON	80.6%	N/A	N/A	9.13	N/A	N/A	
TOTAL	38.1%	35.4%	-2.7%	25.83	33.09	7.26	
STATION #							
565 FAYETTEVILLE NC	40.6%	N/A	N/A	17.97	N/A	N/A	
590 HAMPTON	23.0% X	27.2%	4.3%	41.19	30.52	-10.66	
637 ASHEVILLE-OTTEEN	19.7% X	N/A	N/A	39.22	N/A	N/A	
652 RICHMOND	46.1%	37.8%	-8.3%	22.20	21.15	-1.05	
638 SALEM	21.5% X	42.2%	20.8%	47.31 X	28.52	-18.80	
639 SALISBURY	43.2%	46.2%	3.1%	27.78	12.69	-15.08	
TOTAL	30.7%	38.6%	7.9%	26.39	25.10	-1.29	

Source: Patient Treatment File and Staff Outpatient File  
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TABLE 7D  
 Timeliness of Access to Outpatient Services Among Veterans Discharged from Substance Abuse Programs During the First Six Months Following Discharge, 10/1/95 through 3/31/96, 10/1/96 through 3/31/97, and change, by Facility.

STATION #	OUTPATIENT SUBSTANCE ABUSE				Change	Days to 1st OP Stop in 6 mos. After DC (FY 1997)	Change
	Appx. 100% Outpatient Stop in 30 days After DC (FY 1996)	Appx. 100% Outpatient Stop in 10 days After DC (FY 1997)	Days to 1st OP Stop in 6 mos. After DC (FY 1996)	Days to 1st OP Stop in 6 mos. After DC (FY 1997)			
508	47.4%	54.3%	N/A	24.44	N/A	N/A	N/A
509	40.7%		13.6%	31.92		13.92	-19.00
521	29.0%		N/A	20.63		N/A	N/A
534	46.8%		N/A	19.72		N/A	N/A
544	55.6%		N/A	16.72		N/A	N/A
557	26.4%		N/A	32.99		N/A	N/A
679	45.5%		N/A	29.21		N/A	N/A
680	34.9%		N/A	15.88		N/A	N/A
<b>TOTAL</b>	<b>39.4%</b>	<b>55.0%</b>	<b>15.6%</b>	<b>22.53</b>		<b>16.48</b>	<b>-6.05</b>
<b>STATION #</b>							
516	50.5%	51.7%	1.2%	23.00		12.19	-10.81
546	54.4%		N/A	22.01		N/A	N/A
573	62.2%		N/A	18.46		N/A	N/A
594	25.5%		N/A	31.21		N/A	N/A
673	34.0%		N/A	41.93		N/A	N/A
<b>TOTAL</b>	<b>45.2%</b>	<b>53.0%</b>	<b>7.8%</b>	<b>20.21</b>		<b>13.63</b>	<b>-6.58</b>
<b>STATION #</b>							
596	17.0% X		N/A	52.85 X		N/A	N/A
603	56.4%	45.5%	N/A	17.05		27.53	-5.15
614	44.7%	39.7%	0.8%	32.68		19.34	-15.31
621	35.9%	20.8% X	3.8%	34.65		38.52	-4.01
622	21.0% X	57.3%	-0.1%	42.53		10.52	-6.98
626	58.7%		-1.4%	17.49			
<b>TOTAL</b>	<b>35.9%</b>	<b>40.5%</b>	<b>4.6%</b>	<b>28.07</b>		<b>28.48</b>	<b>0.41</b>

Source: Patient Treatment File and Staff Outpatient File  
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TABLE 7D

Timeliness of Access to Outpatient Services Among Veterans Discharged from Substance Abuse Programs During the First Six Months Following Discharge, 10/1/95 through 3/31/97, and change, by Facility.

STATION #	OUTPATIENT SUBSTANCE ABUSE				Change	Days to 1st OP Stop in 6 mos. After DC (FY 1997)	Change	Days to 1st OP Stop in 6 mos. After DC (FY 1996)	Change
	Any SA Outpatient Stop in 30 days After DC (FY 1996)	Any SA Outpatient Stop in 30 days After DC (FY 1997)	Change	Change					
538	40.7%	36.1%	-4.6%	29.78	25.97	-3.80			
539	42.8%	63.2%	20.3%	35.69	17.10	-18.59			
541	62.0%	71.3%	9.4%	21.37	12.59	-8.79			
552	28.8%	38.3%	9.5%	36.96	27.22	-9.75			
TOTAL	45.3%	58.3%	13.0%	21.91	19.57	-4.34			
506	35.1%	25.8%	-9.2%	34.93	32.29	-2.64			
515	16.1% X	13.5% X	-2.7%	51.37 X	41.82 X	-11.55			
590	24.5%		N/A	34.42		N/A			
553	28.9%	32.8%	3.9%	39.83	22.66	-17.17			
583	49.9%		N/A	27.34		N/A			
610	32.0%	33.6%	1.6%	24.22	24.01	-0.20			
TOTAL	23.4% X	24.6% X	-0.8%	32.15	31.62	-0.53			
535	20.5% X	16.8% X	-3.7%	42.54	33.54	-8.99			
537	56.0%	53.6%	-2.4%	21.77	18.00	-3.77			
536	38.9%	21.6% X	-17.3%	28.29	31.90	3.62			
578	24.8%	37.2%	12.4%	45.95 X	28.79	-17.16			
585	24.4%	93.0%	68.6%	22.22	17.13	-5.09			
676	20.2% X	51.0%	30.8%	52.58 X	27.70	-24.89			
695	21.6% X	13.6% X	-8.0%	47.82 X	55.44 X	7.62			
TOTAL	28.9% X	36.3%	7.4%	33.03 X	29.90	-3.13			

Source: Patient Treatment File and Staff Outpatient File  
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TABLE 7D

Timeliness of Access to Outpatient Services Among Veterans Discharged from Substance Abuse Programs During the First Six Months Following Discharge, 10/1/95 through 3/31/96, 10/1/96 through 3/31/97, and change, by Facility.

STATION #	OUTPATIENT SUBSTANCE ABUSE						Change
	Any SA Outpatient Stop in 30 days After DC (FY 1996)	Any SA Outpatient Stop in 30 days After DC (FY 1997)	Change	Days to 1st OP Stop in 6 mos. After DC (FY 1996)	Days to 1st OP Stop in 6 mos. After DC (FY 1997)	Change	
<b>STATION #</b>							
438	30.5%	64.9%	34.4%	61.51	X	16.25	-45.26
568	47.0%	44.3%	-2.7%	31.62		24.50	-7.12
579	53.9%		N/A	31.24			N/A
656	30.0%		N/A	31.69			N/A
<b>TOTAL</b>	<b>36.2%</b>	<b>49.3%</b>	<b>13.1%</b>	<b>30.93</b>		<b>24.62</b>	<b>-6.31</b>
<b>STATION #</b>							
555	90.5%	58.0%	-32.5%	34.00		20.86	-13.14
574	60.9%	57.7%	-3.2%	35.74		25.24	-10.51
592	33.1%		N/A	41.54			N/A
597	30.5%	63.6%	33.1%	43.17		19.10	-24.07
636	32.8%	36.7%	3.9%	28.08		25.83	-2.25
<b>TOTAL</b>	<b>37.3%</b>	<b>53.3%</b>	<b>16.0%</b>	<b>32.58</b>		<b>23.52</b>	<b>-9.06</b>
<b>STATION #</b>							
452	37.2%	66.4%	29.2%	29.32			N/A
543	26.4%		-40.0%	38.14		28.09	-10.05
589	70.0%		N/A	23.25			N/A
647	46.6%		N/A	33.99			N/A
657	19.5% X	14.9% X	-4.6%	33.76		45.99 X	12.23
686	43.4%		N/A	26.81			N/A
<b>TOTAL</b>	<b>35.1%</b>	<b>19.3% X</b>	<b>-15.8%</b>	<b>24.48</b>		<b>44.95 X</b>	<b>20.47</b>

Source: Patient Treatment File and Staff Outpatient File  
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TABLE 7D

Timeliness of Access to Outpatient Services Among Veterans Discharged from Substance Abuse Programs During the First Six Months Following Discharge, 10/1/95 through 3/31/96, 10/1/96 through 3/31/97, and changes, by Facility.

STATION #	OUTPATIENT SUBSTANCE ABUSE										
	Any SA Outpatient		Any SA Stop in 30 days		Change		Days to 1st OP Stop in 6 mos After DC (FY 1996)		Days to 1st OP Stop in 6 mos After DC (FY 1997)		Change
570	49.9%	30.3%	-19.6%	24.45	34.46	10.01					
580	34.2%	43.6%	9.4%	25.17	14.40	-10.77					
586	53.7%	47.2%	-6.4%	30.12	29.76	-0.37					
598	45.3%	41.3%	-3.9%	26.20	26.68	0.28					
629	81.2%	92.1%	8.9%	12.03	3.31	-4.74					
635	41.1%	40.6%	-0.3%	27.37	24.52	-2.75					
667	47.2%		N/A	28.90		N/A					
TOTAL	45.1%	45.7%	0.6%	19.95	23.17	3.22					
549	47.3%	52.6%	5.3%	33.80	19.77	-14.03					
591	3.9% X		N/A	26.03		N/A					
671	30.7%	36.3%	5.6%	34.29	21.97	-12.31					
TOTAL	36.4%	45.3%	8.9%	29.40	22.60	-6.80					
501	65.5%	50.5%	-14.9%	21.44	9.33	-12.10					
504	18.4% X	16.0% X	-2.4%	41.50	44.92 X	3.42					
519	39.5%	38.8%	-0.7%	36.58	20.71	-15.87					
644	31.8%		N/A	38.74		N/A					
649	3.2% X	5.9% X	2.7%	55.84 X	78.12 X	22.28					
678	44.2%	44.7%	0.6%	26.97	26.09	-10.88					
TOTAL	27.9% X	20.2% X	-7.7%	33.90 X	38.14 X	4.34					

Source: Patient Treatment File and Staff Outpatient File  
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TABLE 7D

Timeliness of Access to Outpatient Services Among Veterans Discharged from Substance Abuse Programs During the First Six Months Following Discharge, 10/1/95 through 3/31/96, 10/1/96 through 3/31/97, and change, by Facility.

STATION #	OUTPATIENT SUBSTANCE ABUSE						Change
	Any SA Outpatient Stop in 30 days After DC (FY 1996)	Outpatient Stop in 30 days After DC (FY 1997)	Change	Days to 1st OP Stop in 6 mos. After DC (FY 1996)	Days to 1st OP Stop in 6 mos. After DC (FY 1997)	Change	
436	46.6%	27.7%	-18.9%	20.57	27.19	6.62	
442	78.7%	N/A	N/A	14.88	N/A	N/A	
554	34.5%	22.5%	-2.0%	38.52	31.79	-6.74	
575	36.6%	36.1%	0.1%	38.04	33.22	-4.82	
660	41.7%	63.6%	20.9%	31.76	12.89	-20.88	
666	39.8%	41.2%	1.4%	30.82	15.48	-15.34	
TOTAL	37.2%	35.6%	-1.6%	28.10	26.44	-1.66	
STATION #							
531	75.4%	80.9%	5.5%	20.19	10.47	-9.72	
648	57.4%	53.7%	-3.7%	19.93	12.72	-7.21	
633	23.4%	28.3%	4.8%	43.79	36.25	-7.54	
663	74.8%	69.8%	-5.0%	13.31	14.23	0.90	
668	89.7%	75.1%	-14.4%	13.03	8.43	-4.60	
687	47.1%	28.7%	-18.4%	27.08	46.37 X	19.30	
TOTAL	55.4%	54.2%	-1.2%	16.34	20.39	4.05	

Source: Patient Treatment File and Staff Outpatient File  
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TABLE 7D

Timeliness of Access to Outpatient Services Among Veterans Discharged from Substance Abuse Programs During the First Six Months Following Discharge, 10/1/95 through 3/31/97, and change, by Facility.

STATION #	OUTPATIENT SUBSTANCE ABUSE							
	Any SA Outpatient Stop in 30 days After DC (FY 1996)	Any SA Outpatient Stop in 30 days After DC (FY 1997)	Change	Days to 1st OP Stop in 6 mos. After DC (FY 1996)	Days to 1st OP Stop in 6 mos. After DC (FY 1997)	Change	Days to 1st OP Stop in 6 mos. After DC (FY 1997)	Change
570	FRESNO	46.1%	42.9%	-3.2%	19.03	15.34	-3.69	
640	PALO ALTO	31.4%	32.9%	+0.5%	28.23	36.96	8.73	
654	RENO	62.6%	60.2%	-2.5%	24.39	13.34	-11.05	
662	SAN FRANCISCO	36.1%	28.1%	-8.1%	33.37	34.52	1.15	
	TOTAL	38.3%	41.8%	3.5%	21.70	26.48	4.78	
593	LAS VEGAS	3.1% X	N/A	N/A	26.03	N/A	N/A	
600	LONG BEACH	50.3%	45.3%	-5.0%	26.03	19.49	-6.54	
605	LOMA LINDA	56.5%	51.1%	-5.4%	24.63	24.27	-0.36	
664	SAN DIEGO	45.7%	45.1%	-0.6%	27.64	14.35	-13.39	
691	LA WADSWORTH	-3.3% X	N/A	N/A	114.10 X	N/A	N/A	
	TOTAL	48.6%	46.4%	-2.2%	21.66	19.13	-2.53	
	ALL VA	40.2%	40.3%	0.3%	33.55	26.71	-6.84	
	AVG	16.9%	18.5%	1.6%	13.04	13.45	0.41	
	S.D.	0.42	0.46		0.40	0.51		
	C.V.							

VISNs or facilities marked by an "X" are over 1 Standard Deviation (S.D.) from the mean in an undesirable direction.

† FY 1996-FY 1997 comparisons may be distorted by mergers.

Note: Risk adjusted for differences to patient characteristics, distance of residence from VA, diagnosis, etc.

Medical centers that discharged fewer than ten patients during the first half of fiscal year 1997 are excluded from the table.

Source: Patient Treatment File and Staff Outpatient File  
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TABLE 7E

Timeliness of Access to Outpatient Services Among Veterans Discharged with a Primary Diagnosis of PTSD, 10/1/95 through 3/31/96, 10/1/96 through 3/31/97, and change, by VISN.

VISN	Any Psych. Outpatient Stop in 30 days		Any Psych. Outpatient Stop in 30 days		Days to 1st OP Stop in 6 mos. After DC		Days to 1st OP Stop in 6 mos. After DC		Change
	(FY 1996)	After DC	(FY 1997)	After DC	(FY 1996)	After DC	(FY 1997)	After DC	
1	69.1%		75.1%		24.11		20.19		-3.92
2	76.6%		70.0%		21.72		27.24		5.52
3	69.4%		71.8%		26.42		21.63		-4.80
4	62.7%		66.7%		30.40		30.96		0.57
5	64.4%		69.2%		29.92		22.98		-6.94
6	57.4% X		57.7% X		34.29 X		35.31 X		1.02
7	50.7% X		55.1% X		37.78 X		35.14 X		-2.64
8	63.5%		64.9%		30.59		29.87		-0.72
9	68.8%		61.3%		26.05		31.87		5.81
10	59.3%		73.0%		35.02 X		24.37		-10.65
11	61.6%		63.6%		30.13		32.28		2.15
12	57.3% X		56.2% X		32.70		31.64		-1.06
13	64.0%		72.5%		31.86		21.79		-10.07
14	66.7%		63.9%		24.10		26.15		2.05
15	73.9%		75.6%		21.71		22.86		1.16
16	59.5%		62.7%		34.37 X		27.76		-6.60
17	65.8%		60.5%		26.01		29.18		3.18
18	61.7%		67.3%		30.63		22.61		-8.01
19	67.2%		60.9%		24.06		32.78 X		8.72
20	54.7% X		54.3% X		32.70		34.19 X		1.49
21	60.3%		57.3% X		31.20		29.73		-1.47
22	63.1%		73.3%		35.00 X		18.62		-16.38
Average	63.5%		65.1%		29.58		27.69		-1.89
S.D.	5.9%		6.6%		4.53		5.01		
C.V.	0.09		0.10		0.15		0.18		

VISNs or facilities marked by an "X" are over 1 Standard Deviation (S.D.) from the mean in an undesirable direction. Note: Risk adjusted for differences in patient characteristics, distance of residence from VA, diagnosis, etc. Source: Patient Treatment File and Staff Outpatient File

APPENDIX - B  
 TABLE 7F  
 Timeliness of Access to Outpatient Services Among Veterans Discharged with a Primary Diagnosis of PTSD, 10/1/95 through 3/31/96,  
 10/1/96 through 3/31/97, and changes, by Facility.

STATION #	Any Psych. Outpatient Visit in 30 Days After DC (PT 1996)	Any Psych. Outpatient Visit in 30 Days After DC (PT 1997)	Change	Days to 1st OP Visit in 6 mos After DC (PT 1996)	Days to 1st OP Visit in 6 mos After DC (PT 1997)	Change
402	55.1%	63.6%	8.5%	32.18	33.36	1.18
405	75.5%	76.2%	0.7%	21.09	15.26	-5.83
518	66.7%	90.0%	23.3%	20.30	12.50	-8.00
523	85.7%	78.1%	-7.6%	17.90	18.53	0.63
525	70.0%	63.6%	-6.4%	29.50	16.40	-13.10
633	63.5%	66.1%	2.6%	28.78	26.53	-2.25
650	61.5%	90.0%	28.5%	27.92	8.56	-19.36
689	80.0%	88.9%	8.9%	15.69	12.03	-3.66
TOTAL	69.1%	73.1%	6.0%	24.11	20.19	-3.92
STATION #						
500	83.6%	87.0%	3.4%	16.53	10.00	-6.53
514	75.0%	50.0%	-25.0%	43.23 X	82.00 X	38.75
528	73.6%	67.0%	-6.6%	27.15	30.64	3.49
532	100.0%	50.0%	-50.0%	5.50	69.00 X	63.50
670	58.8%	46.7%	-12.1%	19.21	39.21	20.00
TOTAL	76.6%	70.0%	-6.6%	21.72	27.24	5.52
STATION #						
526	91.7%	92.4%	0.7%	10.87	9.83	-1.04
577	87.5%	50.0%	-37.5%	11.57	37.35	25.78
581	54.3%	63.8%	9.5%	33.52	26.02	-9.50
604	59.8%	N/A	N/A	33.94	N/A	N/A
620	72.2%	71.6%	0.4%	27.10	24.14	-2.96
630	63.6%	72.4%	8.8%	27.82	16.69	-11.13
632	80.0%	80.0%	0.0%	26.60	35.50	8.90
TOTAL	69.4%	71.8%	2.5%	26.4	21.63	-4.80

Source: Patient Treatment File and Staff Outpatient File

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APPENDIX-B  
 TABLE 7F  
 Timeliness of Access to Outpatient Services Among Veterans Discharged with a Primary Diagnosis of PTSD, 10/1/95 through 3/31/96,  
 10/1/96 through 3/31/97, and change, by Facility.

STATION #	Any Psych. Outpatient Visit in 30 Days After DC (FY 1996)	Any Psych. Outpatient Visit in 30 Days After DC (FY 1997)	Change	Days to 1st OP Visit After DC (FY 1996)	Days to 1st OP Visit After DC (FY 1997)	Change
540	68.5%	71.2%	2.7%	26.93	30.78	3.85
542	62.3%	69.8%	7.5%	29.69	26.08	-3.61
595	53.1%	48.1%	-5.0%	32.97	43.27 X	10.30
642	59.5%	45.8%	-13.7%	32.10	46.91 X	14.81
645	62.3%	50.0%	-12.3%	33.77	37.50	3.73
646	60.0%	71.2%	N/A	27.98	N/A	N/A
693	60.0%	50.0%	-10.0%	39.75	34.50	-5.25
TOTAL	62.7%	66.7%	4.0%	30.40	30.96	0.57
STATION #						
512	80.0%	68.0%	-12.0%	20.38	18.25	-2.13
613	48.0%	68.2%	20.2%	42.33 X	22.76	-19.57
641	50.0%	71.9%	21.9%	10.00	30.07	20.07
688	60.7%	11.2%	-49.5%	31.76	N/A	-31.76
TOTAL	64.4%	69.2%	4.8%	29.92	22.98	-6.94
STATION #						
558	36.6% X	36.7% X	0.1%	41.47	57.33 X	15.86
565	50.0%	30.0% X	-20.0%	46.11 X	41.56	-4.55
590	62.7%	58.2%	-4.5%	23.62	35.68	12.06
637	63.6%	58.8%	-4.8%	36.68	30.75	-5.93
652	44.4% X	45.5%	1.1%	43.13 X	36.06	-7.07
658	60.8%	62.4%	1.6%	34.71	33.11	-1.60
659	61.2%	62.4%	1.2%	34.91	31.56	-3.35
TOTAL	57.4% X	57.7% X	0.3%	34.29 X	35.31 X	1.02

Source: Patient Treatment File and Staff Outpatient File  
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APPENDIX -B  
 TABLE 7F  
 Timeliness of Access to Outpatient Services Among Veterans Discharged with a Primary Diagnosis of PTSD, 10/1/95 through 3/31/96,  
 10/1/96 through 3/31/97, and change, by Facility.

STATION #	Any Psych. Outpatient Visit in 30 Days After DC (FY 1996)	Any Psych. Outpatient Visit in 30 Days After DC (FY 1997)	Change	Days to 1st OP Visit After DC (FY 1996)	Days to 1st OP Visit After DC (FY 1997)	Change
538	47.6%	63.6%	18.0%	45.56 X	30.53	-15.03
539	33.8%	71.4%	23.6%	42.40 X	19.06	-23.34
541	75.9%	69.2%	-6.7%	16.54	30.72	14.18
552	66.7%	81.8%	15.1%	16.40	16.00	-0.40
TOTAL	59.3%	73.0%	13.7%	35.02 X	24.37	-10.65
STATION #						
506	71.7%	62.8%	-8.9%	19.56	21.41	1.85
515	59.3%	59.7%	0.4%	35.60	39.12	3.52
550	78.6%	50.0%	-28.6%	20.86	21.75	0.89
553	22.2% X	75.0%	52.8%	49.78 X	17.50	-32.28
583	0.0% X	N/A	N/A	38.00	N/A	N/A
610	56.4%	77.8%	21.4%	26.28	25.18	-1.10
TOTAL	61.6%	63.6%	2.1%	30.13	32.28	2.15
STATION #						
535	75.0%	50.0%	-25.0%	8.00	33.70	25.70
537	71.9%	52.5%	-19.4%	25.17	39.94	14.77
556	55.4%	65.0%	9.6%	34.67	27.63	-7.04
578	57.7%	37.5% X	-20.2%	28.67	30.33	1.66
607	54.5%	33.3% X	-21.2%	34.63	39.00	4.38
676	49.4%	49.4%	0.0%	38.75	34.61	-4.14
695	72.7%	83.3%	10.6%	24.10	14.73	-9.37
TOTAL	57.3% X	56.2% X	-1.1%	32.70	31.64	-1.06

Source: Patient Treatment File and Staff Outpatient File  
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APPENDIX-B  
 TABLE 7E  
 Timeliness of Access to Outpatient Services Among Veterans Discharged with a Primary Diagnosis of PTSD, 10/1/95 through 3/31/96,  
 10/1/96 through 3/31/97, and change, by Facility.

STATION #	Any Psych. Outpatient Visit in 30 Days After DC (FY 1996)	Any Psych. Outpatient Visit in 30 Days After DC (FY 1997)	Change	Days to 1st OP Visit in 6 mos. After DC (FY 1996)	Days to 1st OP Visit in 6 mos. After DC (FY 1997)	Change
437	FARGO	50.0%	N/A	46.50 X	N/A	N/A
438	SIOUX FALLS	50.0%	0.0%	20.00	20.00	-29.83
568	FORT MEADE†	71.4%	6.4%	32.58	15.50	-17.08
579	HOT SPRINGS†	100.0%	N/A	19.00	N/A	N/A
618	MINNEAPOLIS	69.0%	73.0%	29.37	23.27	-6.10
636	ST CLOUD	55.3%	73.7%	30.20	19.37	-10.83
	TOTAL	64.0%	72.5%	31.86	21.79	-10.07
STATION #						
555	DES MOINES†	36.4% X	34.8% X	41.14	40.70	-0.44
584	IOWA CITY	87.5%	66.7%	19.75	25.80	6.05
592	KNOXVILLE†	74.1%	83.3%	22.93	17.80	-5.13
597	LINCOLN	100.0%	66.7%	12.40	22.67	10.27
636	OMAHA	80.0%	44.4% X	11.44	34.00	22.56
	TOTAL	66.7%	63.9%	24.10	26.15	2.05
STATION #						
452	WICHITA	60.0%	100.0%	25.50	5.75	-19.75
543	COLUMBIA MO	69.2%	100.0%	25.82	6.50	-19.32
589	KANSAS CITY	80.0%	81.3%	20.60	21.81	1.21
647	POPLAR BLUFF	45.5%	50.0%	30.10	35.50	5.40
637	ST LOUIS-John Cochran	60.3%	76.3%	28.98	23.42	-5.56
677	TOPEKA	80.7%	70.5%	18.29	25.74	7.45
686	LEAVENWORTH	100.0%	100.0%	13.25	8.64	-4.61
	TOTAL	73.9%	75.6%	21.71	22.86	1.15

Source: Patient Treatment File and Staff Outpatient File  
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APPENDIX -B

TABLE 7F

Timeliness of Access to Outpatient Services Among Veterans Discharged with a Primary Diagnosis of PTSD, 10/1/95 through 3/31/96, 10/1/96 through 3/31/97, and change, by Facility.

STATION #	Any Psych. Outpatient Visit in 30 Days After DC (FY 1996)	Any Psych. Outpatient Visit in 30 Days After DC (FY 1997)	Change	Days to 1st OP Visit in 6 mos. After DC (FY 1996)	Days to 1st OP Visit in 6 mos. After DC (FY 1997)	Change
502	33.3% X	N/A	N/A	63.00 X	N/A	N/A
520	62.5%	72.0%	9.5%	22.38	22.86	0.48
564	63.0%	62.1%	-0.9%	41.23	28.79	-12.44
580	50.0%	56.7%	6.7%	35.82	29.59	-6.23
586	69.2%	78.3%	9.1%	26.30	27.57	1.27
598	53.4%	59.8%	6.4%	39.42	29.20	-10.22
629	78.2%	63.0%	-15.2%	20.29	21.51	1.22
635	50.0%	62.5%	12.5%	49.13 X	26.50	-22.63
667	81.8%	50.0%	-31.8%	11.90	39.60	27.70
TOTAL	59.5%	62.7%	3.2%	34.37 X	27.76	-6.61
STATION #						
549	85.7%	76.0%	-9.7%	10.63	26.09	15.46
671	63.7%	52.2%	-13.5%	29.08	34.73	5.65
674	62.3%	70.9%	8.4%	26.45	18.67	-7.78
685	37.5%	N/A	N/A	22.80	N/A	N/A
TOTAL	65.8%	60.5%	-5.3%	26.01	29.18	3.17
STATION #						
501	66.7%	70.4%	3.7%	25.42	21.21	-4.21
519	44.8%	18.2% X	-26.6%	31.96	42.63	10.67
644	65.6%	76.1%	10.5%	32.27	21.89	-10.38
678	72.7%	71.4%	-1.3%	31.90	14.75	-17.15
TOTAL	61.7%	67.3%	5.6%	30.63	25.61	-4.02

Source: Patient Treatment File and Staff Outpatient File  
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APPENDIX-B  
 TABLE 7F  
 Timeliness of Access to Outpatient Services Among Veterans Discharged with a Primary Diagnosis of PTSD, 10/1/95 through 3/31/96,  
 10/1/96 through 3/31/97, and change, by Facility.

STATION #	Any Psych. Outpatient Visits in 30 Days After DC (FY 1996)	Any Psych. Outpatient Visits in 30 Days After DC (FY 1997)	Change	Days to 1st OP Visit in 6 mos. After DC (FY 1996)	Days to 1st OP Visit in 6 mos. After DC (FY 1997)	Change
436	25.0% X	0.0% X	-25.0%	56.40 X	89.00 X	32.60
554	71.8%	70.9%	-0.9%	19.38	25.17	5.79
567	70.4%	55.6%	-14.8%	24.04	34.27	10.23
575	88.9%	87.5%	-1.4%	26.33	7.29	-19.04
660	71.4%	71.4%	0.0%	17.43	27.67	10.24
666	10.0% X	15.0% X	5.0%	82.71 X	72.38 X	-10.33
TOTAL	67.2%	60.9%	-6.2%	24.06	32.78 X	8.72
STATION #						
531	42.9% X	54.5%	11.6%	35.41	36.10	0.69
648	61.0%	57.6%	-3.4%	29.21	21.63	-7.58
653	43.8% X	59.3%	15.5%	36.74	34.09	-2.65
663	58.8%	52.4%	-6.4%	31.91	36.58	4.67
687	50.0%	40.0% X	-10.0%	31.67	20.50	-11.17
TOTAL	54.7% X	54.3% X	-0.4%	32.70	34.19 X	1.49

Source: Patient Treatment File and Staff Outpatient File  
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APPENDIX -B

TABLE 7F

Timeliness of Access to Outpatient Services Among Veterans Discharged with a Primary Diagnosis of PTSD, 10/1/95 through 3/31/96, 10/1/96 through 3/31/97, and change, by Facility.

STATION #	Any Psych. Outpatient Visit in 30 Days After DC (FY 1996)	Any Psych. Outpatient Visit in 30 Days After DC (FY 1997)	Change	Days to 1st OP Visit in 6 mos. After DC (FY 1996)	Days to 1st OP Visit in 6 mos. After DC (FY 1997)	Change
459 HONOLULU	63.3%	62.5%	-0.8%	25.07	19.08	-5.99
570 FRESNO	14.3% X	29.4% X	15.1%	70.40 X	56.00 X	-14.40
612 MARTINEZ	83.3%	83.3%	0.0%	10.17	19.00	8.83
640 PALO ALTO	64.9%	65.0%	0.1%	30.43	24.26	-6.17
654 RENO	33.3% X	21.3% X	-11.1%	14.00	70.33 X	56.33
662 SAN FRANCISCO	58.2%	62.5%	4.3%	31.39	22.77	-8.62
TOTAL	60.3%	57.3% X	-3.0%	31.20	29.73	-1.47
STATION #						
593 LAS VEGAS		70.0%	N/A		12.00	N/A
600 LONG BEACH	100.0%	50.0%	-50.0%	7.50	46.50 X	39.00
605 LOMA LINDA	75.8%	84.2%	8.4%	26.94	13.12	-13.82
664 SAN DIEGO	50.0%	53.8%	3.8%	50.57 X	34.08	-16.49
691 LA WADSWORTH	56.7%	75.4%	18.7%	37.98	16.63	-21.35
TOTAL	63.1%	73.3%	10.2%	35.00 X	18.62	-16.38
AVG.	62.7%	62.6%	-0.2%	29.41	29.08	-0.32
SD.	17.6%	17.8%	0.28	12.06	14.18	
CV.	0.28	0.28		0.41	0.49	

VISNs or facilities marked by an "X" are over 1 Standard Deviation (S.D.) from the mean in an undesirable direction.  
 † FY 1996-FY 1997 comparisons may be distorted by mergers.

Note: Risk adjusted for differences in patient characteristics, distance of residence from VA, diagnosis, etc.

Source: Patient Treatment File and Staff Outpatient File  
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TABLE 70

Timeliness of Access to Outpatient Services Among Homeless Veterans Identified in the End-Of-Year Inpatient Homeless Survey, FY 1995, FY 1996, and change, by VSN.

VSN	Overall Timeliness			Substance Abuse		
	Days to 1st OP Stop in 6 mos. After DC (FY 1995)	Days to 1st OP Stop in 6 mos. After DC (FY 1996)	Change (FY 1996)	Days to 1st OP Stop in 6 mos. After DC (FY 1995)	Days to 1st OP Stop in 6 mos. After DC (FY 1996)	Change (FY 1996)
1	38.47	32.15	-6.32	31.89	44.64	-12.75
2	40.94	40.64	-0.30	54.14	50.09	-4.05
3	44.75	34.52	-10.23	45.09	43.49	-1.60
4	31.67	34.52	-1.75	47.29	51.69	-4.40
5	34.21	37.00	-2.79	52.09	63.39	-11.30
6	40.48	39.65	0.83	49.29	45.89	3.40
7	34.10	46.26	-12.16	31.19	48.79	-17.60
8	45.09	35.39	9.70	47.99	50.09	-2.10
9	29.72	31.81	-2.09	37.19	31.09	6.10
10	32.88	19.86	13.02	38.29	75.09	-36.80
11	46.89	25.74	21.15	49.09	61.29	-12.20
12	59.94	37.96	21.98	39.69	55.79	-16.10
13	46.83	26.74	20.09	46.89	62.39	-15.50
14	71.00	34.62	36.38	38.09	50.09	-12.00
15	42.01	37.84	4.17	58.99	68.39	-9.40
16	59.78	37.08	22.70	39.29	38.29	1.00
17	51.17	28.04	23.13	48.89	47.29	1.60
18	34.42	46.83	-12.41	51.29	57.29	-6.00
19	52.28	50.04	2.24	41.29	34.29	7.00
20	48.13	27.94	20.19	52.19	43.89	8.30
21	40.35	34.13	6.22	47.89	48.89	-1.00
22	37.22	32.56	4.66	56.09	57.99	-1.90
Average	45.11	34.23	10.88	47.99	51.29	-3.30
S.D.	9.86	8.20	1.66	7.79	10.29	-2.50
C.V.	0.22	0.24	0.16	0.16	0.20	0.04

VSNs or facilities marked by an "X" are over 1 Standard Deviation (S.D.) from the mean in an undesirable direction.

Source: Patient Treatment Files and Staff Outpatient Files  
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TABLE 7H

Timeliness of Access to Outpatient Services Among Homeless Veterans Identified in the End-Of-Year Inpatient Homeless Survey, FY 1995, FY 1996, and change, by Facility.

STATION #	Days to 1st OP Stop in 6 mos. (FY 1995)	Days to 1st OP Stop in 6 mos. (FY 1996)	Change	Avg Physk OP Stop in 30 days (FY 1995)	Avg Physk OP Stop in 30 days (FY 1996)	Change	Days to 1st OP Stop in 6 mos. (FY 1995)	Days to 1st OP Stop in 6 mos. (FY 1996)	Change	Avg SA OP Stop in 30 days (FY 1995)	Avg SA OP Stop in 30 days (FY 1996)	Change
402 TOGIS	68.14 X	37.00	-31.14	40.0%	66.7%	26.7%	4.50	100.0%	N/A	100.0%	N/A	N/A
405 WHITE RIVER JCT	1.50	12.00	10.50	66.7%	50.0%	-16.7%	0.00	0.0%	N/A	0.0%	N/A	N/A
318 BEDFORD	44.00	49.50	5.50	50.0%	27.3% X	-22.7%	23.72	66.7%	N/A	66.7%	N/A	N/A
523 BOSTON	27.20	36.67	9.47	45.5%	36.4%	-9.1%	44.75	23.18	-18.87	50.0%	60.0%	10.0%
525 BROCKTON	26.33	25.00	-1.33	54.5%	40.0%	-14.5%	50.39	35.00	-15.39	44.4%	20.0% X	-24.4%
608 MANCHESTER	0.00	N/A	N/A	0.0%	N/A	N/A	15.60	N/A	N/A	66.7%	N/A	N/A
631 NORTHAMPTON	19.80	7.00	-12.80	80.0%	100.0%	20.0%	51.33	22.00	-29.33	55.6%	33.3%	-22.3%
650 PROVIDENCE	33.33	N/A	N/A	66.7%	N/A	N/A	0.00	N/A	N/A	0.0%	N/A	N/A
689 CONNECTICUT	34.03	2.00	-32.03	32.6%	100.0%	67.4%	34.47	7.67	-26.80	47.8%	100.0%	52.2%
TOTAL	38.47	32.15	-6.32	51.8%	44.4%	-7.4%	36.86	23.59	-13.27	54.5%	50.0%	-4.5%
STATION #												
500 ALBANY	34.11	5.00	-29.11	66.7%	75.0%	8.3%	64.00 X	N/A	N/A	16.7%	N/A	N/A
514 BATH	22.00	76.00 X	54.00	100.0%	0.0% X	-100.0%	5.00	8.67	3.67	100.0%	100.0%	0.0%
528 BUFFALO	47.50	70.17 X	22.67	44.4%	37.5%	-6.9%	10.29	19.50	9.21	77.8%	33.3%	-44.5%
532 CANANDAUGUA	40.40	32.67	-7.73	50.0%	50.0%	0.0%	21.67	12.94	-8.73	66.7%	63.2%	-1.5%
670 SYRACUSE	45.30	6.00	-39.30	50.0%	100.0%	50.0%	0.00	N/A	N/A	0.0%	N/A	N/A
TOTAL	40.94	40.64	-0.30	54.1%	50.0%	-4.1%	23.43	12.95	-10.48	59.6%	63.5%	3.9%
STATION #												
526 BRONX	42.00	23.78	-18.22	50.0%	46.2%	-3.8%	73.25 X	3.00	-70.25	33.3%	50.0%	16.7%
527 BROOKLYN	36.13	23.44	-12.69	43.8%	33.3%	-10.5%	59.00 X	41.50	-17.50	29.4%	23.1% X	-4.3%
561 EAST ORANGE	29.71	40.89	11.18	50.0%	44.0%	-6.0%	46.67	8.50	-38.17	33.3%	63.6%	30.3%
604 LYONS	29.42	N/A	N/A	69.2%	N/A	N/A	15.67	N/A	N/A	73.3%	N/A	N/A
620 MONTROSE	55.03	37.26	-17.77	38.9%	41.5%	2.6%	50.97	74.18 X	23.21	32.6%	11.4% X	-21.2%
630 NEW YORK	52.48	31.25	-21.23	40.0%	60.0%	20.0%	36.50	24.86	-11.64	41.4%	57.9%	16.5%
632 NORTHPORT	31.25	36.75	5.50	42.9%	38.5%	-4.4%	23.88	8.81	-15.07	55.9%	78.9%	23.0%
TOTAL	44.75	34.52	-10.23	45.0%	43.4%	-1.6%	39.68	33.99 X	-6.29	43.3%	41.4%	-0.8%

Source: Patient Treatment File and Staff Outpatient File  
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TABLE 7H

Timeliness of Access to Outpatient Services Among Homeless Veterans Identified in the End-Of-Year Inpatient Homeless Survey, FY 1995, FY 1996, and change, by Facility.

STATION #	FY 1995			FY 1996			Change						
	Days to 1st CP Snp #	Days to 1st CP Snp 1st CP Snp #	Days to 1st CP Snp 1st CP Snp #	Days to 1st CP Snp #	Days to 1st CP Snp 1st CP Snp #	Days to 1st CP Snp 1st CP Snp #	Days to 1st CP Snp #	Days to 1st CP Snp 1st CP Snp #	Days to 1st CP Snp 1st CP Snp #				
460 WILMINGTON	0.00	62.67 X	N/A	0.0%	50.0%	25.0%	N/A	0.0%	N/A	0.0%	31.3%	31.3%	N/A
540 CLARKSBORO	1.00	27.71	-6.29	60.0%	54.2%	-5.8%	31.00	33.50	-1.50	26.9%	33.3%	6.4%	6.4%
542 COATESVILLE	34.00	48.41	8.11	34.6%	12.8%	-21.8%	8.29	48.17 X	39.88	63.6%	21.0%	-42.6%	-38.6%
595 LEBANON	34.00	32.75	-1.25	57.1%	50.0%	-7.1%	128.67 X	4.00	-124.67	33.3%	100.0%	66.7%	66.7%
642 PHILADELPHIA	51.92	27.80	-24.12	40.0%	58.3%	18.3%	47.00	47.00	N/A	44.4%	6.7%	6.7%	N/A
645 PITTSBURGH-HIGHL	12.00	29.00	17.00	100.0%	100.0%	0.0%	100.40 X	50.23 X	-49.77	30.9%	31.3%	0.4%	0.4%
693 WILKES BARRE	31.67	36.92	-1.75	47.2%	51.6%	4.3%	50.23 X	42.93 X	-7.30	30.9%	31.3%	0.4%	0.4%
TOTAL	300	20.33	17.33	100.0%	80.0%	-20.0%	21.00	18.07	-2.93	60.0%	61.0%	1.0%	1.0%
STATION #	41.00	30.00	-11.00	77.8%	30.0%	-47.8%	11.00 X	91.00 X	80.00	51.9%	16.7%	-35.2%	-35.2%
512 BALTIMORE	36.42	30.86	-5.56	62.5%	55.6%	-6.9%	37.80 X	8.00	-29.80	100.0%	100.0%	0.0%	0.0%
613 MARTINSBURG	31.03	27.00	-4.03	52.0%	63.3%	11.3%	46.29 X	33.42 X	-12.87	43.4%	46.9%	3.5%	3.5%
641 PEERY POINT	34.21	27.00	-7.21	52.0%	63.3%	11.3%	46.29 X	33.42 X	-12.87	43.4%	46.9%	3.5%	3.5%
688 WASHINGTON	20.00	48.33	28.33	25.0%	66.7%	41.7%	0.00	0.00	N/A	0.0%	0.0%	0.0%	0.0%
TOTAL	30.50	27.73	-2.77	75.0%	50.0%	-25.0%	3.40	13.00	9.60	50.0%	50.0%	0.0%	0.0%
558 DURHAM	45.89	27.73	-18.16	47.8%	20.0%	-27.8%	84.33 X	26.83	57.50	63.6%	55.6%	8.0%	8.0%
565 FAYETTEVILLE NC	71.00 X	39.33	-32.67	33.3%	50.0%	16.7%	20.33	20.33	N/A	28.6%	50.0%	21.4%	21.4%
590 HAMPTON	34.29	52.00	17.71	55.6%	30.0%	-25.6%	20.33	9.80	-10.53	28.6%	50.0%	21.4%	21.4%
637 ASHEVILLE-OTEEN	23.75	42.57	18.82	64.3%	45.5%	-18.8%	40.50	21.82	-18.68	40.7%	51.7%	11.0%	11.0%
652 RICHMOND	40.48	39.05	-1.43	49.2%	45.8%	-3.4%	30.70	21.82	-8.88	40.7%	51.7%	11.0%	11.0%
658 SALEM	23.75	42.57	18.82	64.3%	45.5%	-18.8%	40.50	21.82	-18.68	40.7%	51.7%	11.0%	11.0%
659 SALISBURY	40.48	39.05	-1.43	49.2%	45.8%	-3.4%	30.70	21.82	-8.88	40.7%	51.7%	11.0%	11.0%
TOTAL	40.48	39.05	-1.43	49.2%	45.8%	-3.4%	30.70	21.82	-8.88	40.7%	51.7%	11.0%	11.0%

Source: Patient Treatment File and Staff Outpatient File B - 43

TABLE 7H

Timeliness of Access to Outpatient Services Among Homeless Veterans Identified in the End-Of-Year Impediment Surveys, FY 1995, FY 1996, and change, by Facility.

STATION #	Days to 1st OP Stop in 6 mos. (FY 1995)			Days to 1st OP Stop in 6 mos. (FY 1996)			Days to 1st OP Stop in 6 mos. (FY 1996)			Days to 1st OP Stop in 6 mos. (FY 1996)			Days to 1st OP Stop in 6 mos. (FY 1996)		
	Any OP Stop in 30 days	After DC	Change	Any OP Stop in 30 days	After DC	Change	Any OP Stop in 30 days	After DC	Change	Any OP Stop in 30 days	After DC	Change	Any OP Stop in 30 days	After DC	Change
508	34.83	9.00	-25.83	57.1%	100.0%	42.9%	20.35	N/A	83.3%	N/A	83.3%	N/A	N/A	N/A	N/A
509	84.35 X	40.30	-44.05	26.3%	42.9%	16.6%	38.00	-30.83	34.0%	100.0%	100.0%	70.0%	N/A	N/A	70.0%
521	BIRMINGHAM	0.00	N/A	0.0%	0.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
534	CHARLESTON	62.89	23.83	-39.06	41.7%	71.4%	29.7%	7.00	N/A	40.0%	N/A	40.0%	N/A	N/A	N/A
544	COLUMBIA SC	90.33 X	92.50 X	2.17	33.3%	50.0%	6.83	N/A	85.7%	N/A	17.6%	N/A	N/A	N/A	N/A
557	DUBLIN	33.00	10.00	-23.00	60.0%	100.0%	40.0%	58.70 X	N/A	50.0%	N/A	50.0%	N/A	N/A	N/A
679	TUSCALOOSA	50.00	24.80	-25.20	23.5%	42.9%	19.4%	32.88	N/A	43.8%	N/A	43.8%	N/A	N/A	N/A
680	TUSKEGEE†	50.43	44.74	-5.69	31.6%	43.1%	11.5%	10.43	N/A	48.7%	15.6%	28.26	-21.89	46.3%	100.0%
TOTAL	56.10 X	40.26	-15.84	33.1% X	48.7%	15.6%	28.26	7.17	-21.89	46.3%	100.0%	53.8%	N/A	N/A	53.8%
516	BAY PINES	37.10	6.67	-30.43	41.7%	75.0%	33.3%	27.29	-30.35	36.4%	64.0%	27.6%	N/A	N/A	27.6%
546	MIAMI	39.64	48.67	9.03	43.2%	41.7%	-1.5%	13.00	N/A	75.0%	N/A	75.0%	N/A	N/A	N/A
548	W PALM BEACH	17.00	56.40	39.40	71.4%	40.0%	-31.4%	0.00	N/A	0.0%	N/A	0.0%	N/A	N/A	N/A
573	GAINESVILLE	113.14 X	29.00	-84.14	37.5%	66.7%	29.2%	4.33	N/A	75.0%	N/A	75.0%	N/A	N/A	N/A
594	LAKE CITY	45.00	26.14	-18.86	50.0%	43.5%	-4.5%	44.26	N/A	21.1%	N/A	21.1%	N/A	N/A	N/A
672	SAN JUAN	61.71	70.25 X	8.54	40.0%	20.0% X	-20.0%	0.00	N/A	0.0%	N/A	0.0%	N/A	N/A	N/A
673	TAMPA	26.17	14.00	-12.17	62.5%	50.0%	-12.5%	39.77 X	N/A	31.6%	N/A	31.6%	N/A	N/A	N/A
TOTAL	45.09	35.39	-9.70	47.9%	50.0%	2.1%	29.93	6.84	-22.88	47.9%	64.0%	16.1%	N/A	N/A	16.1%
581	HUNTINGTON	26.50	N/A	N/A	33.3%	N/A	0.00	N/A	N/A	0.0%	N/A	0.0%	N/A	N/A	N/A
585	LEWINGTON/LESTO	21.20	N/A	N/A	80.0%	N/A	77.73 X	N/A	N/A	37.5%	N/A	37.5%	N/A	N/A	N/A
603	LOUISVILLE	28.33	91.33 X	63.00	66.7%	20.0% X	-46.7%	12.00	-12.60	100.0%	100.0%	-72.7%	N/A	N/A	-72.7%
611	MEMPHIS	55.50	54.00	-1.50	50.0%	25.0% X	-25.0%	44.63	21.60	100.0%	27.3%	66.7%	14.3%	14.3%	14.3%
631	MOUNTAIN HOME	24.25	42.38	18.13	50.0%	62.5%	12.5%	46.36	1.50	44.86	52.4%	66.7%	36.4%	36.4%	36.4%
632	MURFREESBORO	32.00	N/A	N/A	30.0%	N/A	57.00	26.80	-30.20	20.0%	36.4%	36.4%	N/A	N/A	36.4%
656	NASHVILLE	33.00	36.00	3.00	66.7%	40.0%	-26.7%	12.33	13.00	0.67	75.0%	100.0%	25.0%	25.0%	25.0%
TOTAL	29.72	51.81 X	22.09	37.1%	31.0% X	-26.1%	48.92 X	19.83	-29.07	43.8%	38.5%	-2.5%	N/A	N/A	-2.5%

Source: Patient Treatment File and Staff Outpatient File  
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TABLE 7H

Timeliness of Access to Outpatient Services Among Homeless Veterans Identified in the End-of-Year Inpatient Homeless Survey, FY 1995, FY 1996, and change, by Facility.

STATION #	Days to 1st OP Stop in 6 mos. (FY 1995)			Any Payroll OP Stop in 30 days (FY 1995)			Days to 1st OP Stop in 6 mos. (FY 1995)			Any Payroll OP Stop in 30 days (FY 1995)			Days to 1st OP Stop in 6 mos. (FY 1996)			Any Payroll OP Stop in 30 days (FY 1996)			Days to 1st OP Stop in 6 mos. (FY 1996)			Any Payroll OP Stop in 30 days (FY 1996)				
	Mean	Alter DC	Change	Mean	Alter DC	Change	Mean	Alter DC	Change	Mean	Alter DC	Change	Mean	Alter DC	Change	Mean	Alter DC	Change	Mean	Alter DC	Change	Mean	Alter DC	Change		
538	89.60	X	18.46	-71.14	16.7%	73.3%	56.6%	39.90	27.10	-12.80	34.8%	66.7%	20.9%	89.60	X	18.46	-71.14	16.7%	73.3%	56.6%	39.90	27.10	-12.80	34.8%	66.7%	20.9%
539	CINCINNATI	28.00	6.00	-22.00	100.0%	100.0%	0.0%	4.89	6.64	1.75	69.2%	84.6%	15.4%	28.00		6.00	-22.00	100.0%	100.0%	0.0%	4.89	6.64	1.75	69.2%	84.6%	15.4%
541	CLEVELAND/WADE P	23.38	18.91	-4.47	68.0%	75.0%	7.0%	13.00	16.29	3.29	84.8%	75.0%	-9.8%	23.38		18.91	-4.47	68.0%	75.0%	7.0%	13.00	16.29	3.29	84.8%	75.0%	-9.8%
553	DAYTON	5.00	55.00	50.00	50.0%	50.0%	0.0%	41.38	12.14	-29.24	42.9%	77.8%	34.9%	5.00		55.00	50.00	50.0%	50.0%	0.0%	41.38	12.14	-29.24	42.9%	77.8%	34.9%
TOTAL	32.88	19.86	-13.01	58.3%	75.0%	16.7%	20.55	15.51	-5.04	63.3%	76.2%	12.9%	32.88		19.86	-13.01	58.3%	75.0%	16.7%	20.55	15.51	-5.04	63.3%	76.2%	12.9%	
506	ANN ARBOR	12.00	18.00	6.00	50.0%	60.0%	10.0%	79.00	1.00	-78.00	20.0%	50.0%	30.0%	12.00		18.00	6.00	50.0%	60.0%	10.0%	79.00	1.00	-78.00	20.0%	50.0%	30.0%
515	BATTLE CREEK	34.84	28.50	-6.34	61.0%	70.0%	9.0%	75.38	20.75	-54.63	13.3%	31.8%	18.5%	34.84		28.50	-6.34	61.0%	70.0%	9.0%	75.38	20.75	-54.63	13.3%	31.8%	18.5%
550	DANVILLE, IL	43.30	14.33	-28.97	36.4%	66.7%	30.3%	76.00	10.00	-66.00	0.0%	0.0%	N/A	43.30		14.33	-28.97	36.4%	66.7%	30.3%	76.00	10.00	-66.00	0.0%	0.0%	N/A
553	ALLEN PARK	75.00	30.00	-45.00	30.4%	43.9%	13.5%	23.29	10.00	-13.29	46.2%	50.0%	3.8%	75.00		30.00	-45.00	30.4%	43.9%	13.5%	23.29	10.00	-13.29	46.2%	50.0%	3.8%
583	INDIANAPOLIS	49.84	6.00	-43.84	50.0%	50.0%	0.0%	53.00	11.50	-41.50	50.0%	66.7%	N/A	49.84		6.00	-43.84	50.0%	50.0%	0.0%	53.00	11.50	-41.50	50.0%	66.7%	N/A
610	MAURON IN	53.64	69.50	15.86	53.8%	50.0%	-3.8%	81.50	11.50	-70.00	50.0%	66.7%	16.7%	53.64		69.50	15.86	53.8%	50.0%	-3.8%	81.50	11.50	-70.00	50.0%	66.7%	16.7%
TOTAL	46.99	25.74	-21.25	49.0%	61.2%	12.2%	58.33	15.71	-42.62	23.0%	39.4%	16.4%	46.99		25.74	-21.25	49.0%	61.2%	12.2%	58.33	15.71	-42.62	23.0%	39.4%	16.4%	
533	CHICAGO-LAKESIDE	37.43	13.00	-24.43	40.0%	35.0%	-5.0%	93.00	43.50	-49.50	0.0%	33.3%	33.3%	37.43		13.00	-24.43	40.0%	35.0%	-5.0%	93.00	43.50	-49.50	0.0%	33.3%	33.3%
537	CHICAGO-WESTSIDE	72.83	X	-39.50	41.7%	100.0%	58.3%	21.20	9.80	-11.40	63.0%	80.0%	17.0%	72.83	X	-39.50	41.7%	100.0%	58.3%	21.20	9.80	-11.40	63.0%	80.0%	17.0%	
538	NORTH CHICAGO	48.33	X	-28.43	31.5%	70.6%	39.1%	34.09	34.09	0.00	43.9%	38.5%	-5.4%	48.33	X	-28.43	31.5%	70.6%	39.1%	34.09	34.09	0.00	43.9%	38.5%	-5.4%	
543	ROSEMOUNTAIN	54.32	52.09	-2.23	46.7%	30.8%	-15.9%	57.57	14.00	-43.57	36.4%	43.9%	6.5%	54.32		52.09	-2.23	46.7%	30.8%	-15.9%	57.57	14.00	-43.57	36.4%	43.9%	6.5%
607	MANSION	15.00	0.00	-15.00	100.0%	0.0%	N/A	7.00	1.00	-6.00	50.0%	100.0%	50.0%	15.00		0.00	-15.00	100.0%	0.0%	N/A	7.00	1.00	-6.00	50.0%	100.0%	50.0%
676	TOMAH	59.75	24.94	-34.81	14.3%	53.0%	40.7%	51.33	133.00	81.67	0.0%	0.0%	-18.2%	59.75		24.94	-34.81	14.3%	53.0%	40.7%	51.33	133.00	81.67	0.0%	0.0%	-18.2%
695	MILWAUKEE	21.50	21.50	0.00	66.7%	N/A	N/A	92.23	54.50	-37.73	26.1%	17.0%	-9.1%	21.50		21.50	0.00	66.7%	N/A	N/A	92.23	54.50	-37.73	26.1%	17.0%	-9.1%
TOTAL	59.94	X	27.96	-31.98	39.6%	55.7%	16.2%	47.80	27.77	-20.04	38.6%	42.9%	4.3%	59.94	X	27.96	-31.98	39.6%	55.7%	16.2%	47.80	27.77	-20.04	38.6%	42.9%	4.3%

Source: Patient Treatment File and Staff Outpatient File  
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TABLE 7H

Timeliness of Access to Outpatient Services Among Homeless Veterans Identified in the End-Of-Year Impatient Homeless Survey, FY 1995, FY 1996, and change, by Facility.

STATION #	Days in 1st OP Shop in 6 mos. (FY 1995)			Days in 1st OP Shop in 6 mos. (FY 1996)			Days in 1st OP Shop in 6 mos. (FY 1995)			Days in 1st OP Shop in 6 mos. (FY 1996)			Days in 1st OP Shop in 6 mos. (FY 1995)			Days in 1st OP Shop in 6 mos. (FY 1996)			
	1st OP Shop	After DC	Change	1st OP Shop	After DC	Change	1st OP Shop	After DC	Change	1st OP Shop	After DC	Change	1st OP Shop	After DC	Change	1st OP Shop	After DC	Change	
438	71.00 X		N/A	71.00 X		N/A	71.40 X		N/A	71.40 X		N/A	28.6%		N/A	28.6%		N/A	
548	74.08 X	44.67	-39.41	74.08 X	44.67	-39.41	6.00	80.0%	35.9%	6.00	80.0%	15.00	80.0%	33.3%	15.00	80.0%	46.7%	-46.7%	
579	64.50 X	29.80	-4.00	64.50 X	29.80	-4.00	15.94	50.0%	-8.1%	15.94	50.0%	N/A	72.2%	N/A	N/A	0.0%	N/A	N/A	
618	33.89	10.09	-17.91	33.89	10.09	-17.91	40.31	78.6%	23.0%	40.31	78.6%	N/A	28.6%	N/A	N/A	28.6%	N/A	N/A	
656	28.00			28.00															
TOTAL	46.83	20.74	-26.12	46.83	20.74	-26.12	30.79	63.3%	13.7%	30.79	63.3%	21.00	31.3%	31.3%	-9.79	46.6%	31.3%	-13.3%	
STATION #																			
555	116.67 X	41.50	-75.17	116.67 X	41.50	-75.17	6.50	0.0%	0.0%	6.50	0.0%	49.75 X	43.23	66.7%	43.23	66.7%	60.0%	-4.7%	
574	0.00		N/A	0.00		N/A	28.25	0.0%	N/A	28.25	0.0%	55.00 X	26.75	50.0%	26.75	50.0%	0.0%	-50.0%	
592	32.00	31.31	-0.69	32.00	31.31	-0.69	41.08	53.0%	3.0%	41.08	53.0%	13.00	N/A	24.7%	N/A	24.7%	100.0%	63.3%	
597	91.50 X	26.00	-65.50	91.50 X	26.00	-65.50	49.40	100.0%	100.0%	49.40	100.0%	1.00	-36.40	37.3%	-11.00	60.0%	20.0%	-40.0%	
634	89.67 X	58.50 X	-31.17	89.67 X	58.50 X	-31.17	12.00	4.0%	-6.7%	12.00	4.0%								
TOTAL	71.00 X	34.62	-36.38	71.00 X	34.62	-36.38	34.69	28.0%	50.0%	34.69	28.0%	35.13 X	0.43	34.7%	0.43	34.7%	46.2%	11.5%	
STATION #																			
543	32.00		N/A	32.00		N/A	5.00	0.0%	N/A	5.00	0.0%			N/A	N/A	64.7%	N/A	N/A	
589	32.28	13.60	-18.68	32.28	13.60	-18.68	20.60	20.0%	52.7%	20.60	20.0%			N/A	N/A	80.0%	N/A	N/A	
647	44.33	X		44.33	X		24.50	33.3%	N/A	24.50	33.3%	2.33	-10.47	20.4%	-10.47	20.4%	71.0%	43.6%	
657	40.20	37.46	-4.89	40.20	37.46	-4.89	12.80	66.7%	9.3%	12.80	66.7%			N/A	N/A	0.0%	N/A	N/A	
672	18.88	18.88	-21.82	18.88	18.88	-21.82	82.4%	82.4%	20.3%	82.4%	82.4%			N/A	N/A	0.0%	N/A	N/A	
686	33.81	33.71	1.00	33.81	33.71	1.00	26.75	75.0%	62.5%	26.75	75.0%			N/A	N/A	37.5%	N/A	N/A	
TOTAL	42.01	27.84	-14.17	42.01	27.84	-14.17	29.08	58.9%	68.3%	29.08	58.9%	2.33	-26.74	44.7%	-26.74	44.7%	71.0%	30.3%	

Source: Patient Treatment File and Staff/Outpatient File  
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TABLE 7H

Timeliness of Access to Outpatient Services Among Homeless Veterans Identified in the End-Of-Year Impatient Homeless Survey, FY 1995, FY 1996, and change, by Facility.

STATION #	Days to 1st OP Stop in 6 mos. (FY 1995)			Days to 1st OP Stop in 6 mos. (FY 1996)			Change			
	1st OP Stop in 6 mos.	After DC	Change	1st OP Stop in 6 mos.	After DC	Change	1st OP Stop in 6 mos.	After DC	Change	
<b>STATION #</b>										
503 ALEXANDRIA	1733	26.00	8.67	50.0%	25.0%	X	-25.0%	N/A	0.0%	N/A
520 BLDG	4525	24.33	-40.92	40.0%	66.7%	26.7%	26.7%	6.20	46.7%	41.2%
544 FAYETTEVILLE AR	2100	23.40	21.40	100.0%	60.0%	-40.0%	0.00	N/A	0.0%	N/A
580 HOUSTON	13750	50.50	-77.00	9.1%	21.4%	12.3%	4.00	3.00	66.7%	57.1%
586 JACKSON	7075	68.20	-2.55	21.4%	28.6%	7.2%	72.20	X	N/A	36.4%
598 LITTLE ROCK	1667	41.67	25.00	38.3%	20.0%	X	18.13	18.13	66.7%	63.6%
639 NEW ORLEANS	4322	7.50	-35.72	66.7%	66.7%	0.0%	6.21	2.00	-4.21	100.0%
633 OKLAHOMA CITY	6633	18.33	-30.08	36.4%	50.0%	13.6%	32.70	20.63	-12.07	46.7%
667 SHREVEPORT	5786	57.25	-0.61	40.0%	20.0%	X	-20.0%	N/A	81.2%	51.8%
TOTAL	5973	37.08	-22.65	39.3%	38.3%	X	-1.0%	23.64	-6.47	61.1%
<b>STATION #</b>										
549 DALLAS	1067	21.00	10.33	100.0%	63.6%	-36.4%	-36.39	20.31	-16.08	61.9%
671 SAN ANTONIO	3700	36.21	-0.79	64.3%	40.0%	-24.3%	19.80	N/A	-21.4%	0.0%
683 TEMPLE	3033	2.50	-7.80	21.3%	40.0%	18.7%	0.00	N/A	0.0%	N/A
683 WACO	7893	X	N/A	33.3%	40.0%	6.7%	0.00	N/A	0.0%	N/A
TOTAL	5117	28.04	-23.13	48.8%	47.2%	-1.6%	32.78	20.74	-12.04	43.2%
<b>STATION #</b>										
501 ALBUQUERQUE	2389	87.75	X	60.0%	25.0%	X	-35.0%	3.00	N/A	50.0%
504 AMARILLO	0.00	N/A	N/A	0.0%	N/A	N/A	41.00	N/A	N/A	0.0%
519 BEO SPRING	5133	-3.34	25.0%	66.7%	41.7%	25.83	7.20	-18.03	62.5%	6.9%
644 PHOENIX	3464	28.64	-6.00	56.3%	66.7%	10.3%	20.50	N/A	N/A	33.3%
649 PRESHOTT	0.00	N/A	0.0%	0.0%	N/A	N/A	40.10	71.50	31.40	6.3%
678 TUCSON	3160	49.33	17.75	57.1%	57.1%	0.0%	4.50	N/A	47.1%	-40.0%
TOTAL	3445	46.83	13.41	51.3%	57.7%	6.4%	23.33	2.04	45.2%	23.1%

Source: Patient Treatment File and Staff Outpatient File B - 47

TABLE 7H

Timeliness of Access to Outpatient Services Among Homeless Veterans Identified in the End-Of-Year Inpatient Homeless Survey, FY 1995, FY 1996, and change, by Facility.

STATION #	Days to 1st OP Stop in 6 mos. (FY 1995)			Any Psych OP Stop in 30 days After DC (FY 1995)			Any Physc OP Stop in 30 days After DC (FY 1995)			Days to 1st OP Stop in 6 mos. After DC (FY 1995)			Any SA OP Stop in 30 days After DC (FY 1995)		
	Mean	SD	Change	Mean	SD	Change	Mean	SD	Change	Mean	SD	Change	Mean	SD	Change
426 FORT HARRISON	0.00		N/A	0.0%		N/A	0.00	16.00		0.0%		N/A	0.0%		31.3%
444 CORNER	27.25		-17.92	43.6%		36.4%	34.00	21.17		-11.83		22.2%	0.0%		29.4%
567 FORTYTON	49.25		40.42	20.0%		22.2%	X	0.00		2.2%		N/A	0.0%		0.0%
575 GRAND BUNCTION	32.88		118.00	X		N/A	46.00	X		50.0%		37.00	0.0%		14.7%
660 SALT LAKE CITY	73.88		X	30.0%		100.0%	8.00	8.69		50.0%		8.69	71.4%		0.0%
666 SHERIDAN			-34.14	36.0%		31.6%		70.80	X	-4.4%		-63.97	40.0%		60.0%
TOTAL	53.28		50.04	X		-3.24	41.5%	34.3%	X	-7.2%		42.42	14.65		-27.77
41.9%			42.1%			41.9%						41.9%			-0.2%
STATION #															
531 BORSE	0.00		N/A	0.0%		N/A	4.00	7.40		N/A		5.40	66.7%		100.0%
648 PORTLAND	49.86		-13.86	30.0%		-30.0%	16.71	26.86		-30.0%		4.15	50.0%		66.7%
653 ROSEBURG	60.00		-39.50	42.0%		33.3%	30.44	10.30		-6.6%		-19.94	41.4%		18.9%
663 SEATTLE	48.46		-19.31	59.3%		44.4%	6.71	15.40		-14.9%		8.69	80.0%		63.6%
668 SPOKANE	0.00		N/A	0.0%		N/A	3.75	5.00		N/A		-4.75	100.0%		68.7%
687 WALLA WALLA	28.25		-9.25	75.0%		100.0%	64.60	X		31.0%		-57.40	28.0%		50.0%
TOTAL	48.13		27.94	52.1%		43.5%	21.41	15.10		-8.6%		-6.32	56.0%		55.9%
															-0.1%

Source: Patient Treatment File and Staff Outpatient File  
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TABLE 7H

Timeliness of Access to Outpatient Services Among Homeless Veterans Identified in the End-Of-Year Inpatient Homeless Survey, FY 1995, FY 1996, and change, by Facility.

STATION #	Days to 1st Outpatient Appointment											
	FY 1995	FY 1996										
459 HONOLULU	67.00	X	N/A		33.3%		N/A		7.00		N/A	
570 FRESNO	68.57	X	-13.67		12.5%	X	16.7%	X	2.91		4.09	
612 MARTINEZ	11.50		N/A		100.0%		N/A		15.20		N/A	
640 PALO ALTO	34.15		-2.46		54.3%		53.0%		3.00		N/A	
654 RENO	12.50		77.67	X	65.17		16.7%	X	-50.0%		N/A	
662 SAN FRANCISCO	53.10		-37.43		41.7%		83.3%		26.67		N/A	
TOTAL	40.35		-4.23		47.8%		48.8%		11.00		6.43	
STATION #												
593 LAS VEGAS	70.50	X	-32.00		33.3%		50.0%		0.00		N/A	
605 LONG BEACH	48.50		-16.50		50.0%		50.0%		31.00		-21	
608 LONG BEACH	40.57		-4.67		51.3%		100.0%		19.44		-18.54	
664 SAN DIEGO	43.61		45.10	X	31.49		43.2%		23.08		-30.63	
691 LA WADSWORTH	32.93		-2.93		62.4%		61.2%		0.00		N/A	
TOTAL	37.22		-4.66		56.0%		57.9%		23.76		-5.48	
Average	40.55		-6.08		45.5%		51.1%		29.74		-7.32	
S.D.	25.36		23.34		23.7%		23.3%		24.69		28.3%	
C.V.	0.63		0.64		0.52		0.48		0.95		0.68	

VIDA or facilities marked by an "X" are over 1 Standard Deviation (S.D.) from the mean in an undesirable direction.  
 † FY 1996-FY 1997 comparisons may be distorted by merger.  
 Note: Risk adjusted for differences in patient characteristics, distance of residence from VA, diagnosis, etc.



Attachment

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
-----			
GC ATTORNEY ASSIGNED: BANFIELD, KATHY			
DATE OF EAJA COURT DECISION: SEP 18, 1998			
98-0155	THOMAS, JOHN W.	\$964.86	\$964.86
-----			
SUBTOTAL		964.86	964.86
SUBCOUNT 1			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
-----			
GC ATTORNEY ASSIGNED: ALLEN, MONIQUE			
	DATE OF SAJA COURT DECISION: FEB 25, 1998		
97-1405	STEVENS, ROBINSON, JR.	\$2228.94	\$2228.94
	DATE OF SAJA COURT DECISION: JUN 11, 1998		
97-1698	CARTER, EARNEST, SR.	\$6580.81	\$6580.81
	DATE OF SAJA COURT DECISION: JUN 13, 1998		
97-0606	STRATFORD, STEVEN C.	\$8012.20	\$8012.20
	DATE OF SAJA COURT DECISION: JUL 15, 1998		
97-2071	HARRIS, NORMAN L.	\$895.84	\$895.84
	DATE OF SAJA COURT DECISION: AUG 19, 1998		
97-1335	SKOW, FRED D.	\$2732.55	\$2732.55
-----			
SUBTOTAL		20450.34	20450.34
SUBCOUNT 5			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
-----			
GC ATTORNEY ASSIGNED: CALIS, JAMES			
	DATE OF EAJA COURT DECISION: MAY 8, 1998		
96-0380	HAUSER, THOMAS E.	\$7115.93	\$7115.93
97-0297	COLE, HERMAN L.	\$2623.00	\$1623.00
97-1761	JENVEY, ARTHUR C.	\$772.66	\$772.66
	DATE OF EAJA COURT DECISION: JUN 30, 1998		
97-0454	MORIN, LEON C.	\$6227.52	\$6227.52
	DATE OF EAJA COURT DECISION: JUL 9, 1998		
98-0364	HALLOCK, DONALD	\$550.93	\$550.93
	DATE OF EAJA COURT DECISION: JUL 29, 1998		
97-0200	MERCURIO, FRANK R.	\$50.00	\$50.00
97-2285	COLLINGS, STEVEN L.	\$50.00	\$50.00
	DATE OF EAJA COURT DECISION: AUG 13, 1998		
97-2102	HOCHLEITNER, FREDERICK R.	\$1281.89	\$1281.89
	DATE OF EAJA COURT DECISION: AUG 14, 1998		
98-0416	STAPLETON, ROBERT E.	\$1701.18	\$1701.18
-----			
	SUBTOTAL	20373.11	19373.11
	SUBCOUNT 9		

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
-----			
GC ATTORNEY ASSIGNED: BUTLER, MICHAEL P.			
DATE OF EAJA COURT DECISION: OCT 27, 1997			
96-0917	COLLINS, MARION M., (2)	\$4846.90	\$4500.00
DATE OF EAJA COURT DECISION: DEC 31, 1997			
96-1171	CHANDLER, JACK E., (3)	\$10400.10	\$0.00
DATE OF EAJA COURT DECISION: FEB 20, 1998			
96-1520	BROWN, TONY H.	\$2732.50	\$2732.50
DATE OF EAJA COURT DECISION: MAR 2, 1998			
97-0958	LUCERO, GABRIEL E.	\$1348.13	\$1348.14
DATE OF EAJA COURT DECISION: MAR 10, 1998			
97-0829	WALKER, CLAUDETTE V.	\$3723.14	\$3572.14
DATE OF EAJA COURT DECISION: MAY 8, 1998			
97-0351	SARLO, ROBERT G., (2)	\$3165.60	\$3165.60
DATE OF EAJA COURT DECISION: MAY 20, 1998			
96-1532	ZELLER, WILSON J., JR.	\$1478.54	\$1478.54
DATE OF EAJA COURT DECISION: JUL 27, 1998			
97-0661	WILSON, LARRY M.	\$6556.73	\$6556.73
DATE OF EAJA COURT DECISION: AUG 17, 1998			
97-1724	HARRIS, BILLY B.	\$821.93	\$821.93
-----			
SUBTOTAL		35073.57	24175.58
SUBCOUNT 9			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
-----			
GC ATTORNEY ASSIGNED: CAMPBELL, R. RANDALL			
DATE OF EAJA COURT DECISION: DEC 11, 1997			
96-0941	BRANCH, WILLIAM L.	\$7117.66	\$7117.66
DATE OF EAJA COURT DECISION: MAY 8, 1998			
96-1019	RICHTER, HERBERT L., (2)	\$10935.00	\$10935.00
DATE OF EAJA COURT DECISION: AUG 28, 1998			
89-0079	MOORE, CRAIG J.	\$50642.97	\$50642.97
DATE OF EAJA COURT DECISION: SEP 22, 1998			
97-1623	MORSWORTHY, BENNY R.	\$1895.00	\$1895.00
-----			
SUBTOTAL		70590.63	70590.63
SUBCOUNT 4			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
GC ATTORNEY ASSIGNED: CASSIDY, ED			
	DATE OF EAJA COURT DECISION: OCT 24, 1997		
97-0287	ROSENTHAL, FRANK L.	\$1903.60	\$1903.60
	DATE OF EAJA COURT DECISION: NOV 26, 1997		
97-0084	GLADNEY, KENNETH M.	\$2536.05	\$2536.05
	DATE OF EAJA COURT DECISION: DEC 3, 1997		
96-1455	ARMOLD, ESTON	\$4814.93	\$4160.54
	DATE OF EAJA COURT DECISION: FEB 9, 1998		
96-0700	ROGERS, DAVID J.	\$5308.62	\$0.00
	DATE OF EAJA COURT DECISION: MAR 16, 1998		
96-1655	FRESHMAN, CHARLES PAUL	\$5897.72	\$5897.72
	DATE OF EAJA COURT DECISION: MAY 8, 1998		
91-0801	FRANCO, LUIS J.	\$8977.80	\$8977.80
97-1166	MUSIL, ALAN G.	\$10053.00	\$10053.00
	DATE OF EAJA COURT DECISION: MAY 18, 1998		
97-0916	WILLIAMS, OLIVER T., (438721555)	\$2835.00	\$0.00
	DATE OF EAJA COURT DECISION: MAY 28, 1998		
96-0718	CORDOVA, CAESAR A.	\$5292.75	\$5292.75
	DATE OF EAJA COURT DECISION: JUN 15, 1998		
97-0133	GRZENA, DONALD E.	\$7637.00	\$7637.00
	DATE OF EAJA COURT DECISION: JUN 26, 1998		
97-0220	CAUBLE, WESLEY D.	\$2747.75	\$2747.75
	DATE OF EAJA COURT DECISION: JUN 30, 1998		
96-1761	GARLAND, JAMES, (2)	\$6090.62	\$6090.62
97-0440	OLIVE, CORINNE G.	\$5084.32	\$5084.32
	DATE OF EAJA COURT DECISION: JUL 24, 1998		
97-1847	STEPHENS, LILLIE O.	\$3387.22	\$3387.22
	DATE OF EAJA COURT DECISION: JUL 30, 1998		
97-1529	CHRISTENSEN, KENNETH J.	\$4233.62	\$4233.62
	DATE OF EAJA COURT DECISION: AUG 3, 1998		
96-1523	MARHOLAK, TED	\$7256.58	\$7256.58
	DATE OF EAJA COURT DECISION: AUG 12, 1998		
97-0362	KELLEY, SHIRLEY S.	\$3079.29	\$3079.29
	DATE OF EAJA COURT DECISION: AUG 13, 1998		
96-1543	BRADFORD, BERNARD, JR.	\$8312.50	\$8312.50

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
	DATE OF EAJA COURT DECISION: AUG 14, 1998		
97-0723	KOENIGER, HENRY G.	\$4298.99	\$4298.99
	DATE OF EAJA COURT DECISION: SEP 10, 1998		
97-2077	NUZUM, CHARLES R.	\$4907.23	\$4907.23
	DATE OF EAJA COURT DECISION: SEP 22, 1998		
97-1895	PAZERA, ANTHONY F., (2)	\$4814.35	\$4814.35
SUBTOTAL		108468.94	100670.93
SUBCOUNT 21			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
-----			
GC ATTORNEY ASSIGNED: CHASE, CATHERINE			
DATE OF RAJA COURT DECISION: MAY 8, 1998			
97-1396	PROCTER, DAVID R.	\$4604.37	\$4604.37
97-1944	CLARK, SAMUEL E.	\$2133.50	\$2133.50
DATE OF RAJA COURT DECISION: MAY 27, 1998			
96-1472	HILL, LOWELL R.	\$2343.75	\$2343.75
DATE OF RAJA COURT DECISION: SEP 2, 1998			
97-1810	SMITH, JERRELL D.	\$4053.00	\$4053.00
97-2123	LOWE, RALPH	\$4708.50	\$4708.50
-----			
SUBTOTAL		17843.12	17843.12
-----			
SUBCOURT 5			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
-----			
GC ATTORNEY ASSIGNED: DAVIS, RALPH			
DATE OF EAJA COURT DECISION: DEC 8, 1997			
96-0262	RAY, JACKIE L.	\$7666.66	\$7666.66
DATE OF EAJA COURT DECISION: FEB 20, 1998			
96-0567	PERRZ, ALAN L.	\$3375.00	\$3375.00
96-1077	JOSLIN, WILLIAM H.	\$2827.00	\$2827.00
96-1649	PHILLIPS, TARESA L.	\$1698.35	\$1698.35
97-0266	WILLIS, SIDNEY C.	\$1104.94	\$1104.94
DATE OF EAJA COURT DECISION: FEB 23, 1998			
95-1263	ROEPKE, JOYCE	\$16507.61	\$13264.07
DATE OF EAJA COURT DECISION: MAR 4, 1998			
96-1732	BOOTH, PAUL E., (2)	\$3628.00	\$3268.00
DATE OF EAJA COURT DECISION: MAY 8, 1998			
96-0872	BRUCE, WILLIAM H.	\$4794.50	\$4794.50
96-1704	MAXWELL, TERRY J.	\$8614.75	\$8614.75
97-0728	SCHNELL, MARTIN K.	\$1323.48	\$1323.48
97-1236	KIRM, RAYMOND N.	\$1027.23	\$1027.23
DATE OF EAJA COURT DECISION: AUG 25, 1998			
96-0736	WILKINSON, MARVIN A.	\$2331.25	\$2331.25
DATE OF EAJA COURT DECISION: SEP 16, 1998			
97-0511	SALTER, BILLY C.	\$6795.28	\$6795.28
DATE OF EAJA COURT DECISION: SEP 22, 1998			
97-0396	HANNINEN, DAVID R.	\$4531.20	\$4531.20
-----			
SUBTOTAL		66225.25	62621.71
SUBCOUNT 14			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
-----			
GC ATTORNEY ASSIGNED: DONAWICK, PETER M.			
	DATE OF EAJA COURT DECISION: OCT 1, 1997		
96-0216	BROUSSARD, LOIS S., (2)	\$5625.00	\$5625.00
	DATE OF EAJA COURT DECISION: OCT 16, 1997		
96-1419	ALLEN, TRAVIS E.	\$7024.56	\$6977.58
97-0318	POPE, RONNIE E.	\$1317.40	\$1317.40
	DATE OF EAJA COURT DECISION: NOV 28, 1997		
96-1391	SOTTOSANTI, ALFRED C.	\$6357.80	\$5895.22
	DATE OF EAJA COURT DECISION: DEC 2, 1997		
96-1667	BROWN, NORMAN L.	\$4767.45	\$4689.75
	DATE OF EAJA COURT DECISION: FEB 20, 1998		
97-0509	DAVID, GERALD L., SR.	\$3970.19	\$3970.19
97-0784	MANNINO, SAM	\$5184.45	\$4955.13
	DATE OF EAJA COURT DECISION: MAY 8, 1998		
96-1461	LIVERMAN, LEONARD LEE	\$4720.42	\$4720.42
	DATE OF EAJA COURT DECISION: MAY 11, 1998		
94-0557	HAZAN, SOL J.	\$14970.59	\$14970.59
	DATE OF EAJA COURT DECISION: JUL 28, 1998		
97-2001	WILSON, ARLOW	\$50.00	\$50.00
	DATE OF EAJA COURT DECISION: AUG 28, 1998		
97-2286, (2	YW, (2)	\$4448.27	\$3908.63
	DATE OF EAJA COURT DECISION: SEP 2, 1998		
97-1634	GRIFFITHS, DAVID DAY	\$3815.38	\$3805.51
-----			
SUBTOTAL		62251.51	60885.42
SUBCOUNT 12			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
GC ATTORNEY ASSIGNED: EAGER, ROSALIND E.			
	DATE OF EAJA COURT DECISION: OCT 22, 1997		
96-0308	WILLIAMS, JUNIOR	\$12080.93	\$9500.00
	DATE OF EAJA COURT DECISION: OCT 31, 1997		
96-1686	FARRIS, ROBBIE M.	\$1305.50	\$1255.50
	DATE OF EAJA COURT DECISION: NOV 7, 1997		
97-0196	COOK, LEONARD L., JR.	\$3615.59	\$3615.59
	DATE OF EAJA COURT DECISION: NOV 21, 1997		
96-1366	HOLTOM, GROVER C.	\$3881.61	\$3881.61
	DATE OF EAJA COURT DECISION: NOV 25, 1997		
97-0095	IZEMAN, JEROME L.	\$2050.00	\$2050.00
97-0649	HOLBROOK, MARYBECCA T.	\$1509.87	\$1509.87
	DATE OF EAJA COURT DECISION: FEB 20, 1998		
96-1089	BERGERON, LOUISE A.	\$4744.20	\$4744.20
97-0744	COOK, JULUS S., (3)	\$50.00	\$50.00
	DATE OF EAJA COURT DECISION: MAR 9, 1998		
97-1727	SPALLA, FREDERICK T.	\$964.86	\$964.86
	DATE OF EAJA COURT DECISION: MAR 10, 1998		
97-0363	DREW, MITCHELL B.	\$1879.81	\$1879.81
97-1024	FULLER, WILLARD	\$1697.72	\$0.00
97-1677	BOND, SHERRICE R.	\$3999.00	\$3999.00
	DATE OF EAJA COURT DECISION: MAR 16, 1998		
97-1583	LINDQUIST, JEFFERY R.	\$657.98	\$657.98
97-1665	ONLEY, DONALD L.	\$591.99	\$591.99
	DATE OF EAJA COURT DECISION: MAR 18, 1998		
97-1393	JOHNSON, RICHARD H., (23578010)	\$443.66	\$0.00
	DATE OF EAJA COURT DECISION: MAY 8, 1998		
97-1125	TSIBIDAS, PAULINE	\$3087.50	\$3087.50
97-1512	BEVILLE, ROBIN B.	\$3565.51	\$3565.51
97-1829	SCHROGGINS, CHARLES E.	\$878.63	\$878.63
97-2025	LUURTSEMA, CRAIG A.	\$1100.73	\$1100.73
97-2072	MORRISSEY, JOHN J., JR.	\$982.97	\$982.97
97-2255	RHODES, JAMES W., (2)	\$50.00	\$50.00
	DATE OF EAJA COURT DECISION: MAY 27, 1998		
97-1569	TEMPS, ROBERT T., (2)	\$1899.19	\$1899.85
98-0314	ROWLAND, DERRELL R.	\$333.00	\$333.00
98-0402	CASTILLO, REYNALDO A.	\$50.00	\$50.00

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
	DATE OF EAJA COURT DECISION: JUN 1, 1998		
97-0729	FARR, CARL E.	\$2325.25	\$2275.25
98-0418	YOST, DAVID G.	\$797.29	\$797.00
	DATE OF EAJA COURT DECISION: JUN 5, 1998		
98-0497	SIMS, TERRY	\$1327.50	\$1000.00
	DATE OF EAJA COURT DECISION: JUN 9, 1998		
98-0444	ARMUJO, ALFREDO E.	\$2275.00	\$2275.00
98-0517	HERNDON, EDWARD	\$660.00	\$660.00
	DATE OF EAJA COURT DECISION: JUN 17, 1998		
98-0496	GREEN, GUILLERMO, JR.	\$401.33	\$401.33
	DATE OF EAJA COURT DECISION: JUN 30, 1998		
98-0635	DORSEY, CHARLES E.	\$1856.50	\$1856.50
	DATE OF EAJA COURT DECISION: JUL 21, 1998		
97-2271	TAYLOR, ANDREW R.	\$3136.80	\$3136.80
98-0422	MCCREARY, JACK T.	\$4752.20	\$4752.20
98-0657	DANIELS, THOMAS W.	\$509.87	\$509.87
	DATE OF EAJA COURT DECISION: JUL 24, 1998		
98-0514	OWENS, JAMES O.	\$50.00	\$50.00
98-0644	MARCHESE, ROSARIO R., JR.	\$50.00	\$50.00
	DATE OF EAJA COURT DECISION: JUL 27, 1998		
98-0427	BELSER, CHARLIE J., JR., (2)	\$2162.61	\$2162.61
98-0450	WELCH, KATHERINE A.	\$1506.00	\$1506.00
	DATE OF EAJA COURT DECISION: JUL 30, 1998		
98-0040	SALTZMAN, RONALD A.	\$5793.90	\$5793.90
98-0532	LEPPAN, LOUIS A.	\$792.54	\$792.54
	DATE OF EAJA COURT DECISION: AUG 10, 1998		
97-2296	SILAGHI, PETER J.	\$1612.41	\$1612.41
98-0675	WALTERS, RICHARD L.	\$979.47	\$979.47
98-0678	MCCRAY, LOWIE E.	\$50.00	\$50.00
98-0855	BEISEL, RICHARD H.	\$550.93	\$550.93
	DATE OF EAJA COURT DECISION: AUG 11, 1998		
98-0235	ANDERSON, JOEN L.	\$922.90	\$922.90
	DATE OF EAJA COURT DECISION: SEP 4, 1998		
98-0974	HOOD, JAMES A.	\$493.45	\$493.45
	DATE OF EAJA COURT DECISION: SEP 8, 1998		
98-0619	LYND, LESLIE R.	\$916.02	\$916.02
98-0679	MOONEY, BILLY D.	\$1948.32	\$1948.32
98-0919	HUGHES, HOWARD A.	\$550.93	\$550.93

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
98-1057	KEEL, WILLIAM C.	\$501.66	\$501.66
	DATE OF EAJA COURT DECISION: SEP 22, 1998		
98-0928	WILLIAMS, CAROLYN A.	\$560.00	\$560.00
98-1062	COLON-SANTONI, JOSE G.	\$534.51	\$534.51
	DATE OF EAJA COURT DECISION: SEP 29, 1998		
98-0841	HICKS, LOUIS	\$468.81	\$468.81
98-1066	STEWART, TERRY L.	\$675.00	\$675.00
98-1087	BROWN, JOHN W.	\$595.00	\$595.00
98-1145	HAYNES, DOROTHY J.	\$2180.21	\$2180.21
SUBTOTAL		93356.66	88207.22
SUBCOUNT 56			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
GC ATTORNEY ASSIGNED: FINSNESS, BARBARA			
	DATE OF EAJA COURT DECISION: OCT 10, 1997		
97-0210	DAMERON, LESTER	\$4338.17	\$4338.17
	DATE OF EAJA COURT DECISION: DEC 2, 1997		
97-0296	ROSS, VIOLET	\$2019.00	\$2019.00
	DATE OF EAJA COURT DECISION: MAR 6, 1998		
96-1630	BEYER, KEITH C.	\$7662.73	\$7323.79
	DATE OF EAJA COURT DECISION: MAY 8, 1998		
95-1281	DIXON, KENNETH L.	\$9811.12	\$9811.12
97-0494	DORSH, HAL C.	\$3452.75	\$1452.75
	DATE OF EAJA COURT DECISION: MAY 18, 1998		
96-1057	MILTON, KENNETH N.	\$5289.00	\$5289.00
96-1613	SPEED, GERRY	\$6615.23	\$6615.23
	DATE OF EAJA COURT DECISION: MAY 28, 1998		
97-1223	MORRIS, LEONARD F., (3)	\$5632.00	\$0.00
	DATE OF EAJA COURT DECISION: MAY 29, 1998		
97-1525	VICTORY, WILLIAM W.	\$788.35	\$788.35
	DATE OF EAJA COURT DECISION: JUN 17, 1998		
97-1706	STEWART, GENE W.	\$3129.00	\$3129.00
	DATE OF EAJA COURT DECISION: JUN 23, 1998		
97-1979	INGRAM, DARRELL	\$5471.87	\$5471.87
	DATE OF EAJA COURT DECISION: AUG 28, 1998		
98-0004	PIERCE, JERRY L., (2)	\$1960.29	\$1906.29
	DATE OF EAJA COURT DECISION: SEP 22, 1998		
98-0135	WILLIAMS, RUSSELL D.	\$1610.28	\$1610.28
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SUBTOTAL		57779.79	49754.85
SUBCOUNT 13			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
GC ATTORNEY ASSIGNED: FLYNN, MARY ANN			
	DATE OF EAJA COURT DECISION: NOV 4, 1997		
97-0139	SNYDER, DUANE P.	\$2523.00	\$2523.00
	DATE OF EAJA COURT DECISION: DEC 10, 1997		
96-1453	PARKER, STEVE R.	\$5928.08	\$5928.08
	DATE OF EAJA COURT DECISION: DEC 15, 1997		
96-0025	TOMLINSON, PATRICIA G.	\$5415.66	\$5415.66
	DATE OF EAJA COURT DECISION: FEB 20, 1998		
96-0086	JOHNSON, KENNETH D., (21806725)	\$14685.81	\$14685.81
97-0495	ROME, ALLEN A.	\$4602.13	\$4602.13
97-0641	COLEMAN, JOE W.	\$4865.64	\$4865.64
97-1070	WEBB, PATRICK B.	\$1322.47	\$1322.47
	DATE OF EAJA COURT DECISION: FEB 25, 1998		
97-0501	KAPIOTIS, CHARLES	\$1858.49	\$1858.49
	DATE OF EAJA COURT DECISION: MAR 13, 1998		
97-1291	GRANAM, C.J.	\$1500.00	\$1500.00
	DATE OF EAJA COURT DECISION: APR 2, 1998		
97-0075	CREENMORE, HAROLD	\$50.00	\$50.00
	DATE OF EAJA COURT DECISION: MAY 8, 1998		
96-1036	JONES, JAMES H.	\$5140.00	\$5140.00
97-1257	DIXON, PERCY	\$2824.15	\$2824.15
	DATE OF EAJA COURT DECISION: JUN 15, 1998		
97-2234	KNIGHT, PAUL M., (2)	\$1753.13	\$1753.13
	DATE OF EAJA COURT DECISION: JUL 7, 1998		
97-2158	WANGSBERG, BEVERLY T.	\$2781.16	\$2781.16
	DATE OF EAJA COURT DECISION: JUL 29, 1998		
92-1177	EPERAIM, MORAY L.	\$42423.26	\$42423.26
	DATE OF EAJA COURT DECISION: AUG 13, 1998		
96-1456	BAKER, JOSEPH T.	\$9352.79	\$9352.79
97-1840	HARVEY, GARY W.	\$4994.01	\$4994.01
	DATE OF EAJA COURT DECISION: SEP 23, 1998		
97-2331	SAYGER, SAMUEL S.	\$2300.00	\$2300.00
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SUBTOTAL		114269.78	114319.78
SUBCOUNT 18			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
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GC ATTORNEY ASSIGNED: FORTSCH, GREGORY			
	DATE OF EAJA COURT DECISION: NOV 4, 1997		
95-1163	MORTON, ROBERT W.	\$11530.00	\$8000.00
	DATE OF EAJA COURT DECISION: NOV 28, 1997		
95-0796	LLOYD, JOSEPH	\$9577.94	\$5850.00
	DATE OF EAJA COURT DECISION: DEC 19, 1997		
95-0952	LYTTLE, ROBERT L., JR.	\$4746.01	\$4746.01
	DATE OF EAJA COURT DECISION: FEB 12, 1998		
96-0848	EARNHART, LOLA B.	\$8448.00	\$7000.00
	DATE OF EAJA COURT DECISION: FEB 20, 1998		
96-1066	TALKINGTON, WILLARD M., (2)	\$6954.11	\$6954.11
97-0201	ALLEN, JAMES E.	\$1547.50	\$1547.50
97-0493	TRICE, LOUIS	\$1739.75	\$1739.75
	DATE OF EAJA COURT DECISION: MAR 3, 1998		
97-1076	GORDON, WILLIAM P.	\$1209.42	\$1209.42
97-1325	BROWN, JEFFREY M.	\$3186.56	\$3186.56
	DATE OF EAJA COURT DECISION: MAR 6, 1998		
97-0953	DAVENPORT, JOANNE M.	\$1204.01	\$1150.41
	DATE OF EAJA COURT DECISION: MAR 31, 1998		
96-0709	GARRINO, APOLINARIO R.	\$2301.04	\$1900.00
	DATE OF EAJA COURT DECISION: APR 20, 1998		
96-1217	MCMILL, THOMAS P.	\$8562.84	\$8530.00
	DATE OF EAJA COURT DECISION: JUN 4, 1998		
96-0117	TATE, WILLIAM C.	\$19485.83	\$15000.00
	DATE OF EAJA COURT DECISION: JUN 9, 1998		
97-1527	BENNING, DONALD G., JR.	\$2160.56	\$2160.56
	DATE OF EAJA COURT DECISION: JUL 16, 1998		
97-1477	COFFEY, THOMAS F.	\$3691.00	\$3593.87
	DATE OF EAJA COURT DECISION: AUG 28, 1998		
97-1770	WALLACE, GARY L.	\$2821.75	\$2821.75
	DATE OF EAJA COURT DECISION: AUG 31, 1998		
97-2098	HEATH, WILLIAM E, III, (2)	\$4386.00	\$0.00
-----			
SUBTOTAL		93552.32	75389.94
SUBCOURT 17			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
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GC ATTORNEY ASSIGNED: GALLA, KAREN			
	DATE OF EAJA COURT DECISION: DEC 11, 1997		
96-1073	ROUNDS, BRENDA G.	\$7237.50	\$7237.50
	DATE OF EAJA COURT DECISION: DEC 12, 1997		
97-0184	SCOTT, EDDIE L.	\$4992.00	\$4768.00
	DATE OF EAJA COURT DECISION: FEB 18, 1998		
96-1698	REEDER, MAX L.	\$3324.20	\$3117.45
	DATE OF EAJA COURT DECISION: MAR 9, 1998		
97-0571	MISTER, GEORGE H., (2)	\$928.41	\$928.41
	DATE OF EAJA COURT DECISION: MAR 10, 1998		
96-0433	MURPHY, DONALD R.	\$3996.46	\$2143.34
	DATE OF EAJA COURT DECISION: APR 3, 1998		
97-0956	BURTT, DONALD J.	\$50.00	\$50.00
	DATE OF EAJA COURT DECISION: MAY 8, 1998		
97-1313	HOUSTON, LENNIE S.	\$1819.90	\$1819.90
	DATE OF EAJA COURT DECISION: JUN 1, 1998		
97-0669	SCHULTZ, JOSEPH MAX	\$2093.41	\$2093.41
	DATE OF EAJA COURT DECISION: AUG 4, 1998		
97-1627	COOK, ROY C.	\$2598.65	\$2598.65
	DATE OF EAJA COURT DECISION: AUG 25, 1998		
97-0919	MOYE, CHARLES E.	\$2482.84	\$2482.84
97-2075	MONTAG, RAYMOND V.	\$1454.25	\$1454.25
98-0023	ROSEN, MARK	\$50.00	\$50.00
	DATE OF EAJA COURT DECISION: SEP 11, 1998		
97-1367	ROSE, BRUCE A.	\$3764.43	\$3731.47
-----			
SUBTOTAL		34792.05	32475.22
SUBCOURT 13			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
GC ATTORNEY ASSIGNED: GORDON, AMY S.			
	DATE OF RAJA COURT DECISION: OCT 9, 1997		
96-0847	TORRES-CHIQUES, JOSE E.	\$2650.80	\$0.00
	DATE OF RAJA COURT DECISION: OCT 16, 1997		
97-0050	GROULX, MELVIN HENRY	\$3125.00	\$3125.00
	DATE OF RAJA COURT DECISION: OCT 23, 1997		
97-0214	VEILL, GERTRUDE E.	\$50.00	\$50.00
	DATE OF RAJA COURT DECISION: DEC 8, 1997		
96-0678	O'HANLON, ALVIN M.	\$8658.72	\$7000.00
	DATE OF RAJA COURT DECISION: JAN 14, 1998		
97-0584	JOHNSON, LARRY D.	\$50.00	\$50.00
	DATE OF RAJA COURT DECISION: JAN 15, 1998		
95-0750	SYELO, STEVEN	\$49495.50	\$0.00
	DATE OF RAJA COURT DECISION: FEB 20, 1998		
96-1710	MORRIS, LORNIE C.	\$5620.64	\$5620.64
97-0076	PARISH, ELDRIDGE C.	\$2062.08	\$2062.08
	DATE OF RAJA COURT DECISION: MAR 3, 1998		
97-0747	STEPHAN, WILLIAM J.	\$50.00	\$50.00
97-1086	HENDRIX, WILLIAM	\$1737.50	\$1737.50
	DATE OF RAJA COURT DECISION: APR 2, 1998		
97-1609	CASTLEBERRY, WILLIAM L.	\$50.00	\$50.00
	DATE OF RAJA COURT DECISION: MAY 1, 1998		
96-1098	ROSPLOCH, JOHN M.	\$50.00	\$50.00
	DATE OF RAJA COURT DECISION: MAY 8, 1998		
96-0054	STOTLER, KENNETH L.	\$4340.03	\$4340.03
96-1356	OWENS-GAY, SUSAN G.	\$6341.75	\$6341.75
97-1421	KEIPPER, SCOTT C.	\$682.32	\$682.32
	DATE OF RAJA COURT DECISION: MAY 12, 1998		
96-1743	WEINERT, LEE R., JR.	\$3515.53	\$3515.53
97-1157	TUCKER, TONY E.	\$1173.19	\$1173.19
	DATE OF RAJA COURT DECISION: MAY 27, 1998		
96-1646	SAUBLE, WILLIAM M.	\$4252.50	\$4252.50
	DATE OF RAJA COURT DECISION: JUN 2, 1998		
96-0958	ROSE, PHILLIP D., (2)	\$2433.44	\$2433.44
	DATE OF RAJA COURT DECISION: JUN 15, 1998		
96-0698	FISHER, ARNOLD L., SR.	\$3411.00	\$3411.00
97-0642	DIAZ-BENITEZ, JULIO	\$5959.27	\$5959.27

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
	DATE OF EAJA COURT DECISION: JUL 15, 1998		
97-0203	CAULDER, EARL J.	\$5813.25	\$4500.00
	DATE OF EAJA COURT DECISION: JUL 24, 1998		
97-2259	ROBERTSON, JACKIE D.	\$1323.06	\$1323.06
	DATE OF EAJA COURT DECISION: JUL 28, 1998		
98-0256	GROULX, MELVIN H., (2)	\$3546.23	\$3546.23
	DATE OF EAJA COURT DECISION: SEP 1, 1998		
97-1835	BAILEY, JOHN A.	\$1091.67	\$1091.67
SUBTOTAL		117483.48	62365.21
SUBCOUNT 25			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
GC ATTORNEY ASSIGNED: JOE, DARRYL			
	DATE OF EAJA COURT DECISION: OCT 20, 1997		
97-0123	TATE, PHILLIP E., JR.	\$1951.64	\$1951.64
	DATE OF EAJA COURT DECISION: OCT 31, 1997		
97-0431	WHITE, WILLIAM T.	\$1207.50	\$1197.50
	DATE OF EAJA COURT DECISION: DEC 18, 1997		
97-0236	CLEVINGER, EDWARD S.	\$5029.10	\$5000.00
	DATE OF EAJA COURT DECISION: FEB 20, 1998		
95-0632	BRANDON, PHILLIP L.	\$8937.50	\$8937.50
95-1275	DILLON, BETTY J., (2)	\$7280.27	\$7070.27
96-1475	VOELKER, JACK E.	\$6123.03	\$6123.03
	DATE OF EAJA COURT DECISION: MAR 12, 1998		
97-0307	IRIZARRY, JOSE A.	\$2516.78	\$2516.78
	DATE OF EAJA COURT DECISION: MAR 17, 1998		
96-1370	ANDERSON, MARY L.	\$4050.00	\$4050.00
	DATE OF EAJA COURT DECISION: MAY 8, 1998		
97-0021	CRUZ, FRANCISCO I.	\$6040.00	\$6040.00
97-0282	CHRISTIANSEN, ERIK K., (2)	\$4979.24	\$4979.24
97-0709	BARNHILL, LOUIS B.	\$4680.00	\$4680.00
	DATE OF EAJA COURT DECISION: JUN 3, 1998		
97-1145	MARTINEZ, NELSON	\$1312.50	\$1312.50
	DATE OF EAJA COURT DECISION: JUN 5, 1998		
97-1053	PAIGE, RUFFIN L., JR.	\$3330.61	\$0.00
	DATE OF EAJA COURT DECISION: JUN 11, 1998		
97-1528	MILLER, BRUCE D.	\$2322.95	\$2322.95
	DATE OF EAJA COURT DECISION: JUL 28, 1998		
97-1712	LEIRO, LAWRENCE H.	\$1847.12	\$1847.12
	DATE OF EAJA COURT DECISION: AUG 6, 1998		
98-0003	MCCLEAN, RAYMOND R.	\$50.00	\$50.00
	DATE OF EAJA COURT DECISION: AUG 7, 1998		
97-1602	POLLOCK, RICK A.	\$1905.75	\$1784.25
	DATE OF EAJA COURT DECISION: AUG 10, 1998		
97-1295	HAMILTON, IVAN	\$2640.00	\$2640.00
	DATE OF EAJA COURT DECISION: AUG 19, 1998		
95-0094	STICKLEY, RONDO C.	\$18829.14	\$12000.00
97-1573	WILLIAMS, BERGARD A., (25660589)	\$5966.59	\$5000.00

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
	DATE OF ENAJA COURT DECISION: SEP 1, 1998		
97-2330	MUNOZ-FIGUEROA, TOMAS	\$3719.30	\$3719.30
	DATE OF ENAJA COURT DECISION: SEP 24, 1998		
96-1407	BELANGER, TERRY R., (2)	\$10377.69	\$8370.94
SUBTOTAL		105096.71	91593.02
SUBCOUNT 22			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
GC ATTORNEY ASSIGNED: KATINA, MICHELE R.			
	DATE OF EAJA COURT DECISION: OCT 3, 1997		
96-1299	BARTON, ROBERT H.	\$1798.88	\$1798.88
	DATE OF EAJA COURT DECISION: NOV 28, 1997		
96-0551	FETNER, GEORGE	\$3300.00	\$3300.00
	DATE OF EAJA COURT DECISION: DEC 3, 1997		
96-0661	CARRILLO, ARNOLD	\$5228.00	\$5228.00
	DATE OF EAJA COURT DECISION: FEB 20, 1998		
95-0828	SCHNEIDER, JOHN C.	\$3798.71	\$4027.51
96-0244	JOHNSON, VICTORIA L.	\$5859.00	\$5859.00
96-0393	FOWLER, TOM H.	\$2915.42	\$2915.42
96-1759	COOKSON, JOHN A.	\$2787.35	\$2787.35
97-0395	COLE, WILLIAM P.	\$2379.55	\$2379.55
97-0523	ZAMORA, STEPHEN A.	\$50.00	\$50.00
	DATE OF EAJA COURT DECISION: MAR 4, 1998		
97-0433	WILLARD, DAVID C.	\$2051.44	\$2051.44
	DATE OF EAJA COURT DECISION: MAY 8, 1998		
96-1266	UNTALAN, CRISPIN B.	\$7353.00	\$7198.20
97-0170	DURAN, RICHARD	\$3812.50	\$3812.50
97-0512	GARRETT, TRACY W.	\$1997.28	\$1997.26
97-1176	JOHNSON, CURTIS, JR., (354525000)	\$960.15	\$960.15
	DATE OF EAJA COURT DECISION: JUN 11, 1998		
97-1120	GOFF, CARL L.	\$3504.60	\$2694.30
	DATE OF EAJA COURT DECISION: JUL 13, 1998		
97-0552	PALMER, GILLET	\$4644.00	\$4644.00
97-1557	VAN ELLEN, JAMES R.	\$1961.24	\$1961.24
	DATE OF EAJA COURT DECISION: JUL 14, 1998		
97-1395	LOFTON, BARNEY L.	\$5890.31	\$5890.31
	DATE OF EAJA COURT DECISION: JUL 27, 1998		
97-1655	SEYMORE, JIMMIE L.	\$4335.94	\$4335.94
	DATE OF EAJA COURT DECISION: AUG 7, 1998		
95-1000	MCNEELY, VIOLET V.	\$4362.35	\$4362.35
	DATE OF EAJA COURT DECISION: AUG 28, 1998		
97-0948	WATSON, ANDY	\$4088.84	\$4088.84
97-1480	FORCARO, FRANCIS A.	\$4033.41	\$4033.41

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
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DATE OF EAJA COURT DECISION: SEP 28, 1998			
97-1715	HESTDALEN, BRUCE W.	\$4579.21	\$4579.21
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SUBTOTAL		\$1691.18	\$0954.86
SUBCOUNT 23			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
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GC ATTORNEY ASSIGNED: KOEHLER, ADRIENNE			
DATE OF EAJA COURT DECISION: JAN 22, 1998			
96-0496	SEAN, LAWRENCE G.	\$41462.50	\$12000.00
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SUBTOTAL		41462.5	12000
SUBCOUNT 1			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
GC ATTORNEY ASSIGNED: KRASNEGOR, DANIEL			
DATE OF RAJA COURT DECISION: FEB 20, 1998			
97-0627	KELLY, JOAN K.	\$5674.11	\$5674.11
DATE OF RAJA COURT DECISION: MAR 6, 1998			
97-0558	SIMON, STEVEN C.	\$10422.50	\$10422.50
DATE OF RAJA COURT DECISION: MAY 14, 1998			
97-0769	MUSGROVES, JIMMIE C.	\$2605.14	\$2605.14
98-0030	PATRAMELLA, BENOY	\$1937.00	\$1937.00
DATE OF RAJA COURT DECISION: JUN 9, 1998			
97-2127	HOWLETT, EDISON C.	\$932.97	\$932.97
DATE OF RAJA COURT DECISION: JUL 7, 1998			
97-2010	BRASHEAR, GILBERTE	\$2768.00	\$2768.00
DATE OF RAJA COURT DECISION: JUL 13, 1998			
97-1989	BENNETT, ROBERT E.	\$4386.00	\$4386.00
DATE OF RAJA COURT DECISION: AUG 24, 1998			
94-1029	MICHELL, HAROLD D.	\$6455.21	\$6455.21
DATE OF RAJA COURT DECISION: SEP 1, 1998			
97-0891	LUDLAM, WILLIAM F., SR., (2)	\$4097.65	\$4097.65
DATE OF RAJA COURT DECISION: SEP 8, 1998			
97-1028	ZARYCKI, THADDEUS F.	\$6175.79	\$6175.79
SUBTOTAL		45454.37	45454.37
SUBCOURT 10			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
GC ATTORNEY ASSIGNED: LEONARD, MICHAEL			
	DATE OF EAJA COURT DECISION: OCT 2, 1997		
97-0089	NEFF, VERNON DALE	\$2093.75	\$2093.75
	DATE OF EAJA COURT DECISION: NOV 19, 1997		
97-0073	REGAN, LAYNE M.	\$3683.91	\$3683.91
	DATE OF EAJA COURT DECISION: DEC 11, 1997		
96-0154	RIVERS, RICHARD M.	\$3744.60	\$2753.14
	DATE OF EAJA COURT DECISION: FEB 20, 1998		
97-0187	HEIM, EPBERT L.	\$2749.28	\$2749.28
	DATE OF EAJA COURT DECISION: MAR 13, 1998		
93-0865	LIBERTINE, RICHARD A.	\$4976.40	\$3800.00
	DATE OF EAJA COURT DECISION: APR 3, 1998		
96-1381	HULL, LEROY DON	\$6051.00	\$6051.00
	DATE OF EAJA COURT DECISION: MAY 8, 1998		
96-1136	CARRILLO-ORTIZ, JUAN	\$3946.06	\$3946.06
96-1705	PLUNK, GARREY T.	\$5156.25	\$5156.25
97-0014	HARRISON, RONALD G.	\$2868.15	\$2868.15
97-0500	MOSELEY, EDWARD H.	\$2606.66	\$2606.66
97-1403	LEGGETT, RONALD J.	\$1207.89	\$1207.89
98-0180	WOOD, JEFFREY J., (2)	\$1335.19	\$1335.19
	DATE OF EAJA COURT DECISION: MAY 12, 1998		
97-0615	MARSH, ELSWORTH M.	\$3085.56	\$3085.56
	DATE OF EAJA COURT DECISION: MAY 27, 1998		
97-0993	JOHNSON, JOSEPH M.	\$4158.44	\$4158.44
	DATE OF EAJA COURT DECISION: JUN 8, 1998		
97-1248	TUCKER, TERRANCE L.	\$860.51	\$860.51
	DATE OF EAJA COURT DECISION: JUN 10, 1998		
96-0278	BIGELOW, SCOT	\$23486.09	\$23486.09
	DATE OF EAJA COURT DECISION: JUL 22, 1998		
97-0301	ALBU, DANIEL N.	\$1964.14	\$1964.14
SUBTOTAL		73973.88	71806.02
SUBACCOUNT 17			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
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GC ATTORNEY ASSIGNED: LINDSAY, JOHN D.			
DATE OF EAJA COURT DECISION: OCT 9, 1997			
96-0573	DROSKY, RAYMOND S.	\$50.00	\$50.00
97-0083	ZIENOWICZ, JULIAN	\$2811.92	\$2811.92
97-0443	ROSS, DANIEL G.	\$3594.00	\$3219.00
DATE OF EAJA COURT DECISION: NOV 28, 1997			
96-1659	WATSON, RICHARD A.	\$1906.25	\$1906.25
DATE OF EAJA COURT DECISION: DEC 9, 1997			
97-0213	DOLL, GEORGE R.	\$907.14	\$907.14
DATE OF EAJA COURT DECISION: DEC 16, 1997			
97-0317	JOHNSON, ARTHUR H.	\$2700.75	\$2700.75
DATE OF EAJA COURT DECISION: FEB 20, 1998			
96-0715	GILLESWATER, ROBERT M.	\$6873.97	\$6873.97
96-0738	TAYLOR, HERBERT L.	\$5834.87	\$5834.87
DATE OF EAJA COURT DECISION: FEB 23, 1998			
97-0012	WILLIAMS, CLAUD, JR.	\$1934.06	\$1934.06
97-0519	O'BRAMOVIC, ANTHONY J.	\$1729.57	\$1729.57
DATE OF EAJA COURT DECISION: FEB 26, 1998			
96-0937	SHERMAN, DALE	\$4707.07	\$4707.07
-----			
SUBTOTAL		33049.6	32674.6
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SUBCOUNT 11			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
-----			
GC ATTORNEY ASSIGNED: LLEWELLYN, ADAM			
	DATE OF EAJA COURT DECISION: NOV 20, 1997		
95-0870	POLLARD, VERNON E., (2)	\$5401.25	\$5401.25
	DATE OF EAJA COURT DECISION: NOV 26, 1997		
95-0713	GARLEJO, DAMASO, (2)	\$4571.42	\$4571.42
97-0276	CHARDALL, MARSHALL W., III	\$606.78	\$606.78
	DATE OF EAJA COURT DECISION: DEC 15, 1997		
96-1598	JACKSON, RAYMOND, (5)	\$5264.29	\$5264.29
	DATE OF EAJA COURT DECISION: MAY 8, 1998		
96-0745	MEAGHER, WILLIAM J.	\$7559.18	\$7559.18
97-1085	BERRY, LARRY B.	\$4515.96	\$4515.96
	DATE OF EAJA COURT DECISION: JUN 9, 1998		
96-0338	BUCKMAN, LARRY A.	\$5356.28	\$5356.28
	DATE OF EAJA COURT DECISION: JUL 22, 1998		
97-1806	ROBINSON, GILBERT L.	\$3878.05	\$3878.05
	DATE OF EAJA COURT DECISION: JUL 30, 1998		
96-0148	BELLRICHARD, ANDREW	\$8503.31	\$8503.31
	DATE OF EAJA COURT DECISION: AUG 28, 1998		
97-1592	BROOKS, MAX D.	\$3593.00	\$3593.00
-----			
SUBTOTAL		49249.52	49249.52
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SUBCOURT 10			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
GC ATTORNEY ASSIGNED: MAYERICK, RICHARD			
	DATE OF SAJA COURT DECISION: OCT 9, 1997		
97-0425	PERRY, STEPHEN J.	\$2628.00	\$2628.00
	DATE OF SAJA COURT DECISION: OCT 28, 1997		
97-0300	DIXON, DAVID M., JR.	\$1472.11	\$1472.11
	DATE OF SAJA COURT DECISION: NOV 5, 1997		
96-1224	PEARL, LOUIS J.	\$5812.50	\$5812.50
	DATE OF SAJA COURT DECISION: NOV 24, 1997		
96-0799	RICHMAN, MARVIN	\$6485.53	\$5810.53
96-1434	JOHNSON, WILLIE J.	\$6057.61	\$5807.61
	DATE OF SAJA COURT DECISION: DEC 8, 1997		
96-1559	AIRINGTON, HAROLD L., JR.	\$5127.92	\$5127.92
	DATE OF SAJA COURT DECISION: FEB 20, 1998		
97-0207	GRACIA, HERBERT	\$2406.25	\$2406.25
97-0619	MISAKLIAN, SAVEN	\$3314.18	\$3314.18
	DATE OF SAJA COURT DECISION: FEB 24, 1998		
97-0256	LYONS, ROBERT J.	\$2246.54	\$2246.54
	DATE OF SAJA COURT DECISION: MAY 5, 1998		
97-0666	TREAT, COY DALE	\$3551.21	\$3050.00
	DATE OF SAJA COURT DECISION: MAY 6, 1998		
97-1093	BRACHAM, WILLIAM E.	\$4704.84	\$4127.83
	DATE OF SAJA COURT DECISION: MAY 8, 1998		
96-1560	ETHEREDGE, JOE H.	\$2790.62	\$2790.62
97-1725	CROCKETT, RICHARD D.	\$1526.10	\$1526.10
	DATE OF SAJA COURT DECISION: JUN 15, 1998		
96-0893	KIMMER, ROBERT L.	\$10889.00	\$10899.00
97-0855	STRINE, DONALD E.	\$1166.29	\$1166.29
	DATE OF SAJA COURT DECISION: JUN 29, 1998		
96-1186	HINKEL, MERRITT A.	\$9380.00	\$7500.00
	DATE OF SAJA COURT DECISION: JUL 13, 1998		
96-0623	CUMMINGS, LIVINGSTON V., (2)	\$2787.75	\$2787.75
	DATE OF SAJA COURT DECISION: AUG 7, 1998		
97-1519	LARA, DANIEL J.	\$2895.87	\$2886.52
	DATE OF SAJA COURT DECISION: AUG 10, 1998		
97-1740	DOBNEY, MARK A.	\$5925.00	\$5925.00

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
-----			
	DATE OF EAJA COURT DECISION: AUG 12, 1998		
96-1331	WHORTON, WILLIAM A., (4)	\$15000.75	\$12000.00
	DATE OF EAJA COURT DECISION: SEP 18, 1998		
97-1493	BALL, DARREL W.	\$1232.50	\$1147.50
-----			
SUBTOTAL		97400.57	90432.25
SUBCOUNT 21			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
-----			
GC ATTORNEY ASSIGNED: MCLAUGHLIN, THOMAS A.			
DATE OF EAJA COURT DECISION: OCT 22, 1997			
97-1128	KLOSTERMAN, PAUL R.	\$394.32	\$394.32
DATE OF EAJA COURT DECISION: JAN 11, 1998			
97-0725	HAKES, ROBERT J.	\$520.15	\$520.15
-----			
SUBTOTAL		914.47	914.47
SUBCOURT 2			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
GC ATTORNEY ASSIGNED: MCNAMEE, JOHN D.			
	DATE OF EAJA COURT DECISION: OCT 7, 1997		
96-0084	DIAZ, LUIS GUZMAN	\$3600.00	\$3600.00
	DATE OF EAJA COURT DECISION: NOV 5, 1997		
96-0348	KENNEDY, EDDIE	\$1994.37	\$1994.00
96-1027	FIGUEROA, EDGAR	\$1814.13	\$1814.00
96-1232	GRAYSON, PHILLIP L.	\$2718.75	\$2618.00
	DATE OF EAJA COURT DECISION: NOV 7, 1997		
95-1247	GAINES, WILLIAM C.	\$8108.97	\$6200.00
	DATE OF EAJA COURT DECISION: NOV 12, 1997		
96-0538	HANNING, JERRY R., (2)	\$8026.80	\$7381.35
	DATE OF EAJA COURT DECISION: NOV 21, 1997		
96-1235	PATE, DELORES E.	\$11470.10	\$6500.00
	DATE OF EAJA COURT DECISION: FEB 20, 1998		
96-0884	DRENNWALKER, REDWOLF JACK	\$4718.75	\$4718.75
97-0376	WILLIAMS, LEOTIS C.	\$1987.50	\$1937.50
	DATE OF EAJA COURT DECISION: MAY 8, 1998		
96-1169	SMITH, WHEATSON	\$4265.76	\$4265.76
96-1300	MCINTYRE, JOHN R.	\$6803.01	\$6803.01
96-1500	BAKER, JOHN S.	\$2845.68	\$2845.68
96-1597	MERCIER, DONNA J.	\$4271.10	\$4271.70
97-0781	WASH, JAMES E., (2)	\$7884.19	\$7884.19
	DATE OF EAJA COURT DECISION: MAY 15, 1998		
97-0906	HOGAN, KHEUBAN	\$3455.00	\$0.00
	DATE OF EAJA COURT DECISION: JUN 11, 1998		
97-1638	RAIMONDI, MARIO M.	\$4163.82	\$4163.82
	DATE OF EAJA COURT DECISION: JUN 17, 1998		
97-1461	LEBIEUX, RONALD E.	\$1312.50	\$1312.50
	DATE OF EAJA COURT DECISION: JUL 6, 1998		
97-2018	YANZI, JOHN E.	\$50.00	\$50.00
	DATE OF EAJA COURT DECISION: JUL 15, 1998		
98-0090	DERCO, JOHN, JR., (3)	\$1738.25	\$1738.25
	DATE OF EAJA COURT DECISION: AUG 11, 1998		
97-0959	EDGE, JAMES L., SR.	\$3976.94	\$3976.94
97-1478	RAPPA, RUSSELL	\$2384.00	\$2384.00
SUBTOTAL		\$7589.62	76459.45
SUBCOUNT 21			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
-----			
QC ATTORNEY ASSIGNED: MEADOWS, PETER J.			
DATE OF EAJA COURT DECISION: AUG 21, 1998			
98-0087	WOOTEN, LESLIE G.	\$997.58	\$997.58
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SUBTOTAL		997.58	997.58
SUBACCOUNT 1			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
-----			
GC ATTORNEY ASSIGNED: MORIARTY, JOAN E.			
	DATE OF RAJA COURT DECISION: OCT 17, 1997		
95-1041	ROBINSON, DOMONIC D.	\$2970.00	\$2970.00
	DATE OF RAJA COURT DECISION: OCT 20, 1997		
96-0949	MORD, SARA ELIZABETH	\$4219.13	\$0.00
	DATE OF RAJA COURT DECISION: FEB 24, 1998		
96-0984	ROZAL, LEONARDO A.	\$3626.55	\$3626.55
-----			
SUBTOTAL		10815.68	6596.55
-----			
SUBCOUNT 3			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
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GC ATTORNEY ASSIGNED: MAZAROV,ARI			
DATE OF SAJA COURT DECISION: AUG 28,1998			
98-0628	BALLARD,OSCAR	\$1439.86	\$1439.86
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SUBTOTAL		1439.86	1439.86
SUBCOUNT 1			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
-----			
GC ATTORNEY ASSIGNED: O'CONNOR, GARY			
DATE OF EAJA COURT DECISION: MAY 20, 1998			
97-0042	MILLS, JOSEPH D., II	\$4644.00	\$4644.00
DATE OF EAJA COURT DECISION: AUG 25, 1998			
97-2115	KEVLIN, HARRY R.	\$3336.50	\$3336.50
DATE OF EAJA COURT DECISION: SEP 23, 1998			
97-0289	SETTLES, O.V.	\$4902.00	\$4902.00
DATE OF EAJA COURT DECISION: SEP 24, 1998			
96-0420	HARVEY, PAUL D.	\$1375.00	\$1375.00
-----			
SUBTOTAL		14257.5	14257.5
-----			
SUBCOUNT 4			

DOCKET #	APPELLANT NAME	\$ CLAIMED	. \$ PAID
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GC ATTORNEY ASSIGNED: SAVINO, TOM			
	DATE OF EAJA COURT DECISION: MAY 19, 1998		
97-0673	HIMSLEY, DENNY A.	\$3498.98	\$3498.98
	DATE OF EAJA COURT DECISION: JUN 17, 1998		
97-0719	PRIDE, BESSIE C.	\$2478.12	\$2478.12
97-1663	WILLIAMS, RUTHERFORD R., (2)	\$2767.50	\$2767.50
	DATE OF EAJA COURT DECISION: JUN 22, 1998		
96-1154	MCGUFFIN, DAVID A.	\$13579.77	\$11200.00
	DATE OF EAJA COURT DECISION: JUN 29, 1998		
96-1248	BETTIES, ARTHUR G., JR., (2)	\$5809.78	\$5250.00
	DATE OF EAJA COURT DECISION: AUG 12, 1998		
97-1199	PANETTA, RITA D.	\$2854.10	\$2854.10
-----			
SUBTOTAL		30988.25	28048.7
SUBCOUNT 6			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
-----			
GC ATTORNEY ASSIGNED: SELFON, LEONARD			
	DATE OF EAJA COURT DECISION: DEC 16, 1997		
96-0651	EVERETT, DONALD L.	\$810.00	\$0.00
	DATE OF EAJA COURT DECISION: DEC 19, 1997		
96-1119	UNDERWOOD, JAMES L.	\$5376.00	\$5376.00
	DATE OF EAJA COURT DECISION: DEC 29, 1997		
96-0609	SWAGGERTY, LEONARD R.	\$2452.93	\$2452.93
96-1049	KEEFER, ROBERT E., (2)	\$2821.00	\$2821.00
97-0043	BELL, BILLIE J.	\$1175.00	\$1161.25
97-0169	NAMAY, EUGENE E.	\$1178.20	\$1170.20
97-0474	WYMER, WILLIAM	\$1374.88	\$1374.88
	DATE OF EAJA COURT DECISION: JAN 29, 1998		
97-0768	VIENS, ROGER F., (2)	\$3362.11	\$3362.11
	DATE OF EAJA COURT DECISION: FEB 20, 1998		
97-0254	GATES, JOHN C., IV	\$1934.06	\$1934.06
	DATE OF EAJA COURT DECISION: MAY 8, 1998		
97-0675	WEATHERSPOON, VICTOR S.	\$2473.17	\$2473.17
	DATE OF EAJA COURT DECISION: MAY 27, 1998		
97-0016	FOSTER, ROBERT L., (C29493303)	\$5116.63	\$4794.50
	DATE OF EAJA COURT DECISION: JUN 9, 1998		
97-0299	FOX, JUDITH W.	\$3530.75	\$3530.75
	DATE OF EAJA COURT DECISION: JUN 11, 1998		
96-1380	TAYLOR, FREDRICK J., (2)	\$2362.50	\$2362.50
	DATE OF EAJA COURT DECISION: JUN 17, 1998		
96-1151	ALMEYDA-LOPEZ, JUAN E.	\$6439.65	\$6439.65
	DATE OF EAJA COURT DECISION: JUL 21, 1998		
96-0767	CURTIS, HENRY C., (2)	\$10793.94	\$10793.94
	DATE OF EAJA COURT DECISION: SEP 22, 1998		
97-0130	BRACKEN, LARRY J.	\$5418.00	\$5418.00
97-1717	BLAKE, DOUGLAS A.	\$1231.80	\$1231.80
	DATE OF EAJA COURT DECISION: SEP 29, 1998		
96-1757	HOLMES, ROY R.	\$6814.04	\$6814.04
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SUBTOTAL		64664.66	63510.78
SUBCOUNT 18			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
-----			
GC ATTORNEY ASSIGNED: SENSEMAN, CRIS			
	DATE OF EAJA COURT DECISION: JUN 5, 1998		
97-1095	SEEGARS, JEFFERY L.	\$2414.61	\$2414.61
	DATE OF EAJA COURT DECISION: JUL 6, 1998		
97-0763	TAYLOR, JOSEPH A.	\$7921.75	\$7921.75
	DATE OF EAJA COURT DECISION: JUL 29, 1998		
97-1791	KROGGY, WILLIAM R., SR.	\$3612.50	\$3612.50
	DATE OF EAJA COURT DECISION: SEP 3, 1998		
98-0147	BIERNBAUM, JOSEPH	\$3860.90	\$3860.90
	DATE OF EAJA COURT DECISION: SEP 11, 1998		
97-2066	HARQUAIL, DAVID	\$10605.00	\$10605.00
	DATE OF EAJA COURT DECISION: SEP 23, 1998		
97-2126	GIBSON, DENNIS W.	\$4385.88	\$4385.88
	DATE OF EAJA COURT DECISION: SEP 24, 1998		
97-0878	RIVERA, RAFAEL F.	\$9546.12	\$9546.12
-----			
SUBTOTAL		42346.76	42346.76
SUBCOURT 7			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
GC ATTORNEY ASSIGNED: SIMS, JACQUELINE M.			
DATE OF EAJA COURT DECISION: OCT 7, 1997			
96-0971	CREIGHTON, DOUGLAS R.	\$10393.89	\$9873.06
DATE OF EAJA COURT DECISION: OCT 21, 1997			
96-0425	JONES, CHARLES R.	\$4490.00	\$4490.00
DATE OF EAJA COURT DECISION: NOV 24, 1997			
96-0785	COYLE, BENNY L.	\$1657.50	\$1657.50
DATE OF EAJA COURT DECISION: DEC 5, 1997			
96-1555	MARTIN, DAVID B., (2)	\$8118.87	\$7668.87
DATE OF EAJA COURT DECISION: FEB 20, 1998			
96-0167	MCCREE, JAMES P., SR.	\$7303.63	\$7303.63
96-0685	SPRINGER, JOHN D.	\$5409.91	\$5409.91
96-1018	SHARPE, JORDIE W.	\$4407.00	\$4407.00
96-1334	LEWISTER, CARL	\$7287.71	\$7287.71
96-1511	LAWRENCE, GLENN W.	\$7128.99	\$7128.99
DATE OF EAJA COURT DECISION: MAR 16, 1998			
96-0351	THEYRY, NORVILLE D.	\$6127.50	\$6127.50
DATE OF EAJA COURT DECISION: MAY 8, 1998			
96-0557	FLYNT, WILLIAM L.	\$4196.33	\$4196.33
95-0649	CAREY, MARY	\$7462.72	\$7462.72
96-0601	GARRISON, JAMES L.	\$3800.00	\$3800.00
96-0851	GONZALES, ANTONIO J.	\$6668.01	\$6668.01
96-0933	TULLOS, CLAIBORNE MILTON	\$5934.00	\$5934.00
97-0264	BERRY, SCOTT J.	\$3794.90	\$3794.90
DATE OF EAJA COURT DECISION: JUL 6, 1998			
97-2277	KEY, GARLAND D.	\$3851.90	\$3851.90
DATE OF EAJA COURT DECISION: AUG 12, 1998			
97-1863	MEEKS, DOUGLAS	\$2062.50	\$2062.50
DATE OF EAJA COURT DECISION: AUG 13, 1998			
98-0001	MURRAY, WILLIAM F.	\$1273.59	\$1273.59
DATE OF EAJA COURT DECISION: AUG 17, 1998			
96-0918	ROSE, JACK O., (3)	\$5425.34	\$5425.34
SUBTOTAL		106794.29	105823.46
SUBCOUNT 20			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
GC ATTORNEY ASSIGNED: SIMHAMAHAPATRA, RUDRENDU			
	DATE OF EAJA COURT DECISION: OCT 1, 1997		
97-0168	GAMMON, SHIRLEY T.	\$836.06	\$836.06
	DATE OF EAJA COURT DECISION: OCT 2, 1997		
96-1127	FRENCH, GREGORY C.	\$6668.05	\$6668.05
	DATE OF EAJA COURT DECISION: FEB 20, 1998		
96-0800	KINZINGER, BETH L.	\$5885.31	\$5885.31
96-0881	CROWDER, OTIS R.	\$3634.93	\$3634.93
96-1689	OLSHAVSKY, ANDY	\$3728.99	\$3728.99
97-0544	APRAHAMIAN, NORMA L.	\$5400.00	\$5400.00
	DATE OF EAJA COURT DECISION: FEB 26, 1998		
97-0387	CLOUD, WILLIAM R.H.	\$1680.82	\$1680.82
	DATE OF EAJA COURT DECISION: MAR 9, 1998		
97-0096	RAUS, STEVEN	\$2742.94	\$2742.94
	DATE OF EAJA COURT DECISION: MAR 10, 1998		
97-0101	RIVERS, DEREK K., (2)	\$3941.55	\$3941.55
	DATE OF EAJA COURT DECISION: MAY 8, 1998		
97-0810	MCCORD, ALVIE L.	\$1790.38	\$1790.38
	DATE OF EAJA COURT DECISION: MAY 13, 1998		
97-1485	MILLER, WALLACE C.	\$50.00	\$50.00
	DATE OF EAJA COURT DECISION: JUN 8, 1998		
96-0737	PERSONS, CHARLES A.	\$12402.84	\$12402.84
	DATE OF EAJA COURT DECISION: JUN 12, 1998		
97-0471	COLAMER, PAUL J.	\$6232.39	\$6232.39
	DATE OF EAJA COURT DECISION: JUN 16, 1998		
95-0445	KAWAD, MONANG	\$11545.85	\$0.00
	DATE OF EAJA COURT DECISION: JUL 17, 1998		
97-0947	BLOUNT, CLUDIE S.	\$34088.25	\$34088.25
	DATE OF EAJA COURT DECISION: AUG 7, 1998		
97-0017	KREJCI, DENNIS B.	\$6234.12	\$5994.12
	DATE OF EAJA COURT DECISION: SEP 8, 1998		
97-0400	SOUTHERLAND, THOMAS P.	\$4721.12	\$4721.12
97-0867	VOGT, FRANKIE REYES	\$4030.00	\$4030.00
97-0890	DOWNS, WILLIAM M.	\$2812.50	\$2812.50
97-1530	DEGOURVILLE, ALLAN C.	\$2896.14	\$2896.14

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
	DATE OF SAJA COURT DECISION: SEP 10, 1998		
97-1228	SELLINGER, GREGORY S.	\$2590.52	\$2590.52
97-2283	SEATON, FREDERICK W.	\$2200.82	\$2200.82
	DATE OF SAJA COURT DECISION: SEP 18, 1998		
98-0154	MOORE, CHRIS E.	\$1943.12	\$1943.12
	DATE OF SAJA COURT DECISION: SEP 23, 1998		
96-0628	FITSPATRICK, ALFRED E., (2)	\$9601.21	\$9601.21
SUBTOTAL		137657.91	125872.06
SUBCOURT 24			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
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GC ATTORNEY ASSIGNED: SIMKINS, TODD			
	DATE OF EAJA COURT DECISION: OCT 21, 1997		
96-1291	SKINNER, MARSHALL R.	\$7300.65	\$7300.65
	DATE OF EAJA COURT DECISION: OCT 24, 1997		
96-0835	HEALY, JERRY F.	\$5934.00	\$3954.00
	DATE OF EAJA COURT DECISION: NOV 10, 1997		
96-1379	JACKSON, CURTIS A.	\$2757.18	\$2757.18
	DATE OF EAJA COURT DECISION: NOV 12, 1997		
97-1127	CLARK, ROGER L.	\$489.56	\$489.56
	DATE OF EAJA COURT DECISION: DEC 2, 1997		
96-1479	FRUSAK, WALTER J., JR.	\$6758.25	\$6758.25
	DATE OF EAJA COURT DECISION: FEB 20, 1998		
96-0268	SNUFFER, JERRY L.	\$7582.00	\$7582.00
97-1211	RUPPENTHAL, JEROME E.	\$625.12	\$625.12
97-1610	BOEH, DAVID H.	\$344.18	\$344.18
	DATE OF EAJA COURT DECISION: MAR 5, 1998		
96-0347	NORRIS, FLOYD O.	\$11287.50	\$11287.50
	DATE OF EAJA COURT DECISION: MAY 8, 1998		
95-0639	DIAZ-BARRIENTOS, TERESA	\$3686.98	\$3686.98
97-1432	SMART, HOMER LEE	\$3043.75	\$3043.75
97-1601	BATTLE, HARVEY L., JR.	\$1820.55	\$1670.55
97-1816	GROSS, NATHANIEL F.	\$1166.83	\$1166.83
	DATE OF EAJA COURT DECISION: JUN 17, 1998		
97-1230	LAW, RUBIN	\$4425.17	\$4435.17
	DATE OF EAJA COURT DECISION: JUN 22, 1998		
96-0921	SPENCER, LEWIS B.	\$8996.00	\$6370.00
	DATE OF EAJA COURT DECISION: JUL 7, 1998		
98-0371	MULLINS, JERRY M., (2)	\$1147.81	\$1347.81
	DATE OF EAJA COURT DECISION: AUG 28, 1998		
97-1000	ALMEDGAN, DIANE L.	\$4222.12	\$4222.12
97-1768	SAPPINGTON, LEO R.	\$2364.14	\$2364.14
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SUBTOTAL		73951.79	69205.79
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SUBCOUNT 18			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
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GC ATTORNEY ASSIGNED: SMALLS, MICHAEL R.			
DATE OF EAJA COURT DECISION: OCT 10, 1997			
95-0158	CAULEY, THEODORE C.	\$8250.00	\$0.00
DATE OF EAJA COURT DECISION: OCT 15, 1997			
96-1279	MAGEE, JIMMY E.	\$1860.50	\$1860.50
DATE OF EAJA COURT DECISION: NOV 12, 1997			
93-0802	WISS, JIMMY R. (2)	\$10131.75	\$10131.75
DATE OF EAJA COURT DECISION: DEC 9, 1997			
95-0786	AGOSTO, IVAN TORRES	\$8045.03	\$8045.03
DATE OF EAJA COURT DECISION: FEB 20, 1998			
96-0326	ORYNICE, JOHN (2)	\$4864.00	\$4864.00
96-1290	JIMENEZ-ORTIZ, RUBEN	\$4496.25	\$4496.25
96-1473	GLENACROSS, SARAH E.	\$3402.30	\$3402.30
97-0129	GRUBS, FLOYD H., JR.	\$4992.00	\$4992.00
DATE OF EAJA COURT DECISION: JUN 2, 1998			
96-0781	ROBINSON, CHARLES	\$4773.00	\$4773.00
97-1420	NEARTON, HOWARD H.	\$1346.77	\$1346.77
DATE OF EAJA COURT DECISION: JUN 29, 1998			
97-0231	GUY, WYOME L.	\$3485.00	\$3485.00
DATE OF EAJA COURT DECISION: JUL 30, 1998			
97-1718	FULPS, JERRY W.	\$1250.00	\$1250.00
97-1787	COX, KENNETH D.	\$1300.00	\$1300.00
DATE OF EAJA COURT DECISION: SEP 24, 1998			
97-0377	BROWN, MARY H.	\$6911.06	\$6911.06
97-0756	KETCHUM, STEVEN (2)	\$3828.83	\$3828.83
DATE OF EAJA COURT DECISION: SEP 28, 1998			
96-1671	NITTLEIDER, DANNY L.	\$2092.40	\$2092.40
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SUBTOTAL		71028.89	62778.89
SUBCOUNT 16			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
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GC ATTORNEY ASSIGNED: TRUJILLO, PATRICIA			
DATE OF EAJA COURT DECISION: OCT 22, 1997			
97-0302	HORTON, GARLAND W.	\$833.34	\$833.34
DATE OF EAJA COURT DECISION: OCT 27, 1997			
97-0295	BROWN, MERRITT C.	\$11240.00	\$9000.00
DATE OF EAJA COURT DECISION: NOV 4, 1997			
96-1052	LAGER, RICHARD	\$1171.80	\$1171.80
DATE OF EAJA COURT DECISION: NOV 24, 1997			
96-0987	LANDAAS, OSCAR R.	\$2857.50	\$2857.50
97-0852	PATCH, DANNY R.	\$675.02	\$675.02
DATE OF EAJA COURT DECISION: FEB 20, 1998			
97-0608	CATLETT, CHARLES W.	\$2612.40	\$2612.40
DATE OF EAJA COURT DECISION: MAR 27, 1998			
97-1040	JOHNSON, GREGORY W., (2)	\$1624.40	\$0.00
DATE OF EAJA COURT DECISION: MAY 8, 1998			
97-0967	OLIVER, RONALD D.	\$5373.10	\$5373.10
97-1309	BURTON, WYMAN	\$4007.00	\$4007.00
97-1611	DOVE, BETTY A.	\$982.97	\$982.97
DATE OF EAJA COURT DECISION: JUN 9, 1998			
96-1336	BASS, JACKIE M.	\$5298.35	\$5298.35
DATE OF EAJA COURT DECISION: JUN 16, 1998			
98-0105	SIPES, R.J. EDWARD	\$2433.25	\$2433.25
DATE OF EAJA COURT DECISION: JUN 22, 1998			
96-1218	REYES, GUS J.	\$9880.75	\$0.00
DATE OF EAJA COURT DECISION: JUL 27, 1998			
97-0693	RAMOS-ORTIZ, EMILIO	\$5149.65	\$5149.65
97-1287	STARONHEATHER, WALDO T.	\$3409.27	\$3409.27
DATE OF EAJA COURT DECISION: AUG 10, 1998			
98-0178	KNOCK, JOHN A.	\$3450.59	\$3450.59
DATE OF EAJA COURT DECISION: AUG 21, 1998			
98-0065	TUCCI, JOSEPH A.	\$2787.31	\$2787.31
DATE OF EAJA COURT DECISION: SEP 24, 1998			
96-0592	HANE, VIRGIL A.	\$7581.08	\$7581.08
-----			
SUBTOTAL		71367.78	57622.63
SUBCOUNT 18			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
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GC ATTORNEY ASSIGNED: MAGEBORN, ANDREW			
	DATE OF EAJA COURT DECISION: NOV 21, 1997		
96-1552	CHECKETT, DENNIS M.	\$1390.58	\$1390.58
	DATE OF EAJA COURT DECISION: NOV 25, 1997		
96-0363	FUJAREK, MARYLYN D.	\$3790.91	\$3541.43
	DATE OF EAJA COURT DECISION: DEC 10, 1997		
96-1268	HOVER, TERRY W.	\$8615.73	\$8315.73
	DATE OF EAJA COURT DECISION: DEC 18, 1997		
96-1269	GULLION, NORVAL M.	\$5112.78	\$5112.78
	DATE OF EAJA COURT DECISION: JAN 29, 1998		
95-1049	O'CONNOR, WILLIAM E.	\$8648.64	\$8648.64
	DATE OF EAJA COURT DECISION: FEB 20, 1998		
95-1142	BARNEY, JAMES L., (2)	\$11120.00	\$11120.00
96-0979	ANDREWS, BETTY C.	\$4848.84	\$4848.84
	DATE OF EAJA COURT DECISION: FEB 24, 1998		
96-1393	GARRETT, FRED T. (410304414) (2)	\$4522.00	\$4522.00
97-0848	TAYLOR, ROBERT J.	\$2032.07	\$2032.07
	DATE OF EAJA COURT DECISION: MAR 6, 1998		
96-1568	DICKEY, RAYMOND C.	\$4992.29	\$4992.29
	DATE OF EAJA COURT DECISION: MAR 12, 1998		
97-0726	KING, KYLE D.	\$1626.09	\$1626.09
97-1032	SCRUGGS, JOSEPH M.	\$5067.71	\$5067.71
	DATE OF EAJA COURT DECISION: APR 17, 1998		
96-0254	BOWMAN, GORDON P.	\$8639.91	\$0.00
	DATE OF EAJA COURT DECISION: MAY 8, 1998		
97-0415	SMITH, LYLE K.	\$3237.50	\$3237.50
	DATE OF EAJA COURT DECISION: MAY 12, 1998		
96-1713	GREEN, JOHN R.	\$6146.91	\$6146.91
97-0071	LONDGREN, DONALD J.	\$5116.80	\$5116.80
	DATE OF EAJA COURT DECISION: JUN 3, 1998		
97-1428	JENKINS, GEORGE M.	\$1146.02	\$1146.02
	DATE OF EAJA COURT DECISION: JUL 9, 1998		
97-1075	MULLING, LARRY E.	\$2586.24	\$2586.24
	DATE OF EAJA COURT DECISION: JUL 30, 1998		
97-0298	BEARDEN, THELMA L.	\$4389.72	\$0.00

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
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DATE OF EAJA COURT DECISION: AUG 28, 1998			
96-1476	BANISTER, MARION C.	\$5934.00	\$5934.00
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SUBTOTAL		98964.74	85385.63
SUBCOURT 20			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
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GC ATTORNEY ASSIGNED: WASHINGTON, CAROLYN F.			
	DATE OF EAJA COURT DECISION: OCT 20, 1997		
96-0354	ZINK, RONALD M.	\$2209.68	\$2209.68
	DATE OF EAJA COURT DECISION: FEB 20, 1998		
97-0034	MCGINNIS, CLETUS W.	\$2913.05	\$2913.05
	DATE OF EAJA COURT DECISION: MAR 13, 1998		
95-0933	HALLE, WILLIAM W., IV, (2)	\$4901.88	\$4901.88
96-0372	MANUETA, REYNALDO R.	\$8673.81	\$8673.81
	DATE OF EAJA COURT DECISION: MAR 16, 1998		
97-0977	BALES, JOE B.	\$6634.18	\$6634.18
	DATE OF EAJA COURT DECISION: APR 28, 1998		
95-1237	HELFER, STEPHEN L., (2)	\$10990.07	\$0.00
	DATE OF EAJA COURT DECISION: JUL 15, 1998		
96-0137	TOWER, PATRICK	\$2473.50	\$2473.50
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SUBTOTAL		38796.17	27806.1
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SUBCOUNT 7			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
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GC ATTORNEY ASSIGNED: WILLETT, LISA			
DATE OF EAJA COURT DECISION: JUN 9, 1998			
97-0918	KENT, PETER R., SR., (3)	\$4006.13	\$4006.13
DATE OF EAJA COURT DECISION: SEP 15, 1998			
97-0460	WINFIELD, JOSEPH C.	\$3835.30	\$3835.30
DATE OF EAJA COURT DECISION: SEP 16, 1998			
96-1272	ANDERSON, JERVIS K.	\$6703.00	\$6703.00
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SUBTOTAL		14544.43	14544.43
SUBCOUNT 3			

DOCKET #	APPELLANT NAME	\$ CLAIMED	\$ PAID
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GC ATTORNEY ASSIGNED: WUCHINICH, SUSAN A.			
	DATE OF EAJA COURT DECISION: DEC 29, 1997		
97-1320	DELBON, TOMAS C.	\$540.84	\$540.84
	DATE OF EAJA COURT DECISION: FEB 24, 1998		
97-1213	MONTGOMERY, CHARLES B.	\$50.00	\$50.00
	DATE OF EAJA COURT DECISION: MAR 3, 1998		
97-1659	JOHNSON, LESLIE A., JR.	\$1102.51	\$1102.51
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SUBTOTAL		1693.35	1693.35
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SUBCOUNT 3			
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TOTAL		2309667.47	2059556.55
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COUNT 529			

