

**POTENTIAL BUDGETARY SAVINGS WITHIN VA:  
RECOMMENDATIONS FROM VETERANS' SERVICE  
ORGANIZATIONS**

---

---

**HEARING**  
BEFORE THE  
**COMMITTEE ON VETERANS' AFFAIRS**  
**U.S. HOUSE OF REPRESENTATIVES**  
ONE HUNDRED TWELFTH CONGRESS  
FIRST SESSION

NOVEMBER 15, 2011

**Serial No. 112-34**

Printed for the use of the Committee on Veterans' Affairs



U.S. GOVERNMENT PRINTING OFFICE

71-386

WASHINGTON : 2012

---

For sale by the Superintendent of Documents, U.S. Government Printing Office  
Internet: [bookstore.gpo.gov](http://bookstore.gpo.gov) Phone: toll free (866) 512-1800; DC area (202) 512-1800  
Fax: (202) 512-2104 Mail: Stop IDCC, Washington, DC 20402-0001

## COMMITTEE ON VETERANS' AFFAIRS

JEFF MILLER, Florida, *Chairman*

CLIFF STEARNS, Florida	BOB FILNER, California, <i>Ranking</i>
DOUG LAMBORN, Colorado	CORRINE BROWN, Florida
GUS M. BILIRAKIS, Florida	SILVESTRE REYES, Texas
DAVID P. ROE, Tennessee	MICHAEL H. MICHAUD, Maine
MARLIN A. STUTZMAN, Indiana	LINDA T. SANCHEZ, California
BILL FLORES, Texas	BRUCE L. BRALEY, Iowa
BILL JOHNSON, Ohio	JERRY McNERNEY, California
JEFF DENHAM, California	JOE DONNELLY, Indiana
JON RUNYAN, New Jersey	TIMOTHY J. WALZ, Minnesota
DAN BENISHEK, Michigan	JOHN BARROW, Georgia
ANN MARIE BUERKLE, New York	RUSS CARNAHAN, Missouri
TIM HUELSKAMP, Kansas	
MARK E. AMODEI, Nevada	
ROBERT L. TURNER, New York	

HELEN W. TOLAR, *Staff Director and Chief Counsel*

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Veterans' Affairs are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

# CONTENTS

November 15, 2011

	Page
Potential Budgetary Savings Within VA: Recommendations from Veterans' Service Organizations .....	1
OPENING STATEMENTS	
Chairman Jeff Miller .....	1
Prepared statement of Chairman Miller .....	36
Hon. Michael H. Michaud, Democratic Member .....	2
Hon. Corrine Brown, Acting Ranking Democratic Member .....	9
Prepared statement of Congresswoman Brown .....	37
WITNESSES	
Joseph A. Violante, National Legislative Director, Disabled American Veterans .....	4
Prepared statement of Mr. Violante .....	37
Carl Blake, National Legislative Director, Paralyzed Veterans of America .....	5
Prepared statement of Mr. Blake .....	41
Accompanied By:	
Ian de Planque, Deputy Director, National Legislative Commission, The American Legion .....	4
Raymond C. Kelley, Director, National Legislative Service, Veterans of Foreign Wars of the United States .....	4
Diane M. Zumatto, National Legislative Director, American Veterans (AMVETS) .....	4
Todd Grams, Executive in Charge for the Office of Management and Chief Financial Officer, U.S. Department of Veterans Affairs .....	27
Prepared statement of Mr. Grams .....	46
Accompanied By:	
Diana M. Rubens, Associate Deputy Under Secretary for Field Operations, Veterans Benefits Administration, U.S. Department of Veterans Affairs .....	27
William Schoenhard, FACHE, Deputy Under Secretary for Health for Operations and Management, Veterans Health Administration, U.S. Department of Veterans Affairs .....	27
Belinda J. Finn, Assistant Inspector General for Audits and Evaluations, Office of Inspector General, U.S. Department of Veterans Affairs .....	29
Prepared statement of Ms. Finn .....	53
Accompanied By:	
Linda Halliday, Deputy Assistant Inspector General for Audits and Evaluations, Office of Inspector General, U.S. Department of Veterans Affairs .....	27
Sondra McCauley, Deputy Assistant Inspector General for Audits and Evaluations, Office of Inspector General, U.S. Department of Veterans Affairs .....	27
MATERIAL SUBMITTED FOR THE RECORD	
Deliverable from the Department of Veterans Affairs .....	60
Post-Hearing Questions and Responses for the Record:	
Hon. Bob Filner, Ranking Member, Committee on Veterans' Affairs, Letter to Joseph A. Violante, National Legislative Director, Disabled American Veterans .....	62
Hon. Bob Filner, Ranking Member, Committee on Veterans' Affairs, Letter to Carl Blake, National Legislative Director, Paralyzed Veterans of America .....	63

	Page
Post-Hearing Questions and Responses for the Record—Continued	
Responses from Joseph A. Violante, National Legislative Director, Disabled American Veterans and Carl Blake, National Legislative Director, Paralyzed Veterans of America .....	64
Hon. Jeff Miller, Chairman, Committee on Veterans' Affairs, Letter to Honorable Eric K. Shinseki, Secretary, U.S. Department of Veterans Affairs .....	67
Response from Honorable Eric K. Shinseki, Secretary, U.S. Department of Veterans Affairs to Hon. Jeff Miller, Chairman, Committee on Veterans' Affairs .....	68
Follow-Up Questions from Hon. Jeff Miller, Committee on Veterans' Affairs and Responses from Honorable Eric K. Shinseki, Secretary, U.S. Department of Veterans Affairs .....	74
Hon. Bob Filner, Ranking Democratic Member, Committee on Veterans' Affairs, Letter to Honorable Eric K. Shinseki, Secretary, U.S. Department of Veterans Affairs .....	75
Response from Honorable Eric K. Shinseki, Secretary, U.S. Department of Veterans Affairs to Hon. Bob Filner, Ranking Democratic Member, Committee on Veterans' Affairs .....	78
Question 8 Attachment 1 for Hon. Bob Filner, Ranking Democratic Member, Committee on Veterans' Affairs .....	90
Question 11 Attachment 2, Fee Data Disbursed Amounts .....	94
Question 11 Attachment 3, Wait Times .....	95

**POTENTIAL BUDGETARY SAVINGS WITHIN VA:  
RECOMMENDATIONS FROM VETERANS'  
SERVICE ORGANIZATIONS**

---

**TUESDAY, NOVEMBER 15, 2011**

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

The Committee met, pursuant to notice, at 10:01 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [Chairman of the Committee] presiding.

Present: Representatives Miller, Bilirakis, Roe, Stutzman, Denham, Runyan, Benishek, Buerkle, Huelskamp, Turner, Brown, Reyes, Michaud, Sánchez, McNerney, Donnelly, Walz, and Barrow.

**OPENING STATEMENT OF CHAIRMAN MILLER**

The CHAIRMAN. Good morning, everybody. Welcome to this morning's hearing. Ms. Brown will be the Ranking Member when she arrives but I want to go ahead, in view of the witnesses that are here with us today, so thank you for joining each of us this morning. We are going to review recommendations from several veterans' service organizations for possible savings within the Department of Veterans Affairs. And I want to say at the onset, thank you to the VSOs for answering the call and sending some information in that we could have a hearing on and talk about ways that money can be saved at VA.

We are in an unprecedented time of fiscal restraint in America, one that is long overdue. The Budget Control Act is the law of the land. It has put in place caps for the next decade. It is on discretionary spending for every account in government, including VA. These caps will permit overall government spending to grow at roughly 2.5 percent annually. Needless to say, the next 10 years that we are looking at will look very differently than the last decade.

Now it is my belief that veterans spending and defense spending remain an absolute top priority to this Nation and to this Congress. Maintaining our defense is a clear constitutional charge of this Congress and I include the care for those who have fought for our freedom as an inextricable part of that constitutional charge.

With that said, no agency should ever be exempt from a constant effort to become more efficient or root out waste, fraud, and other questionable spending. It is with this in mind that I solicited the help of the veterans' service organizations, some of which are here today, to help find savings within VA which then could be redi-

rected to provide better care and benefits to our veterans. The VSO response was outstanding. And again, I say thank you for that response.

They provided nine areas for us to examine. And I am so pleased that they are here today to discuss those savings and other areas of potential savings within our government. Some of what they recommended, such as VA's questionable payment of bonuses that go to already well paid employees, are addressed in legislation reported from this committee and has already been passed by the House.

Other recommendations require ongoing scrutiny and today's hearing continues our committee's oversight to that end. I want to also thank the VA for its participation in today's hearing. I believe that there are sincere efforts underway. It has been documented in several ways, the successes that they have already enjoyed which shows that Secretary Shinseki is in fact serious about VA's stewardship of taxpayer dollars.

Nevertheless there are areas that need improvement and continued oversight. The VA Office of Inspector General's testimony will confirm that this morning what we have talked about in regards to bonuses being paid, and I want to thank the VA OIG for its work with the Committee with VA and with veterans advocates in all of our common purpose.

Before I close let me touch on one other issue that is on everyone's mind, one that Carl Blake raises in his opening statement for the Paralyzed Veterans of America. Namely, the question of whether VA medical care is exempt from indiscriminate cuts that would occur across government accounts under a sequester order. Now it is my firm hope and my expectation that the Joint Select Committee will rise to its calling and produce a bill which saves a minimum of \$1.2 trillion over the next decade that can clear the Congress and be signed by the President. However, should that not happen a week from tomorrow veterans and their loved ones deserve to know now whether VA will be affected by a looming sequester order. It is my belief that VA is absolutely exempt. But only the Office of Management and Budget is vested with the authority to determine the sequester rules. To date, OMB has not been clear on this point. Mr. Grams, I hope that you can shed some light on the administration's position when you appear on our second panel this morning

Again, I thank all of our witnesses for their attendance this morning. I now turn to our Ranking Member for his opening statement. Mr. Michaud, you are recognized.

[The prepared statement of Jeff Miller appears on p. 36.]

**OPENING STATEMENT OF HON. MICHAEL H. MICHAUD,  
DEMOCRATIC MEMBER**

Mr. MICHAUD. Thank you very much, Mr. Chairman, for holding this hearing today. I also would like to thank our witnesses for joining us and helping this committee continue its important work ensuring that veterans get the resources they need while making sure that the VA is a careful steward of these resources. Some of my colleagues here in Congress look at potential budget savings within the VA as a way to reduce our overall budget deficit. In my

view, we should be looking at ways to provide services and benefits that are more cost effective in order to provide resources where we need them the most down the road, as we continue to ensure that the VA has what it needs, but needs what it gets.

This way, the VA's budget request will be better aligned to meet the needs we are all hearing about from our veterans and our constituents. I applaud our VSOs for being active participants in this conversation and in this process as well. It is vital that you continue to point out where improvements in VA programs are necessary and continue to identify programs that are not working as well as they should be. I also want to thank the VA Inspector General for the fine work your office has done in identifying where improvements can be made and areas where the VA can improve.

One of my foremost concerns is to make certain that the resources get to the veterans. There simply must be oversight and accountability within the VA system. This is also important to ensure that all of you get the accurate information you need in order to formulate realistic budgets that are truly need based. I am troubled that in the audits and reports that we get from the Inspector General's Office there seems to be a consistent pattern in what they find wrong, in lack of financial controls, and in lack of policies and procedures to ensure that staff follow management directives.

I would like to know what the VA is doing to fix these problems. And even more importantly, what the VA is doing to proactively identify problems that lead to wasteful spending and lack of accountability. This is the key role of effective management. And I would like to be assured that these issues are being identified and addressed routinely and not merely in response to the IG reports and congressional oversight.

One of the areas of concerns identified by the VSOs is the issue of funding holdbacks at the VA central office and in the VISNs. We all have heard anecdotal stories of local hiring freezes or our local facilities not having the resources that they need. I look forward to the discussion on this issue.

I also look forward to learning how the VA is currently doing with its budget projections and third party collections estimates, and what in general terms we should expect in looking forward to the budget submission in February.

I have the utmost faith in Secretary Shinseki and wholeheartedly support his efforts to transform the VA. The VA faces many problems and I understand it takes time to change course. I just want to be sure that we are heading in the right direction and moving in the right direction we will need the input from the VSOs as you go back and talk to your members about where they think the VA has gone astray and where we can continue trying to get it back on track.

So once again, Mr. Chairman, I want to thank you for having this hearing and I want to thank our panelists as well for coming. And I yield back the balance of my time.

The CHAIRMAN. I thank Mr. Michaud for his fine comments. I associate myself with them. And I thank the first panel for being here. We have two witnesses that are here with us. First, Joe Violante, National Legislative Director for the Disabled American Veterans; and Mr. Carl Blake, the National Legislative Director for

the Paralyzed Veterans of America. They are accompanied by other folks with them today. We appreciate all of you appearing. And I don't know if Joe, you are first? We will recognize you for your opening statement.

**STATEMENTS OF JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; ACCOMPANIED BY IAN DE PLANQUE, DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; RAYMOND C. KELLEY, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; AND DIANE M. ZUMATTO, NATIONAL LEGISLATIVE DIRECTOR, AMVETS**

**STATEMENT OF JOSEPH A. VIOLANTE**

Mr. VIOLANTE. Thank you, Mr. Chairman. And thank you for holding this hearing this morning about inefficiencies, duplication, and waste within the VA. Mr. Chairman, earlier this year in response to your request our organizations developed and presented to the Committee a number of recommendations regarding possible waste and inefficiency within VA and we appreciate the opportunity today to discuss these further.

First, however, it is important to recognize that simply cutting VA's budget in the absence of detailed justifications and evidence of savings will more likely result in a loss of accessibility, quality, and safety of services veterans depend on rather than lead to true deficit reduction. For example, a decade earlier VA proposed and Congress approved several successive budgets that cut billions based primarily on the presumption of unspecified management efficiencies. In the end, no savings were actually realized and Congress was forced to provide supplemental appropriations. But not before thousands of veterans were turned away or forced to wait for VA health care services.

So in order to ensure that VA actually eliminates duplication, inefficiency, and waste rather than just cut services we must begin with an accurate and transparent budget process to measure whether savings are achieved. Based on VA's fiscal year 2012 budget proposal there are a number of questions about the year ahead, such as: did VA's planned carryover funding from fiscal year 2011 to fiscal year 2012 and 2013 actually occur? And how will VA measure whether savings from proposed operational improvements materialized?

In addition, as you look for savings in VA keep in mind that there exists sufficient unfunded and underfunded needs. For example, VA's Strategic Capital Investment Planning Process identified about 5,000 capital projects that should be completed within 10 years at a cost estimated between \$50 billion and \$60 billion.

Looking ahead as this Committee, the Supercommittee, and Congress look to reduce the national debt, we hope you will draw the line at taking money away from disabled veterans. Both the Senate and the House recently passed legislation to provide a COLA increase to veterans disability compensation without one dissenting



vote. It would be disgraceful if the Supercommittee now tried to take this money back.

Mr. Chairman, in the spirit of eliminating duplication of our own my colleague from PVA will focus on the first five areas discussed in our letter and I will focus on the last four, beginning with inspection at state veterans homes.

Currently most state homes undergo regular inspection by both the VA and the Centers for Medicare and Medicaid services. Given that the CMS inspections already cover 150 of the 158 criteria required by VA, why not consider eliminating this overlap of effort to reduce the administrative burden of both the VA and state veterans homes?

Turning to VBA, we regularly hear reports that the regional offices spend an inordinate amount of time and resources shredding nonessential paperwork sometimes right down to Post-it notes, and even assigning senior GS level employees to oversee this work. It is our understanding that VBA has made changes over the past 6 months. However, we recommend the Committee examine whether current shredding practices are appropriate to protect and preserve veterans' records.

Another area that merits scrutiny is the practice of brokering claims between VBA regional offices, particularly the cost of transporting these brokered claims. According to the Inspector General report released in September VA brokered over 200,000 claims in fiscal year 2010 and it is our understanding that these claims are usually transported via FedEx. Why not consider reallocating the money spent on shipping paper files to digitizing them instead, especially considering VBA's ongoing transition to paperless processing?

We also have concerns about VBA's use of mandatory or authorized overtime as a regular practice to address increased workloads. Is mandatory overtime the most effective way to increase employee productivity? And does heavy reliance on overtime have negative effects on the quality of the work performed? We would recommend that the Committee ask VBA for answers to these important questions.

Mr. Chairman, that concludes my testimony. I will be more than happy to respond to questions.

[The prepared statement of Joseph A. Violante appears on p. 37.]

The CHAIRMAN. Thank you. Mr. Blake.

#### **STATEMENT OF CARL BLAKE**

Mr. BLAKE. Chairman Miller, Members of the Committee, on behalf of Paralyzed Veterans of America I am pleased to be here today to discuss the ongoing debate about deficit and debt reduction and how it might affect the Department of Veterans Affairs.

As you know and as Joe mentioned, PVA along with AMVETS, the Disable American Veterans, the American Legion, and the Veterans of Foreign Wars addressed this issue in a letter provided to the Committee in April of 2011. Since my statement fully explains the ideas addressed in our joint letter from earlier this year I will limit my comments to the issues of immediate concern. However, we all here on the panel look forward to questions as it relates to the many issues that we outline in our letter.

Once again this year Congress has failed to fulfill its obligations to complete work on the appropriations bill funding the Department of Veterans Affairs by the start of the new fiscal year on October 1, 2011, nearly 2 months ago. Meanwhile, the VA is operating based on the parameters of Public Law 112-36, the Continuing Appropriations Act for Fiscal Year 2012. As we understand it the VA has implemented an across the board reduction in all program spending of approximately 1.5 percent.

For the advance appropriation for VA health care to be superceded or misinterpreted by short term CRs and result in a reduction of VA health care funding that was already approved is absolutely outrageous. This concern is further amplified by the points we raised in our letter concerning the growth in various levels of administration, the holdbacks that occur at the VA, and the SES bonus levels. And yet we are here today to further discuss savings that can be realized within the VA. As we outlined in our letter to the Committee earlier this year the veterans' service organizations are not so naive as to think that cost savings cannot be found within the VA. But the question remains, to what end?

The context of this hearing is to identify savings within the VA that can presumably be returned to the Treasury for deficit and debt reduction. However, we believe the VA is already failing to meet the demands being placed on its health care and benefits systems. And I do not even need to go into great detail to discuss those concerns. We would argue that any savings realized by the VA should be used to fill gaps in services now or be immediately reinvested into the system to make it function more effectively and efficiently.

Ultimately discretionary spending in the VA accounts for approximately \$62 billion. Of that amount nearly 90 percent of that funding is directed towards the VA health care programs. As the Joint Select Committee addresses the possibility of reductions in discretionary spending across the entire Federal Government, including the VA, it is important to emphasize that any cuts to VA spending will have a direct impact on the delivery of health care services and benefits to veterans and their families.

Additionally we are concerned that in the event the Joint Select Committee fails to agree to a bipartisan solution or the House or Senate fails to approve the Committee's recommendations, an automatic trigger would occur that would immediately cut an additional \$1.2 trillion in Federal spending. The triggers would target two principal areas of the Federal budget, national security spending and all other domestic programs. While we believe all VA programs are excluded from automatic cuts by Public Law 111-139 the statutory Pay As You Go Act of 2010 questions remain about whether or not VA health care spending in particular could be included broader discretionary spending reductions. And Mr. Chairman, we appreciate your comments in your opening about your view on how this should be handled.

However, we have been informed that the final arbiter that will determine whether or not spending is cut from VA programs is the Office of Management and Budget. To say that this fact is worrisome would be a major understatement. As you know, the VA is the best health care provider for veterans, providing primary care

and specialized health services is an integral component of VA's core mission and responsibility to veterans. Across the Nation VA is a model health care provider that has led the way in various areas of medical research, specialized services, and health care technology. Any reduction in spending on VA health care programs would only serve to degrade these critical services. In the end it is easy to forget that the people who are ultimately affected by the wrangling over the budget and this ongoing debate about cutting the deficit are the men and women who have served and sacrificed so much for this Nation. We hope that you will consider these men and women as you continue to investigate areas for potential savings within the VA.

This concludes my testimony. I would be happy to answer any questions about my statement and the letter that we have provided. Thank you.

[The prepared statement of Carl Blake appears on p. 41.]

The CHAIRMAN. Thank you, Mr. Blake. Mr. Blake, you talked about the VSO recommendation on fee basis care coordination. And I am trying to kind of wrap my head around how we can encourage VA to move on this front. And I guess the question that I ask is are you suggesting that VA move towards having a large network of regional providers? Where we can be assured that the same prices are being paid to all of the providers? And how do we move forward? I mean, I am an advocate, as many know, for being able to provide that health care as close to home as we can possibly get it. And if necessary in the private sector and outside the VA network. So could you expound on that? And Mr. Violante, if you would add to it as well I would appreciate it.

Mr. BLAKE. Well I will do my best to answer that question. I am not sure that we are suggesting a large regional network that might look something like TRICARE in the way it provides its benefits to servicemembers. However, you know, one of the complaints that we hear quite often is when particularly PVA members get fee service out in the community there are complications because more often than not that VA has no provider agreements with providers in the area. Which complicates the pay for the care that's provided. And it can ultimately lead to higher costs because I guess you could argue that with some competition or with the provision of agreements that you might have a better system.

There has also been some ongoing discussion, and I am not saying that we, or the Independent Budget, or the American Legion have advocated for it, there has also been some discussion about more of a nationalized plan for how fee basis care gets done. Which we just do not believe actually occurs at this time. So I do not know if that really answers the question.

Mr. VIOLANTE. I do not know that I could add any more to that. I mean, what we would like to see is a more effective program out there when individuals are sent out to the private sector to ensure, number one, that the care will be totally provided for, the payments will be provided for, and that VA continues to manage that veteran's care instead of just sending them out to any doctor that is out there.

The CHAIRMAN. And I concur that VA does need to continue to help manage that veteran's care. But I, in listening to both of your

answers I think it is clear that there probably needs to be some type of a network that is established where you do know where the providers are, that VA knows what the reimbursement rate is going to be for those providers, and you will actually have, as you said Mr. Blake, competition where folks will be wanting to get onto that provider list so that they too can be providing health care to our veteran population.

I wanted to talk a little bit, yesterday, I am sure you probably already have seen it, but the Office of Inspector General has released their report on retention bonuses. It was not a very positive result. I think basically they said 80 percent of the bonuses that were given either were not, I think the term not justified or appropriate. And there is a lot of money out there that unfortunately does not appear to meet the test that those of us on this committee would want them to meet, nor the veterans' service organizations. So I would like to ask, and I know this is a softball to you, but what do you, if you have seen this report, what do you think about what the report says?

Mr. VIOLANTE. Mr. Chairman, I have not seen that report yet. One thing though I think we do want to make clear is when you are looking at the bonuses that VA not be singled out. Because we certainly do not want to put VA at a disadvantage throughout the government. But we certainly would like the structure of who gets what and why they get it looked at. And we would hope that Congress would do the same government wide.

The CHAIRMAN. Let me just take a moment and read to you the summary portion, where it says that VA lacked clear guidance, oversight, and training to effectively support the program. VHA and VHCO approving officials did not adequately justify and document retention incentive awards in accordance with VA policy. VA officials did not effectively use the personnel and accounting integrated data system to generate timely review notices. And VA officials also did not always stop retention incentives at the end of set payment periods. Mr. De Planque?

Mr. DE PLANQUE. Well, thank you, Mr. Chairman. And I think, and dovetailing on what Mr. Violante said, I think this is a problem that is kind of endemic across the board. But one of our greatest concerns, and this is exactly what you were addressing there, is that there is not a clear indication of what the standards are for these things. I think the VA put out, the Secretary put out their goal of 125 days, no case pending more than 125 days and 98 percent accuracy. And in the year 2010 where both of those figures went back the number of cases over 125 days almost doubled and the accuracy rate dropped several percentage points, that all of these bonuses were still going out. And so if that was kind of your mission statement, this is what was concerning I think to the American Legion and to the other groups as well, if that is your mission statement, 125 days and 98 percent accuracy, and you fail in both of those categories, why are there still bonuses going out?

I understand the importance of retention and that you want to be able to keep employees in place and that it is a competitive job market and there are things that are there. But I think there is also a natural reaction on behalf of people, and you have seen this in Wall Street companies that took a bail out and their executives

were getting bonuses and a lot of people were very angry about things like that in other organizations. When you see that attitude, that you are not meeting the goals that are apparent and yet people are still getting bonuses for that, that is what causes the confusion. And if we could get a more clear indication of what are these bonuses based on? Are they not based on the stated mission statement of 125 days and 98 percent? That is what we are looking for as organizations, is more clarity in that range.

Mr. BLAKE. And Mr. Chairman I think, you know, there are sort of two levels of questions here. Because our letter addresses SES bonuses but that trickles down even to the lower levels and individuals who receive bonuses. And it is sort of a, there are two ways of looking at this. One is our concern about whether they should get bonuses if they are failing to presumably meet performance standards which may or may not exist. The other is, and we have had this discussion with the VA, sometimes it just does not seem to pass the smell test. And Ian referenced this. You know, when times are tight and people are struggling people do not want to be reminded that, you know, some people are going to get bonuses regardless. And whether they are justified or not, because we are not here to suggest that some folks in the VA, and maybe many folks in the VA, do not deserve a bonus. But sometimes you have to make hard choices. And this falls into that category also. Notwithstanding the comments that Mr. DePlanque made about our concerns about performance standards and whether bonuses are even justified in the first place.

The CHAIRMAN. Thank you very much. Ms. Brown, I understand that you have to leave us a little early so Mr. Michaud has passed to you for the first questions.

**OPENING STATEMENT OF CORRINE BROWN, ACTING  
DEMOCRATIC MEMBER**

Ms. BROWN. Thank you, and I want to thank you for holding this hearing. We just had Veterans Day and I know we all were involved in many, many activities around Veterans Day. I want to thank all of the veterans for their service. I ask that my full statement be submitted for the record. There are a few things here I want to focus in on. We ran two wars on the credit card. And so the idea that we are going to penalize veterans who have already paid their dues is totally unacceptable to me. My grandmama always said when you have your head in the lion's mouth, you ease it out. And so we cannot penalize people that have already paid their dues.

I am very proud of the fact that I was involved in the Congress that gave veterans advanced appropriations and gave the Department of Veterans Affairs the largest budget increase in the history of the United States. And this Office of Management and Budget, I do not know exactly who they report to, I mean, they do not, I do not necessarily think they report to the Congress or the administration. They make the decisions independent it seems. How to find out who is in charge of them is something I have not found out in nineteen years. Because when we send certain bills, or we pass certain bills, they come back and say, "We are not doing it." And it is not implemented. So, you know, that is a challenge.

I want to focus in on the fact that one-third of the veterans on the streets are homeless. And I have been working with different agencies. And I want to know what we can do as far as getting the VA to work with these different agencies. Because I understand that they are the hardest to get refinanced, or get them from foreclosing. Not the VA but working with them and that administration.

And another area as far as how we get additional employees. One of the problems is how long it takes, let us say a nurse, to go through the system. The nurse is already certified by the state, certified by the organization. But yet we are losing to other hospitals because it takes so long for the processing. So we have many, many challenges. The Secretary is working on it. We have other safety issues pertaining to how we do certain procedures in the hospitals, in the VA. Those are the things that I am interested in. And any savings that we have from deficit reduction, and we can all look at how we can cut back, should go directly into veterans programs, assistance, and you know, when you talk about rules and regulations, that is where we need to cut down on some. So with that, does anyone wish to respond to my comments?

[The prepared statement of Corrine Brown appears on p. 37.]

Mr. DE PLANQUE. Thank you, Congresswoman. I would actually like to address specifically where you were just mentioning homeless veterans, which is definitely a very big concern. And I know Mr. Blake and Mr. Violante also brought up our concerns about sequestration. While VA programs may be protected from sequestration as we believe, Department of Labor and Housing and Urban Development programs, many of which help homeless veterans, are not necessarily going to be protected by this. And so this is a big concern of the American Legion with the sequestration issue looming. In that sometimes we fail to see that the issues of veterans encompass more than just the Department of Veterans Affairs.

Ms. BROWN. And we are just getting HUD to start working with the VA, which is major. So that we can work in conjunction to stop them from becoming homeless vets. So we are now getting HUD, Labor, and VA working together. And when you cut, even though if you do not cut VA, when you cut these programs some of my colleagues do not see a correlation between the three. Does anyone else have anything to add? I have 35 seconds.

Mr. VIOLANTE. I would just like to say we certainly agree. And we said in our letter that any savings that are found should be re-invested in VA because there are so many unmet needs that need to be addressed. And personally I agree that, you know, we are fighting a war off budget. We should be able to care for those men and women who we have put in harm's way when they come back. And hopefully Congress will continue to keep VA funded at the proper levels.

Ms. BROWN. Well you can rest assured I will continue to do my part. Thank you, sir, for your service.

The CHAIRMAN. Mr. Roe.

Mr. ROE. Thank you, Mr. Chairman. And thank the Committee for being here. I, too, want to associate myself with the remarks of Ms. Brown. I feel like that veterans who carried the war, that we have as a country placed in harm's way to do what we have

asked them to do to protect our freedoms, that now we provide the benefits we promised them, period. Very simple. We do need to be more efficient, however, though. I mean we had an Oversight and Investigation Subcommittee hearing not long ago where a wounded warrior had eight different caregivers. I could not figure that many of them out and neither could the wounded warrior. So there are things that we need, to be streamlined within the balance.

Secondly, Ms. Brown is absolutely right. I happened to be sitting next to a veteran yesterday who works at the VA and spoke with him. I will not say what he does, but he is fairly high up in our local VA, who had taken almost 6 months to hire a physician and, actually no, this was a nurse practitioner. And he had lost several to the private sector because they could not make a decision. About how he had interviewed them, but they could just not get them through the steps. And so he is losing quality people. The VA needs to look at its own, get in a mirror and look at how it can do its own business more efficiently. Because I can tell you in the private sector, if I find a good employee, I hire them. Period. If I find somebody that is good here in the Congress, I hire them and I put them to work. And I do not know what the VA does to take 6 months to hire a nurse practitioner, but that is ridiculous. There are things we can do to improve that.

I totally agree with everyone who said that savings that we find in the VA should be reinvested in the program. Because there are needs out there that are going to be coming forward in the very near future when these soldiers matriculate out of the military and into the VA system that we do not have the resources right now budgeted to take care of them. And I think those efficiencies should be placed back in. I 100 percent agree with you on that. Any comments on those things?

Mr. BLAKE. Well I would first address the point about the efficiencies. The one caution I would have is if we are going to find efficiencies they cannot be vague, they have to be specific. We have to know exactly where the VA is finding those dollars from and how they are going to be reinvested. To simply say, "Well, we are going to save \$500 million," that is a little too vague for our liking. Because inevitably without some clear understanding of how that is going to happen that may never actually be realized. And so it is a false assumption.

Your point about hiring, it is no coincidence that the House is getting ready to take up the Vow to Hire Heroes Act, which I believe all of us here have supported. And you spoke not only to the problem of hiring in the VA, there was a gentleman who spoke at the press conference last week who was an Iraq veteran who talked about the problems in getting hired in the private sector. Who has all the skills to presumably perform a function in the health care field and yet no job opportunity opened itself up because of the problems with certification, and licensure, and stuff like that. So we look forward to all these opportunities to allow veterans in particular to come back into the workforce. And I think the VA is, I think the VA has set a pretty good example already. And it could certainly help improve its workforce we believe by bringing a lot of these newer veterans back into the workforce, its own workforce.

Mr. ROE. One of the things we worked on while I was home was some veterans homeless issues. And where they, the veteran had a case coordinator in the HUD VASH program. If they slipped down into the HUD system they did, but they did not have case coordinator if they had just the voucher program. I looked at that and I said, "Well how many people would it take here locally at our VA medical center to solve that problem?" Because without the care coordinator, someone to do that with them, they just slip right back to where they were. You do not gain anything. You actually go backwards. And it looks like it is not that many people, where you could get a case coordinator with that veteran who is just on the voucher program. I did not realize it until I was walked through it exactly how that worked. Where HUD VASH has got a clinical case coordinator. The HUD system does it, they fall down there, they cannot get the HUD VASH just yet. But if you are just out where you are in a voucher program you do not have that case coordinator. I think that is something we definitely need to look at that would help reduce homelessness. And it would not take that many more people, I think, to do that. Are you all aware of that?

Mr. VIOLANTE. I am not. But we certainly would be willing to take a look at that and see how we can improve that program.

Mr. ROE. Thank you. I yield back.

The CHAIRMAN. Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman. If I recall correctly the Appropriations Committee mandated that the VA get a handle on the fee based services that the VA provides. And the underpinning of the program that the VA undertook was Project HERO, which I understand has not been a big success. My question is, do you believe that the VA should get back to the original intent and actually try to standardize fee-based services?

Mr. BLAKE. I do not think I can give a yes or no specifically, but it is certainly something we think needs to be addressed further. Since you mentioned HERO, I cannot say that I know for certain but I believe we have been told that they are looking at now rolling out HERO onto a national level, which is of real concern to us given the questions you just raised. So while that is going on we are not convinced that that necessarily fixes any of the problems as it relates to the fee based problem.

Mr. MICHAUD. Do you agree?

Mr. VIOLANTE. I agree with Carl.

Mr. MICHAUD. My second question, you mentioned the survey for state veterans nursing homes. Actually, I was at the Caribou State Veterans Nursing Home in August. CMS came in 1 week and did their survey and rated them 100 percent. The VA came in the next week, did their survey, and they also got 100 percent. So there is a lot of duplication within two sister Federal agencies. It is my understanding also that there are about 43 state veterans nursing homes that CMS does not come in to do their survey. How would you address that issue with these 43 state veterans nursing homes? I agree that they should get rid of that duplication, but there could be a problem with the 43.

Mr. BLAKE. VA would have to sign a contract. They already signed a contract with all the nursing homes. Just reduce the num-



ber of contracts that they do and still continue to have those 43 under contract.

Mr. MICHAUD. Okay. My question relating to nursing home as well, when you look at cost it is also my understanding that it is a lot cheaper with state veterans nursing homes than VA nursing homes themselves. Would you comment on the fact that we might want to look at utilizing state veterans nursing homes if the beds are available versus VA since it is more costly?

Mr. BLAKE. I think the fact that it is more cost effective is definitely something worth considering. The problem is ensuring you have the capacity. One of the challenges we have dealt with in recent years is the VA has a mandate to have a certain number of beds capacity within its own system and it is woefully under the number that it is mandated to have. And yet it becomes an excuse to sort of get out of the long term care business altogether because you are not backfilling the capacity outside of the VA, which goes back to my original point about our concern about whether that demand could be met outside of the VA system or not. Even though it is certainly more cost effective.

Mr. MICHAUD. And my next question, and I know we are focused on the VA, but if you look at the other sister agency where there is a lot of cost is the Department of Defense. When you look at cost efficiencies within the VA system is there a way that you might be able to utilize the Department of Defense? A good example is for instance one of the problems with troop readiness among the Guard and Reserves is dental care. However, the VA in some of their facilities does not offer dental care because they say the need is not there. Here might be a situation where they could actually do a joint project with the Department of Defense on dental care. And that is just one example. Any comments?

Mr. DE PLANQUE. Well I think we certainly need to look at all sorts of things. However, historically the Department of Defense and VA do not have a very good record of communicating well with each other. This is something that has been a point of contention I think for all of our organizations for several years now. And so if we were going to move towards a direction towards that I think we would want to make sure that we had really clear lines of communication sorted out. Because as it is now in terms of virtual lifetime electronic record and everything, that seems so far behind at this point. And so the ability of those two organizations to communicate with each other is really troubling. And if you were going to double down on that bet with other efficiencies you may be creating more problems. And that would be a concern that we would want to look at.

Mr. MICHAUD. Thank you. I see I have run out of time, Mr. Chairman. Thank you very much.

The CHAIRMAN. Mr. Stutzman.

Mr. STUTZMAN. Thank you, Mr. Chairman. And thank you to the panel for being here today, and thank you for your work, and what you do for our veterans. And thank you for your service as well. I had a really good couple of weeks over the past couple of weeks meeting with veterans across the district and also in Iowa with Mr. Braley where we did a Subcommittee hearing on economic opportunity in both Waterloo and in Fort Wayne. And the challenges

that we see for our veterans right now is they face a tough economy.

I want to talk a little bit about some of the notes in your letter, joint letter. And as, obviously as the Economic Opportunity Subcommittee focuses on utilizing the VA for connecting veterans with businesses and those who are looking to hire, some of the challenges that we heard during these hearings and also during the open house that I had in Fort Wayne was some of the frustration with just the delay in the care, from our local hospital, and just the challenges. They are trying to figure out what are the challenges that our VA has. And you mention in here, while funding was indeed reduced the demand and need for resources were not. And, you know, our veterans are obviously the ones that we want to make sure are receiving these services that they need. Could you talk a little bit about that. Is it just funding? Is it administrative costs? What is taking some of the time for VA to make sure the services are provided and are prompt and are making sure that it is in a timely fashion for veterans? Are there budget challenges? I mean, I know there is a lot to go on. But I would like to comment a little bit about that.

Mr. VIOLANTE. Well certainly there are budget challenges. And one of the things that we talk about is transparency in the budget process. And we are very grateful for the fact that we were able to get advance appropriations for VA because that has been helpful. But one of our concerns was that while VA's model is excellent and we believe that if you put the right numbers in you get the right numbers out, but there is tinkering that goes on. And I think the GAO report shows that the numbers that come out are not always what is presented to Congress for the needs. And OMB shaves some dollars off.

So we need transparency in the process. We need to know that the assumptions that VA are making are accurate. And that what is coming out, their needs, the veterans' needs, are being accurately presented to Congress for VA's needs. We have seen too many gimmicks that have gone on over the years in efficiencies, where we can save \$1 billion here. But we have never seen any of those savings put forth to show us that the money was indeed saved. So what happens is services are cut back. So what we need is to see some transparency in this process. And we hope that we can see that over the next year. Again, with the GAO reporting on VA's model and the numbers. But if you look at last year, the last one that GAO did you can see that we are not getting an accurate reflection of what is needed.

We also have concerns too about some of the carryover that is going on from the current year, or from 2011, and whether or not that was actual savings that were generated or just cut back. And we are seeing examples down in Florida, in Arizona, of fee based care that is being denied because they do not have sufficient funding.

Mr. BLAKE. And I think it is, it all can sort of be traced back to a budget concern. But it has an impact on staffing and capacity concerns. And it has a trickle down effect. You know, we hear fairly frequently from a lot of local facilities that say I have run out of money, or I cannot hire the people, or, you know, have these issues.

And it is impacting their ability to meet demand. And yet the Under Secretary for Health testified earlier this year during the budget hearings that a lot of these complaints that come from the facilities are a conflict between what they want and what they need. Well that makes for a good sound bite but how do you qualify that? Because if a facility comes to me and says they are running out of resources and they cannot meet the demand, where is the disconnect?

You know, it kind of boggles our mind when, you know, when every year in July we start hearing from facilities who are saying, "I am going to be out of money by the end of the month and the fiscal year starts 2 months from now." And it certainly runs a red flag up the pole for us and we start asking questions. And there is no clear answer as to how that happens. We have pointed to some of this in our letter and in discussions in the past about, you know, it is a fact that the VA has seen substantial increases in its overall budget in the last several years. And yet it seems like on a regular basis when we talk to people at the local facility what might have been a 10 percent increase at the national level translates to a 1 percent at the hospital. And that is sort of oversimplifying it because there is obviously more to it than that. But if it is simply based on some demonstrated need qualify that a little better for us so that we understand. Because we are not convinced that that is happening the way it should.

Mr. STUTZMAN. Thank you very much. I appreciate both of your comments. I yield back.

The CHAIRMAN. Mr. Reyes.

Mr. REYES. Thank you, Mr. Chairman. And thank you, gentlemen, for being here. One of the, in a series of meetings with veterans, and including town halls, one of the big frustrations expressed to me, and I have a veteran population basically of about 70,000 in the West Texas, Southern New Mexico area, is the inconsistency in terms of, through the veterans grapevine, in terms of the types of services that veterans get in different VA facilities. That, I was wondering if you could comment on that? And I am trying to get hold of whether or not it is an isolated complaint, or is it something that you hear collectively through your organizations?

Mr. BLAKE. I would say it is a vague complaint because veterans all have their own view of what their services should be and then there is ultimately a determination of what services they are eligible for and what benefits they are eligible for. And so it is, it is hard to say. It could be an isolated situation. We certainly hear on at least a few occasions from other facilities around the country where people are concerned about whether they are getting consistent services. But I, I am not sure that there is a clear answer to the problem. We would almost have to hear directly from them and let them explain to us exactly what the problem is that they see and sort of dig down deeper than that.

Mr. DE PLANQUE. One of the things that we have come across in the System Worth Saving Reports, and you know we will talk about if you have seen one VA facility you have seen one VA facility. And you know there is a balance in, I have a healthy respect for VA and what they try to do in balancing a level of standardization so that you are getting the same quality of care everywhere

that you get but also reflecting different regional areas have different regional challenges. You know, the challenges you would face running a health care system in the State of Montana are going to be different from the State of New Jersey, just in terms of access to urban centers and things like that.

So it is difficult, again, and I think Carl made an excellent point about, without knowing specifics and being able to compare that I think it is a difficult line that VA walks. And I have a respect for that they are trying to do that. I know we would like to see more standardization and more consistency VISN to VISN in terms of delivery of what they can do. But also you have to reflect that there are going to be different challenges in different areas, and not everything is going to necessarily be feasible in every area. And so we also try to recognize that as well.

Mr. REYES. Anybody else? The other question most often addressed to me, deals with the Secretary's priority for identifying homeless veterans. We have made a concerted effort in my district to try to get to as many of the homeless as possible to identify them. Is, do you have any recommendation individually as organizations about what else we might be trying to do that? I mean, it is a major priority. But it is very frustrating because we seem to be missing many of the, many of the people with the most urgent needs in the homeless community.

Mr. VIOLANTE. That is a very tough question, Congressman. I mean it, I know the Secretary has put a big emphasis on reducing the number of homeless vets and eliminating them in 5 years. How do you find them is another question. I do not know the answer to that. I know that people are trying to do everything they can, even at the local levels, chapters, going out and trying to find them. But as to how we find them all, I just do not know the answer to that one.

Mr. DE PLANQUE. One of the things that, and I think Dr. Roe made the point earlier in terms of coordinators and that is something we want to look into. Coordination I think is a big thing. When you have multiple organizations like the Department of Veterans Affairs, you also have the Housing and Urban Development. But then you also have community organizations, the American Legion, VFW, all of our veterans' organizations that are out there in the community trying to reach out. You have faith based organizations that are doing a lot of work that are out there. So the tricky part is coordination of so many moving pieces. I think you hope that if enough people are out there casting nets, you are going to get everything. But, it is a concern that there will always be people who are going to slip through. And it is just aggressively being out there and trying to coordinate that.

Mr. REYES. Good. Thank you, Mr. Chairman. Thank you, gentlemen.

The CHAIRMAN. Mr. Denham.

Mr. DENHAM. Thank you, Mr. Chairman. First of all I also chair the Committee on Public Buildings. One of the things we are looking at across the Nation is all of the government owned buildings for each different agency on where we can consolidate, where we can sell off things that we do not need, and bring revenue back to the government. Has VA inventories surplus or underutilized prop-

erties that could either be sold off or rehabilitated to accommodate increasing needs of our veteran community?

Mr. KELLEY. Yes, they have. There are, I do not have the number off the top of my head, but they have over 1,000 buildings that are being evaluated for repurposing or being demolished. And every time, they have a list of criteria to try to find some other use for it either internally or externally through a partnership with either another government organization or a private organization to use that. And the majority of those are being used for homeless veterans.

Mr. DENHAM. Thank you. And I would request that this committee receive a list of that evaluation. Secondly, cost of brokering, it seems like that has become a standard practice and continues to escalate in price as well as overtime is continuing to be reauthorized. Every veteran town hall that we have conducted in the district and throughout the state, the issue always comes up about how quickly or how long it takes, to process a claim. And at the same time, it seems like it continues to come at a great expense. What efforts are being done to digitize that and make sure that we are not going back over and over and over on the same information?

Mr. DE PLANQUE. Well I know one of the things that was addressed earlier was the idea of taking some of the money that they are using for brokering, and hopefully VA can look at this, and moving it towards digitizing the claims. We all have a lot of hope that as they move to a fully electronic system, as that process continues that it is going to make it a lot easier if they do have to broker or share information between offices. That you can do it instantaneously once that system is up. VA has been very good about meeting with the veterans' organizations and keeping us posted on the capabilities of the electronic system. And it certainly should have the capability to do that. And hopefully there will be some savings there and they can start turning that towards getting a lot of these cases moved towards that. VA can probably answer better exactly what they are doing on that, though.

Mr. VIOLANTE. And there may be legitimate reasons for the brokering, such as the Agent Orange Nehmer cases. But the question becomes then in a lot of different offices what we hear from our national service officers is that their regional office is brokering 150 cases to some other offices. And then in turn they are receiving 200 cases from some other office that they are working on now. So it creates quite a problem for the representatives of the veterans and for the veterans in some cases when their case is being dealt with at another regional office instead of their local one.

Mr. DENHAM. My concern and my frustration continues to be that we have the Department of Defense not working with the VA, who is not working with the local veterans' centers. And if we had one system that we were able to have communication you would not only decrease the backlog and create more efficiency in the case work but you would reduce costs at the same time. Congressman Roe and I just went over to a, and Mr. Walz, Congressman Walz, went over to Afghanistan recently. And one of the things we saw was the lack of communication between the various parties. You know, it started with me going to get shots. And, you know, we all

do not keep our shot records over the decades. And yet there is no reason that information should not be in the system itself. So rather than create casework for every single instance that we need information we ought to have that accessible throughout the process and reduce costs at the same time.

The same situation came up with disabled veterans that were at Ramstein. There was no question that they were disabled. But yet they were going to have to go through an exhaustive process to transfer from DoD to VA. One would think that this would not only be our number one priority in the case of making sure our veterans are receiving the proper benefits, but the best opportunity to save costs at the same time.

Mr. VIOLANTE. Well the administration announced a couple of years ago I believe that one of their lofty, long term goals was to have essentially a seamless system, from the day you enter the military until the day you died as a veteran. And that should be the ultimate goal and fashion—

Mr. DENHAM. I understand. And the frustration is that is the long term goal. We are going to have more veterans returning home in the next year than we have since Vietnam. We cannot afford for the long term.

Mr. VIOLANTE. Congressman, I agree wholeheartedly. And what I was going to say is it has been my experience since that one of the real roadblocks in this has been DoD's reluctance to come to the table and really work with the VA on getting some of these things done. I think the VA, the VA is ultimately in the business of serving the veteran and anything that can make that process better they are working towards that end. But you have to have a willing partner. And in my time here in Washington, I would argue that DoD has not been the most willing partner in fixing that problem.

Mr. DENHAM. And I would agree in my short time that I have been here. But this committee is looking at cost savings for the VA. And you have a Supercommittee that is meeting, as well as sequestration that is on the horizon that between the two of them we ought to have many willing partners to reduce costs. And I think that there is a way to increase benefits and decrease costs at the same time. So what we are looking for is, you know, that best case scenario. You know, timing is everything in politics. And right now we have the timing to be able to push something through that should not be based on the long term but should be based on right now. So we are looking for recommendations in that area and we would look forward to seeing your recommendations on digitizing the entire system.

Mr. DE PLANQUE. One really quick note, and I just think we would also be remiss at this point if when we talk about DoD and VA here, we cannot forget that the states are involved in this. The National Guards and the communication of those records, that often gets overlooked. And that is a big problem. And we run into that a lot where you have a veteran coming back who has records that are in Afghanistan, and Landstuhl, and whatever active duty post that they mobilized through, and their state has got the records. And DoD and VA communication is its own problem, but

we also cannot forget the state National Guards. That is a big component of that and has especially been over the last 10 years.

The CHAIRMAN. Ms. Sánchez.

Ms. SÁNCHEZ. Thank you, Mr. Chairman. I want to thank our panelists for being here today. Over the break that we just had I had an opportunity to visit the VA facility in Long Beach, which is undergoing quite a bit of modernization and construction. And it's nice to see the upgrade of that facility. And just in speaking with veterans during the past week there seems to be an agreement generally speaking that services at the VA are improving. So it looks like there is a path of improvement that VA is undergoing that folks seem to be happy with. However, there are still many areas that are ripe for improvement and there are still many veterans that are underserved in many capacities. It strikes me that if we could find efficiencies, or find the inefficiencies rather, in the VA in terms of how it delivers care and help fix those then there would not be a need for cuts overall because the savings that you get from inefficiencies could be put towards trying to do more outreach, or trying to make sure that the need is being met for returning veterans. And it seems to me that that is the better case scenario than just random overall cuts which are not targeted and could cut some essential programs where in fact more resources are needed.

And while I am heartened to hear about the improvements, and one of the things that I got a chance to see firsthand were these new patient centered care models, where patients are not having to run all over the place to different specialists that they need but the doctors are actually brought to the patients themselves. There is still this, the IG has still identified a consistent pattern regarding the lack of financial controls and the lack of procedures to ensure that staff are following management directives. And that seems to be a persistent theme with the IG.

I am curious, and I know there are many areas that people have discussed where there could be cost savings, what you think the single best approach is to trying to confront that intractable problem would be with respect to the lack of financial controls and making sure that staff are following management directives? Because it seems to me that if we could fix that one problem there are a lot more efficiencies that would follow. Any of the panelists?

Mr. VIOLANTE. I certainly agree with your assessment. But you probably need to ask VA what problems they are seeing in getting the word down to all of their employees to follow what has to be done. I mean, in this Committee and the Subcommittee on Oversight has a big part to play in that, too, by getting VA in here and exploring some of these areas. And that was basically the hope of our letter was to identify some areas to get the Committee to start focusing on and getting VA in here to explain. I mean, they may have some legitimate reasons for why things are happening the way they do, or what is going on. But you know, we would like to see those areas explored. And certainly what you are speaking about is one of those areas.

Ms. SÁNCHEZ. So your belief is that through increased congressional oversight of VA you think that those inefficiencies can be identified and dealt with?

Mr. VIOLANTE. Well it would certainly help to identify those inefficiencies. I mean, you know, we get information from our members, from our employees who are out there. But we do not have, you know, all the answers. We do not know why certain things are happening, if there is legitimate reasons for it. But certainly to get VA in here to explain those is what we are really looking for. Because we do not have all the explanations. We just have a lot of questions.

Ms. SÁNCHEZ. Anybody else?

Mr. BLAKE. I do not think congressional oversight is the magic bullet. You know, the GAO and the Inspector General do reports quite frequently on the internal workings of the VA and more often than not there are lists of recommendations. And the question becomes, what steps has the VA taken to address any of those recommendations? As sort of a side example, PVA has an agreement with the VA where we do site visits with the spinal cord injuries around the country. Long Beach is one of them. We identify problems and we raise questions. And the VA takes steps to address the problems that we raise. But I am not, but when the GAO or the IG provides a similar report I am not sure that similar actions take place. And so—

Ms. SÁNCHEZ. So it would be, would you say if there were some kind of enforcement mechanism that would correlate to findings and recommendations, that that might—

Mr. BLAKE. Well I am not sure what enforcement is because it sort of implies punishment. And I am not sure that you want to punish the VA for not taking active steps towards some end. But I guess something down that road is what we are looking for.

Mr. DE PLANQUE. I think if we all look at this as partnership. I think all of the groups that are here, we have a partnership with your committee here, we have a partnership with the VA. And we can offer advice. And when we write a letter and come up with things, we are meaning to start a dialogue. And to start that process back and forth. And you are right, you do not want to create the idea of punishment. But consequences.

Ms. SÁNCHEZ. Well that is what I am saying. I mean—

Mr. DE PLANQUE. And there needs to be some sort of follow through. And I do feel like we may have a lot of these hearings, and we may say a lot of the same things at a lot of the hearings, and it does not seem like things get done sometimes. And so, that can lead to a lot of frustration with people. But as long as we maintain the idea that we have a partnership, and that we have an open dialogue, and that we are all working towards the same end, trying to deliver the best services we can get for the veterans, I think making sure that all of the partners at the table maintain that attitude towards partnership and towards being open with their dialogue discussions, and being receptive to saying to the critiques and different viewpoints offered by others. I think keeping an open mind about that will certainly help.

Ms. SÁNCHEZ. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Runyan.

Mr. RUNYAN. Thank you, Mr. Chairman. And thank you all for your testimony. I raise it all the time when ultimately you are talking about partnerships, and Secretary Shinseki says it all the time,



it is accountability. I mean, it is holding each other accountable throughout those partnerships. But it is ironic that in your access to care example you used Montana and New Jersey. Because, quite frankly, my constituents a lot of time their biggest problem is access to that care. Whether in South Jersey you have to go to East Orange, Philadelphia, or Wilmington. It is an issue.

The thing that puzzles me about it, because the chairman kind of spoke about it earlier, you know, do we develop a network? Obviously, you know, the signature injuries of this conflict we have been in, and will continue to be, PTSD and TBI. Are we prepared to tackle that? We still have not conquered what veteran came back from Vietnam with, with Agent Orange. And we are going to pile this on top of that. Are we able to tackle that? And without the access to the care, are we pushing these medical decisions, are veterans pushing them off just because they do not want to make the commitment to travel? Specifically our young ones coming back where they are still out, they are trying to battle this, you know, 20 percent, 40 percent unemployment thing. They cannot take two, three, two days off to go try to get the treatment and figure out what it is. Is there an avenue there that we can possibly, you know, look at something like this to help them? And not to prolong these issues? Because we know when we prolong health decisions they pile up and become more costly at the end of the day.

Mr. BLAKE. I am not sure if I am going to answer your question but I am going to try. I think the problem is framing the question of access. I am a regular user of the VA and I talk to a lot of veterans when I go to the VA on a regular basis. And you hit the nail on the head. It is always a question of access. And generally the complaint I hear is actually getting into the VA in a timely fashion, their access. I rarely if ever hear a complaint about the quality of the services that are provided. However, that gets spun into their concern about access so they want to go to their local provider. That is not the same thing. And I think the question of access differs depending on whether you are talking about Montana or New Jersey. Because the access problem in Montana is, there is no health care. But there may not be a VA facility, but there may not be any health care in some rural areas. Look at Alaska and the options they have there.

Whereas in New Jersey the problem is you have a very centralized population and massive demand into a single facility. And most of those people still want to go to that facility. So it is hard to satisfy their concerns because at the end of the day they want to get into the VA because they know that is where the best care is. And so I am not sure that even if you give them another, a different opportunity, that addresses their ultimate access concern. I don't know I answered that question.

Mr. RUNYAN. Well but giving them the opportunity could potentially avoid critical health care decisions that have to be made down the road.

Mr. DE PLANQUE. Mr. Runyan, I think part of the issue is, for access is the amount of service. Right now VA is at 121 percent capacity at their VA facilities. In 2002 they were around 90 percent capacity. So growth of demand, the facilities have not grown at the same rate.

VA has an exceptional capital assessment plan in place. They have really studied hard, understand where the gaps are, what needs to be done to fill those gaps. Funding is the issue, we continually underfund VA, to make sure that they can fill those gaps. To make sure there is enough facilities in New Jersey to cover everybody that comes in, make sure that there are CBOCs in rural Montana. We do not have the funding to do that right now. And at the end of the day, that is your access issue.

Mr. BLAKE. And there is another problem. Because you could also look at it in terms of if I want to go see my primary care doctor I want to just go see my local primary care doctor. But then if a veteran incurs something much more significant, a serious illness, or a spinal cord injury, or incurs some other, much more specialized type of service is required, they are not going to have access to that in the private setting, no matter where they are at. The fact is the VA is the best in this country when it comes to providing all the broad array of specialized services. And so while we might allow for convenience, which is going to see your local provider, then you could ultimately have a negative impact on that veteran's care if they cannot then get into the VA when they need real serious health care services.

Mr. DE PLANQUE. One thing to bring up on this, and this is something we used to deal with on a regular basis in the Army, is that when a problem would come up you could easily develop a work around that would work for that moment. Which is good, and you have to adapt, and overcome. The problem was all too often the work around became the standard at that point. And so you basically set up a flawed system. So rather than saying there is a flaw in the system right now, we all understand that it is very important to be able to get that care to those veterans immediately and we want to do that. But we want to make sure that we are not overlooking that flaw because we came up with a work around and we do not have to pay attention to it anymore.

And so as a long term system I think most of us agree that we want to be able to deliver VA care. And there is a lot of things when we talked about making sure VA management is still available, if people were getting outside care, because there are things with VA's record keeping that they do that no other health care system in the world does in terms of being able to oversee total patient management and see potential issues outside of things and identify things that might slip by hidden as unseen wounds. There are things VA can do with that. And so I think ultimately we want to be able to get VA access for those people. However, in the short term we still have to get the care to the people. And so we want to look at a system that is going to be able to get care to the people right now when they need it but not overlook the error that there is a, say a cadre of people that are not getting care in the Pine Barrens or wherever it is. And that is the thing that we want to remember. Is not forget the error that caused us to do that work around.

Mr. RUNYAN. Thank you, Chairman. I yield back.

The CHAIRMAN. Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman. You know the Committee and the Congress has increased the VA budget significantly

over the last four or 5 years. And I really like hearing from your point of view that it is a partnership between this committee, the VSOs, and the VA, because that is, while we do not always have the same thing in mind, we want the veterans to get the best service we can, but we also want to see the best bang for the buck. My first question is general, have we gotten the best bang for the buck over the last 5 years? Has that increase in spending really filtered down to increased benefits? Mr. de Planque, do you want to take a shot at that?

Mr. BLAKE. Somebody mentioned earlier that the capacity of the VA is at 120 percent. Well that would suggest to me that we are getting far more bang for the buck than we might have anticipated. Is there some dissatisfaction? Sure. But the VA must be doing something right if there is that kind of demand on the system even with it being apparently seriously overburdened.

Mr. DE PLANQUE. People are using it and wanting to use it. And we are, and this is something we definitely have to keep track of, because they are talking about big force scale downs and things like that. So we are putting a lot more veterans who are going to be out there into the system and there is going to be a lot more load on the VA. I think we have seen the volume even of VBA, and what VBA is dealing with, the number of claims that they are having to deal with, their volume is increasing exponentially. And so we are sympathetic in some ways to what they are trying to deal with as far as that. However, we do have concerns. Carl mentioned earlier and he was picking random numbers out but the idea that you might increase a budget 8 percent but only 1 percent is trickling down. And that is where I think a lot of us have concerns, that the budgets are going out there.

And you know, my colleague Ray just talked about that we are not meeting the construction budgets. And all of us sitting here at this table back in the budget talks in the spring mentioned that we thought that the construction budgets, major and minor construction, were underfunded. And that the proposal was not going to meet the needs that they need to meet their infrastructure needs for the future.

So spending is going there but there are probably concerns that not all of it is getting to the right places. And we are still raising the flags about those things. So that is infrastructure spending that you have to do if you want to be able to maintain the system to deal with the volume. The demand for veterans is there, and there was a time when I think veterans were afraid of or did not want to go to the VA. I think that is largely changing. I think that you know we have all talked about, when you can get the access to the care, and when you can get there, I know Carl mentioned it, I use the VA as my health care provider and I could not be happier with the care that I get. So we are delivering a good quality product when we can get the veterans to it. But I think we are falling short in some places of getting those dollars down to the street level and making sure that the investment is getting to all the places it needs to get to.

Mr. MCNERNEY. Thank you. Well I appreciated the effort that went into the letter, the VSO letter. One of the things you mentioned was the size of the general administration budget. Is there

some concern there that that could be an area where trimming could be done?

Mr. VIOLANTE. That is a question we hope you are going to ask VA when their panel gets here. Our estimation is that there may be too many administrative staff. I mean, obviously you need administrative staff. But are they at a number that far exceeds the benefit? Should some of those people doing hands on service, whether it is claims work for veterans, or health care work on the medical side, it is a real issue. When you look at the increases over the years in admin I think they are growing at a very rapid rate. And the question becomes can we get a better bang for our buck if those people were in different positions?

Mr. BLAKE. And it is not to say that there might not be a logical reason for that increase. The VA sort of tried to explain back in the beginning of the year, when that was the first question that popped up in a lot of people's minds is this does not, I got back to it does not pass the smell test. I look under their chart and directly underneath general administration is the Veterans Benefits Administration, which was recommended at a decrease from the previous year. And that may be justified as well but we all know the struggles that VBA is obviously facing with regards to processing claims. And those two things just do not seem to line up with the world view of what is going on within the VA.

Mr. DE PLANQUE. And you know when they are talking about kind of record amounts of overtime for VA employees. And yet when they are asked, you know, do you have the number of employees on the ground level to meet the needs and they say yes, and then they start plussing up the central office staff, but all the people out in the regional office are working overtime, and double shifts, and things like that. That is what raises flags for us. And obviously, VA is going to be better able to answer that. And there may be very, very good answers for why the expansion is where it is. But these are the reasons that these flags come up for groups like us as we look at this, is because we see that they are struggling out on the pointy end of things dealing with the situation. And we want to make sure that the resources are getting there so they can deal with that. And so that you are not overtaxing the employees who are having to deal with that on a daily basis. Because if you are working 60, 70 hour weeks, the quality of those individual hours may be going down a little bit. And we do not want that to be happening either.

The CHAIRMAN. Mr. Walz.

Mr. WALZ. Well thank you, Mr. Chairman, for holding this, and thank you to all of you. As a veteran I cannot tell you how happy I am that you are out there. This has been very good for me again. I know you are always there. Ian, I had at the top of my sheet, "Great partners with VA and us," this partnership idea that we have always been there. And I think the best partners are those that are holding us accountable to every dollar. That we are the strongest supporters of the VA and the harshest critics, and I think it should run amongst all of us. So I think you brought up some great points.

I think there are some, and you brought up some great truisms. My frustration with the whole, you know, this is such great stuff

I wish the Supercommittee could be here. But since we are not on the politburo we are here to try and pass that on, to pass it on.

But it is very frustrating to me that this, these false choices or whatever that all spending is created equal. We are here to make sure that no taxpayer dollar is wasted. And I said the VA is a sacred responsibility because that is one less dollar going to the care of veterans. That is the way you see it, about making sure the needs are there, making sure they are accountable. So this is not harsh criticism about that. I want to know this too, where they are going. But we do these blanket statements, that all spending is bad, we cut it, we do all this, without asking what are your specifics? Where would you say that? What about the need? And yes, we need to get processing times down but we added an awful lot of Agent Orange folks to that. And did we give them the resources to address that need?

So I guess for me, and I think all of us know this, I just came out of a meeting before this one started without outgoing Surgeon General Schumacher and the great work that has been done in Army medicine. The incredible work that has been down range identifying mild traumatic brain injuries and percussive blast with the idea that addressing them early will reduce the long term costs and the long term danger and loss of productivity to those members.

But my frustration, and all of us have beat our heads against the wall over this issue, we all know this is a seamless transition, where the heck is Armed Services? We sit here and hold these hearings by ourselves, talking about DoD, and talking about they do not cooperate, they do not get along together, VA and DoD do not cooperate. Are we doing it? Are we making a strong effort here to hold that joint meeting, to bring those folks in, to make the decision makers there, get that in. I know you guys have been there. You are absolutely right on, you are spot on on this, you are at the point. I hear your concerns too on this, Carl, you are talking about this, the nine to one. I hear it from folks out there and I go right to the point of where they are delivering it. How many more nurses have been added to this ward? None since then. Well we gave money out there. How many more patients have been added? Seventeen percent more. That is the issues I am looking at, the numbers we are out trying to look at.

So I do think VA needs to have some answers on that. I am one, the teacher in me always was complaining any time the principals got something, or whatever. Or why are they getting it? Or whatever. Well I know the research shows the best schools are the ones that have the best principals. I also know that administration means a lot and it does a lot, it allows our people to do their jobs. But it has to be appropriate.

And somehow we are going to have to crack this congressional barrier between Armed Services and VA, get serious about this. I don't know, we, and this was last Congress, Mr. Chairman, it was all of us in this, but the previous one before your chairmanship we had offers from Secretary Shinseki and Gates to sit together here with this on that. We never brought them. They have never been here.

So I apologize for my frustration on this. I am not telling you anything. I am preaching to the choir. Keep where you are at. Keep talking about this. Force these accountabilities. Make us more efficient. Make a realization. As Mayo Clinic says, we have two of the most fantastic hospitals in the world 90 minutes from each other, Mayo Clinic and the VA hospital in Minneapolis. Those are two, not just the best VA hospital, the best hospital. And that is what we owe to these warriors.

So I do not necessarily have a question but you brought up some great suggestions. I just want you to know that I think my responsibility, maybe you could respond to this, would it help if we collaborated here with Armed Services? If you want to, I am the one who will get in trouble for complaining so you can—

Mr. VIOLANTE. I think that would help greatly. It is something we would like to see is this Committee and Armed Services Committee sit down with VA and DoD and find out where the glitch is. I think about what Senator Webb said when he first came into the Senate that when he was a staffer on the Committee 25 years ago, 30 years ago, they were talking about seamless transition and here we are still talking about it. And I do not quite understand why there is a problem. But I think having both of the parties sit down in front of the Committees and talk about where the problems are may help to resolve the situation.

Mr. WALZ. Well I, this is important, your institutional knowledge is critical on this. Because when I came, you know, oh, I'm cutting edge here, I am asking, because I could see people looking at me, "Really? You are the first guy who ever mentioned seamless transition." You know? And now I see new members getting excited about it. But they get it, they are there. But we seem to keep passing this on to each new members and then members of Congress leave, and a new one comes in, and say, "I have this great idea. DoD and VA should communicate." And at some point it has got to go. We have to get it done.

So I yield back, Mr. Chairman. Thank you for indulging me in that mini-rant, there.

The CHAIRMAN. Thank you, Mr. Walz. Point well taken. An invitation is in the printer as we speak, and we will work on doing that as quickly as possible. Mr. Bilirakis has waived his questions and we appreciate you being here to testify at this hearing. And with that, you are excused.

I would like to call the second panel forward. As they are making their way to their seats I will go ahead and introduce them. Mr. Todd Grams, Executive in Charge of the Office of Management and Chief Financial Officer for the U.S. Department of Veterans Affairs. He is accompanied by Diana Rubens, the Associate Deputy Under Secretary for Field Operations of Veterans Benefit Administration. Mr. William Schoenhard, the Deputy Under Secretary for Health Operations and Management of the Veterans Health Administration. We have Belinda Finn, the Assistant Inspector General for the Audits and Evaluations for the VA Office of Inspector General, who is accompanied by Ms. Linda Halliday, the Deputy Assistant Inspector General for Audits and Evaluations, and Sondra McCauley, the Deputy Assistant Inspector General for Au-

ditions and Evaluations for the VA Office of Inspector General. Mr. Grams, you are recognized.

**STATEMENTS OF TODD GRAMS, EXECUTIVE IN CHARGE FOR THE OFFICE OF MANAGEMENT AND CHIEF FINANCIAL OFFICER, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY DIANA M. RUBENS, ASSOCIATE DEPUTY UNDER SECRETARY FOR FIELD OPERATIONS, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND WILLIAM SHOENHARD, FACHE, DEPUTY UNDER SECRETARY FOR HEALTH OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND BELINDA J. FINN, ASSISTANT INSPECTOR GENERAL FOR AUDITS AND EVALUATIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY LINDA HALLIDAY, DEPUTY ASSISTANT INSPECTOR GENERAL FOR AUDITS AND EVALUATIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND SONDRA MCCAULEY, DEPUTY ASSISTANT INSPECTOR GENERAL FOR AUDITS AND EVALUATIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS**

#### **STATEMENT OF TODD GRAMS**

Mr. GRAMS. Good morning, Chairman Miller, Ranking Member Filner, and Members of the Committee, and Congressman Michaud. I am accompanied today by Bill Shoenhard, VHA's Deputy Under Secretary for Health for Operations and Management; and Diana Rubens, VBA's Deputy Under Secretary for Benefits for Field Operations. I am pleased to be here with my colleagues and to be at the table with Belinda Finn and her colleagues from VA's Inspector General's Office. I also want to recognize our partners and friends, the Veterans' Service Organizations. They continue to serve as tireless advocates for our Nation's veterans.

Mr. Chairman, today's letter is centered on a joint VSO letter provided to this committee earlier this year. The letter responded to your request for ways that VA could identify areas where there are opportunities for greater value of VA resources and in the end provide more and better services to veterans. I have two central points in my remarks this morning. First, VA has taken significant steps over the past 3 years to become more effective and efficient. And second, there is more we need to do.

Any large organization intent on maximizing value must have strong financial management operations. The release today of our auditors' fiscal year 2011 report on VA's financial statements marks the second year in a row of strong improvement. The most significant problems auditors can find are referred to as material weaknesses and the second most significant are called significant deficiencies. In 2008 VA had three material weaknesses and 16 significant deficiencies in financial management. Today we have no material weaknesses in financial management and two significant deficiencies.

These and other accomplishments have strengthened our financial management and we must continue to get better. For example, although we have reduced improper payments in pension and edu-

cation programs, the continuing issues in fee basis care have to be effectively addressed to stop unnecessary expenditures. And while we have reduced retention allowances across the VA, an audit released by the IG yesterday confirms that this is an area for improvement.

Collections by VA are a major funding source for our health care systems and we are working to turn the tide in our revenue collections with initiatives such as the Consolidated Patient Accounting Centers which centralize and standardize collection activities.

The Veterans Equitable Resource Allocation system, or VERA, is the way we ensure that health care dollars get to where veterans need care. There is a belief however that the recent increases in health care funding are not reaching veterans who need it when in fact over 97 percent of our medical care budget goes either to the field or to national health care programs like CHAMPVA. It is also worth mentioning that if at any time during the year a VAMC or a VISN director believes they require more funding we have an open and equitable process to ensure those needs are analyzed and, if justified, funded.

For performance awards at the Senior Executive Service level we have taken action to make our executives more accountable and to tie performance to results. More specifically the percentage of executives at the VA who receive a top outstanding rating has been reduced by one-third since 2008. The VSOs also raised questions about the growth in staff offices. A strong headquarters is required to drive transformation. It is important to note that increases in staff offices have increased proportionately with the VA system over the past 3 years and, as such, staff offices continue to consume about 1 percent of VA's total staffing. The increases we have made in staff offices have allowed us to establish organizations that are leading efforts to provide outreach to let veterans know about what benefits they have earned, to address our wounded warriors' transition from DoD, to eliminate homelessness, and to provide greater assistance to survivors.

On conference and travel expenditures, VA has tightened its guidelines to demand examination of teleconference alternatives, use of local venues, and trainer approaches before approval of each conference event.

My written statement, Mr. Chairman, also highlights changes underway at VBA that are centered on eliminating the disability claims backlog, changes that focus on our people, our processes, and our technology, all at the same time. The written statement also responds in some detail to the benefits issues raised by the VSOs in their letter.

Mr. Chairman, in closing, I do believe the VSO letter that is the center of attention today raises the right question. How do we do more for veterans and how do we do it better, in a time of fiscal constraint? Thank you for the opportunity to appear before your committee this morning.

[The prepared statement of Todd Grams appears on p. 46.]

The CHAIRMAN. Thank you, sir. Ms. Finn.



**STATEMENT OF BELINDA J. FINN**

Ms. FINN. Thank you, Chairman Miller. Chairman Miller and Members of the Committee, thank you for the opportunity to testify this morning. With me today are Linda Halliday and Sondra McCauley, the Deputy Assistant Inspectors General who are directly responsible for the work I will be discussing. As auditors we are deeply committed to identifying budgetary savings in the Department of Veterans Affairs and we have read the recommendations from the veterans' service organizations with great interest.

Of the many issues raised by the VSO, we believe the improved management and oversight of medical care provided outside of VA facilities, commonly known as fee care, offers the greatest opportunity for savings. Under the program VA medical centers authorize veterans to receive treatment from non-VA health care providers when VA cannot provide the care. Fee care costs increased from \$1.6 billion in fiscal year 2005 to \$4.4 billion in 2010. And this amount will continue to grow as health care costs rise and the demand for health care increases.

Our findings in the area of fee basis care have addressed the processes to authorize and pay fee claims, inefficiencies in VHA's payment processing organization, controls to prevent and detect fraud, and opportunities to bill third party insurers for fee care claims. We estimated that VA could save \$293 million annually from improving authorization and payment procedures and \$134 million annually from streamlining its payment model. Also, VA could be paying at least \$114 million in fraudulent payments and missed revenue opportunities of about \$110 million annually. Between these four reports we identified approximately \$650 million in annual potential savings. VHA has agreed with all of our recommendations and is taking action to streamline its fee care payment process.

Our written statement also outlines the results of our audit work related to other issues raised by the VSOs, such as claims brokering, employee compensation issues, and the use of overtime in VBA. As Chairman Miller just mentioned, we just released our latest report on employee retention incentives yesterday. In this report covering retention incentives at the VA central office and VHA, we questioned the appropriateness of 126 out of 158 incentives, or approximately 80 percent. These problems happened because the VA personnel needed guidance, oversight, and training to effectively administer the program. Both VHA and VA have agreed with our recommendations and findings and will be taking corrective actions.

In addition to the issues raised by the VSOs we believe VA can reap substantial benefits by improving its processes in acquisition, delivery of health care and compensation benefits, information technology management, and workers compensation for employees injured on the job. Improving acquisition practices seems particularly prone to savings since VA purchases goods and services in excess of \$10 billion annually.

VA has also long experienced challenges in managing its information technology investments. In response to these problems VA implemented the Program Management Accountability System, known as PMAS, in 2009. In September of this year we reported

that VA lacks controls to ensure data reliability of the information in PMAS, verify project compliance with the PMAS process, and track the project cost. Until these issues are addressed VA risks further IT cost overruns, schedule slippages, and performance problems.

Several of our ongoing audits address other concerns raised by the VSOs, or have the potential to identify significant savings. We expect to issue final reports on these audits in calendar year 2012.

Mr. Chairman and Members of the Committee, thank you again for the opportunity to be here. We will be pleased to answer any questions that you may have.

[The prepared statement of Belinda J. Finn appears on p. 53.]

The CHAIRMAN. Thank you very much, Ms. Finn. I would like to start, Mr. Grams, with you. I told you in my opening statement that I was going to ask a question in regards to sequestering. We all know that it is OMB that actually is the one that interprets the sequester rules. And so our question, the VSOs raised it, this committee has raised it, are veteran dollars exempt if we go into sequestering?

Mr. GRAMS. Thank you, Mr. Chairman. We did note that in the letter that you and Ranking Member Filner sent to the Supercommittee you indicated your view that existing law exempted all VA programs from sequestration. The administration and the Secretary are committed to ensuring veterans get the care that they need. Your letter to the Supercommittee also noted possible legal ambiguities to the Budget Control Act and how it applies to VA with regard to sequestration.

We are researching those ambiguities. We are working with OMB. As soon as we have the resolution to that legal question we will inform the Committee right away.

The CHAIRMAN. We have been working on the issue now for 3 months. How long do you think it is going to take to get an answer? I mean, the Supercommittee has to make their recommendations next week. And this Congress has to approve or disapprove of them right before Christmas. So I mean, 90 days is not long enough to get a ruling from OMB?

Mr. GRAMS. Mr. Chairman, we are hoping to have the issue resolved shortly so that we can know—

The CHAIRMAN. Could you give us an idea of when the request was made to them as to whether or not veterans were exempt?

Mr. GRAMS. Mr. Chairman, that request went from our General Counsel's Office to OMB General Counsel's Office. I will go back and get you that date, sir.

The CHAIRMAN. I think all of us would appreciate if that is something that immediately when the law was signed by the President, if it was something that VA recognized was important to get an answer to this committee. I think all members of this committee certainly expect to know something very quickly. So I would like to hear something as quickly as possible.

Mr. Grams, in your testimony you highlighted the importance of conferences, because they enable VA to among other things share best practices and provide opportunities for your employees to establish and enhance their professional contacts with relationships within VA. From a cost standpoint, fiscally only, how much does

VA spend annually on conferences of 50 people or more? And what over the last few years has been the trend of conferences? Are we having more of them or are we having less of them?

Mr. GRAMS. Mr. Chairman, in 2011 we spent a little over \$100 million for conferences at the VA. Those conferences are used for a variety of goals and objectives. They can include symposia. They can include leadership meetings. For example, in VBA when their leadership and teams get together to evaluate the updating and the reevaluation of the VBA compensation schedules, that falls under the title of conferences. When VHA's leadership gets together to set and discuss major clinical and health care policy and financial policy across VHA, that also falls under that category.

You asked for the trend, sir? In looking at this, in 2009 it was about \$92 million so it has gone up a bit over the last 2 years. And I think that reflects our efforts to try to integrate the VA, have better communication, and better coordinate among leaders and managers.

The CHAIRMAN. Is that the dollar amount has increased? Or the number of conferences have increased?

Mr. GRAMS. That is the dollar amount that I was giving you.

The CHAIRMAN. Do you know whether or not conferences have increased? Or is that something you need to take for the record as well?

Mr. GRAMS. If I could take that for the record, I will get that for you.

The CHAIRMAN. Absolutely. You have mentioned teleconferencing. I know that the Chief of Staff has called, or submitted a directive calling for maximizing the use of teleconferences. Can you give the Committee an idea of where VA is now? Has that risen? And because of the maximization have we seen fewer conferences?

Mr. GRAMS. Mr. Chairman, we are making greater use of VTC through the efforts of our Chief Information Officer. And not only was teleconferencing part of the August memo that you are referring to from our Chief of Staff tightening up on conferences, he is requiring a detailed business case for each conference as well as ensuring that we are selecting economical venues. We are looking at holding things, if possible, within a 50-mile radius of the vast majority of the people who need to be at the conference—having those events being at VA venues, as opposed to having to buy the venue from the private sector.

It is also worth noting in that same memo that you referred to, Mr. Chairman, that the Chief has charged us with reducing the costs of travel and conferences by 25 percent below the 2010 level. That is consistent with the President's new executive order that is requiring a 20 percent reduction across a variety of areas such as multiple IT units, printing, travel, and what they call swag.

The CHAIRMAN. No \$16 muffins, though?

Mr. GRAMS. No, sir.

The CHAIRMAN. Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman. Mr. Grams, I would like to follow up on the chairman's question as far as the sequestration issue. What is the VA's position and General Counsel's?

Mr. GRAMS. Our General Counsel is, has looked at the history of everything building up all the way back to I think Gramm-Rudman, up to the act for today. They are continuing to discuss this with OMB, sir. And as soon as they have an answer to that question we will let the Committee know.

Mr. MICHAUD. When you deal with OMB on this issue but other issues, do you say this is the way you feel it should be?

Mr. GRAMS. Our General Counsel will be providing to OMB during that exchange what they have found as they have looked at the law and the statute.

Mr. MICHAUD. And what is that? Do you support the Committee's understanding of what the law is?

Mr. GRAMS. I think as the Committee pointed out in their letter that, based on history, it would appear that VA would at least to a large extent be exempt from sequestration. But as the Committee also noted in your letter, there are ambiguities to the law and that is what we have asked our lawyers to—

Mr. MICHAUD. Okay. I do not know how to make this question clearer. Do you agree with the Committee's recommendation? Because the problem that I see is if we are saying this is our interpretation of the law. You are saying you are waiting for OMB to answer. But on the sideline you are saying well we really do not care. Do you have a position or do you not have a position on this?

Mr. GRAMS. At this point we do not have an official position, Congressman. We are working with OMB to develop the administration's interpretation of the law.

Mr. MICHAUD. So your General Counsel does not know what the laws say? They do not have a position?

Mr. GRAMS. Have they taken a position? No, sir. That is not their role before they discuss these matters with OMB. They have researched the law and my understanding is that they are working with OMB to come up with the right answer to that question.

Mr. MICHAUD. So they do not have a position on it? They are waiting, well I guess my only concern is what is the use of having your General Counsel if they cannot take a position and make a recommendation to OMB?

Mr. GRAMS. Well, I think it, if I am misunderstanding you or if it is semantics, I apologize, sir, I think it is not our General Counsel's role to take a position, per se. This has to be worked out within the administration so the administration provides Congress with one consistent answer. The General Counsel has taken a technical review of the law and provided their information to OMB as part of those deliberations.

Mr. MICHAUD. Okay. So in their technical review of the law, what is that? What is their recommendation under their technical review of the law?

Mr. GRAMS. The General Counsel with the information that they have provided to OMB will lead to their final conclusion in working this out, sir, so that we can give Congress one answer.

Mr. MICHAUD. So they provided their technical review to OMB already?

Mr. GRAMS. That is my understanding.

Mr. MICHAUD. Can you provide the Committee with a copy of that?

Mr. GRAMS. I will go back and make that request of our General Counsel, sir.

The CHAIRMAN. Will the gentleman yield?

Mr. MICHAUD. Yes.

The CHAIRMAN. A 2010 law, it says this specifically, and this is where I do not understand why there is so much consternation. Veteran programs, the following programs shall be exempt from reduction under any order issued under this subchapter. The subchapter being emergency powers to eliminate budget deficits. All programs administered by the Department of Veterans Affairs. And that is why I am trying to, I do not think any of us understands where the foginess is coming from in regards to that comment.

Mr. GRAMS. Mr. Chairman, as you know when interpreting the law, it is not only looking at a particular provision at a given time but it is going back and looking at the history and other provisions that it may or may not reference. I would, if I recall right, believe that in the letter going to the Supercommittee, it raised issues about potential ambiguities and that is what we are trying to work out, sir, so that when we give Congress the answer we give you, the right answer one time.

The CHAIRMAN. So using that rationale if I went up to subsection A it says benefits payable under old age, survivors, and disability insurance program established under Title 2 of social security it also says shall be exempt from reduction under any order issued under this sub, so social security beneficiaries better be concerned too, correct?

Mr. GRAMS. Sir, as the CFO of the VA I am hesitant to comment on the law as it applies to social security. But I appreciate your question and concern.

Mr. MICHAUD. So what you are telling me is the General Counsel does not have a legal opinion on this matter?

Mr. GRAMS. Congressman Michaud, if it is okay I would like to go back and relay your concern to our General Counsel's Office and request that they respond appropriately.

Mr. MICHAUD. I just want to know if they have a legal opinion on the matter. I mean, if they do not have a legal opinion then why do we have a General Counsel? Probably we could save money there. I mean that is why you have a General Counsel, to give you legal opinions. And this appears to be a question of whether or not it is, whether or not we will have to comply with sequestration. but if you could get back to the Committee I would appreciate it.

My other question when you look at cost savings, and it is an issue that was brought up by the VSOs. And I know the Under Secretary as well had talked about saving costs. It gets back to the nursing home issue. Is that something that you are looking at? Is trying to streamline the process so if there is duplications with CMS and the VA as far as the surveys for nursing homes, to eliminate duplication?

Mr. GRAMS. Congressman, I will ask Mr. Schoenhard to respond to that.

Mr. MICHAUD. Thank you.

Mr. SCHOENHARD. Congressman, yes, we are looking at that. As you pointed out, sir, in the earlier panel there is a number of facilities that are not CMS certified. And we take very seriously the

oversight and the review of veterans for which we have fiduciary responsibility for their care as we are providing these funds. So we would need to work through the large number of facilities that are not certified. We need to balance how we would do that with access. I guess one could take the position they should all be CMS certified. That might restrict access. I am not sure that is the answer. There are a number of areas that we look at that CMS does not look at, but we appreciate the efficiency with which that might be achieved. And we will continue to study that. But we need to do so most mindful of the safety and the quality of care for our veterans.

Mr. MICHAUD. I agree. And if I recollect when I saw the two surveys they are very similar, number one. Number two, actually there was a report, and I believe it was a former admiral, a former member of Congress, talked about a nursing home facility the VA operated that was not very good. When you looked at the safety, as matter of fact, I think the report talked about maggots coming out of wounds of a veteran that was in a VA facility. And that was a couple of years ago. And it was Admiral Sestak, I believe, that brought that forward to the Committee. So if you really could look at that. And I would like to see a side by side of what the VA asks as well as the CMS. Because I think this is an area we might be able to save, you know, some money. So.

Mr. SCHOENHARD. We will certainly do that, sir.

Mr. MICHAUD. Thank you. I yield back.

Mr. BILIRAKIS [presiding]. Mr. Grams, I am concerned about the antiquated process the VA is using to broker claims. Approximately how much does the VA spend per year on brokering claims?

Mr. GRAMS. Thank you, Congressman. I am going to ask Ms. Rubens from VBA operations to address your question.

Mr. BILIRAKIS. Very good. You are recognized.

Ms. RUBENS. Thank you, Mr. Grams. The prospect of brokering is one that VBA utilizes currently. I say currently because we have some longer-term plans in place, allowing us to increase some organization capacity and ensuring that veterans are being served as effectively as possible. The stations that we currently broker to are our more effective and efficient offices.

Long-term, though, we also understand and having heard the comments from the first panel as well, the need to move away from physical shipment. The issue becomes one of establishing that paperless approach to allow us to do away with brokering to ensure that that is a cost that we no longer have to incur. As we establish that capacity to manage surges, if you will, in a handful of regional offices we've also had the opportunity to benefit from the IG's report on brokering. Some of its recommendations will allow us to see some savings by avoiding shipping cases that have been prepared for a rating decision to another office to be rated. This has been put in place at the IG's suggestion as well as the suggestion that we consolidated the Nehmer readjudication claims during fiscal year 2011. We felt as though we needed to ensure we had the most effective utilization of those resources.

Mr. BILIRAKIS. Approximately how much would it cost to implement a paperless system?

Ms. RUBENS. Mr. Bilirakis, I apologize. I do not have the full figures with me for implementing that full paperless implementation. It is an overarching approach that VBA is using to engage in transformation, recognizing that we cannot continue to do business as we have and expect to meet the needs of today's veterans. The receipt of claims has increased tremendously in the last 3 years. As we change not only the training that we provide people, we are changing the process that we are utilizing, and implementing technology; we have components for each of those. I will need to get for you the record, the technology portion, for implementing our Veterans Benefits Management System.

Mr. BILIRAKIS. Give me a time frame. I know you want to implement this. When will it become reality? Give me an approximate time frame.

Ms. RUBENS. Certainly. For the efforts that are all encompassing, across people, process, and technology, we are in the midst of the implementation for it. The full component, that will begin in January. For the technology piece, the implementation of the Veterans Benefits Management System is actually a three-phased approach. We are into the third phase. We have two offices that are currently engaged in helping us to establish the appropriate requirements, provide testing and feedback to ensure that the new paperless system provides us what we need from the repository where the electrons will be housed and that the systems themselves will allow us to operate in that paperless environment, replacing our current processing systems.

Mr. BILIRAKIS. How much time do you think we will save as far as for the constituents regarding processing of claims if we move to a paperless system?

Ms. RUBENS. Yes, sir. Today as we look at the overall transformation we are targeting to meet the Secretary's very ambitious goals of completing all claims within 125 days at 98 percent quality by 2015.

Mr. BILIRAKIS. Very good. Thank you very much. Anyone else want to ask a question? Did you have any? I think we are basically finished here. On behalf of the Committee I thank each and every one of you for your testimony and we look forward to working with you of course in the future. Based on what I have heard today there is no small amount of work. It can be done. In other words, we have to keep working on it. I repeat my earlier desire to work with members on both sides of the aisle to ensure America's veterans have access to the benefits and services that they deserve.

I ask unanimous consent that all members have five legislative days in which to revise and extend their remarks. Hearing no objection, so ordered. I want to thank the panel for their testimony. Thanks again for your attendance at today's hearing. And the Committee is adjourned. Thanks so much.

[Whereupon, at 12:00 p.m., the Committee was adjourned.]

## A P P E N D I X

### Prepared Statement of Hon. Jeff Miller, Chairman, Committee on Veterans' Affairs

Good morning everyone. Welcome to this morning's hearing.

Today we will review recommendations from several veterans service organizations for possible savings within the Department of Veterans Affairs.

As everyone knows, we are in an unprecedented time of fiscal restraint in America, one that is long overdue. The Budget Control Act, now the law of the land, has put in place for the next decade caps on discretionary spending for every account in government, including VA. These caps will permit overall government spending to grow at roughly 2.5 percent annually.

Needless to say, the next 10 years will look vastly different than the last 10 in terms of spending. Now, it is my belief that veterans' spending and defense spending remain the absolute top priority going forward. Maintaining the Nation's defense is a clear constitutional charge of the Congress—and I include the care of those who have fought for our country's freedom as an inextricable part of that charge.

With that said, no agency should ever be exempt from a constant effort to become more efficient in its operations, or root out waste, fraud, and other questionable spending.

It is with this in mind that I solicited the help of the leading veterans' organizations to highlight areas of potential savings within VA, which could be redirected to provide better care and benefits to veterans.

The VSO response was outstanding. They provided nine areas for the Committee to examine, and I am so pleased they are here today to discuss those and other areas of potential savings. Some of what they recommended, such as VA's questionable payment of bonuses to already well-paid employees, were addressed in legislation reported from the Committee and passed by the house.

Other recommendations require ongoing scrutiny, and today's hearing continues the Committee's oversight function to that end. I also want to thank the participation of VA at this hearing.

I believe there are sincere efforts underway—and documented success in several areas already—which show that Secretary Shinseki is serious about VA's stewardship of taxpayer dollars.

Nevertheless, there are many areas that need improvement and continued oversight.

The VA Office of Inspector General's testimony will confirm that this morning and I thank the VA OIG for its work with the Committee, VA, and veterans' advocates in our common purpose.

Before I close, let me touch on one other issue that is on everyone's mind, one that Carl Blake raises in his opening statement for the Paralyzed Veterans of America. Namely, the question of whether VA medical care is exempt from indiscriminate cuts that would occur across government accounts under a sequester order.

Now, it's my firm hope and expectation that the Joint Select Committee will rise to its calling and produce a bill which saves a minimum of \$1.2 trillion over the next decade that can clear the Congress and be signed by the President. Should that not happen a week from tomorrow, however, veterans and their loved ones deserve to know, now, whether VA will be affected by a looming sequester.

It's my belief that VA is absolutely exempt. But only the Office of Management and Budget is vested with the authority to determine the sequester rules. To date, OMB has not been clear on this point.

Mr. Grams, I hope you can shed some light on the Administration's position when you appear on our second panel.



Again, I thank all of our witnesses for their attendance this morning.

I now turn to our Ranking Member for her opening statement. Ms. Brown, you are recognized.

---

**Prepared Statement of Hon. Corrine Brown**

Chairman Miller, Ranking Member Filner, thank you for holding this hearing today.

It is important to make sure that veterans get the resources they need while making sure the resources are not wasted.

I am pleased to have been a member of this Committee who worked with leadership to increase the VA budget by its largest amount in its history. We need to continue to support these increases while not wasting the resources that need to help both current and future veterans. And at no time have I ever advocated to balance the budget on the backs of our veterans. When the VA saves money, it puts those resources back into the veteran, not the General Fund.

I thank the VSOs for the work they do and their involvement in this process. Their Independent Budget helps keep this committee honest when allocating resources for the upcoming fiscal year and makes sure the accounts that need funding, get it.

One of my foremost concerns is to ensure that the resources get to the veterans. It is important that the Departments of Veterans Affairs, Housing and Urban Development and Labor work together to help veterans. Housing and Veterans. Homeless veterans are one of the worst marks on our policies. How can these young men and women be cast off to the side after serving their country? The three departments need to work together to solve the problem, because it is not happening separately.

I fully support the work that Secretary Shinseki has begun at the VA. As this committee has said repeatedly, the culture of working against the veterans needs to change to where they are the advocate for the veteran. The Secretary is moving the VA in that direction. It takes time.

I look forward to hearing the testimony of the witnesses today.

Thank you Mr. Chairman.

---

**Prepared Statement of Joseph A. Violante, National  
Legislative Director, Disabled American Veterans**

Chairman Miller, Ranking Member Filner, and Members of the Committee:

Thank you for inviting me to testify about areas within the Department of Veterans Affairs (VA) that should be scrutinized by Congress to ensure that inefficiency, duplication and waste are minimized or eliminated. On behalf of the Disabled American Veterans (DAV), and in partnership with my colleagues from The American Legion, Veterans of Foreign Wars (VFW), AMVETS, and Paralyzed Veterans of America (PVA), I am pleased to appear before you this morning.

Earlier this year, in response to your request, DAV, VFW, PVA, AMVETS and The American Legion worked together to develop recommendations for areas within VA where inefficiency or waste might be uncovered and eliminated. We have been pleased to see that since we submitted our recommendations on April 4, both the General Accountability Office (GAO) and VA's Office of Inspector General (VAOIG) have produced reports that touch on several of our recommendations, and we have incorporated some of their comments into our testimony. Like you and all members of this Committee, we believe that the precious resources allotted to VA must be wisely and efficiently spent, especially when our Nation faces fiscal and economic crises resulting from massive government deficits and debt. Every dollar that is misspent is one that cannot be used to help a veteran in need.

However, it is also important to recognize that simply cutting VA's budget in the absence of detailed justifications or evidence of savings, is more likely to result in a loss of accessibility, quality and safety of the services veterans depend on, rather than true deficit reduction. Furthermore, we believe such an approach will likely lead in the future to additional, avoidable spending to "fix" problems that manifest as a direct result of underfunding essential services for veterans.

For example, a decade ago, the Bush Administration proposed several successive VA budgets, each of which proposed to make substantial "management efficiencies" and thereby reduce the need for billions of dollars in direct appropriations. Although funding was indeed reduced, no efficiencies were ever documented to have been achieved while the demand and need for resources continued to rise. As a consequence, after several such budget cycles, newly-confirmed Secretary Nicholson in

2005 returned to Capitol Hill just weeks after presenting the FY 2006 budget and admitted VA was seriously underfunded by more than a billion dollars. In the end, Congress provided the requested supplemental appropriations to cover the unmet demand, but not before thousands of veterans were turned away or forced to wait for vital VA health care services.

For these reasons, we urge this Committee to closely examine a number of troubling elements of VA's budget and appropriations that seem to echo these same problems from the past. For example, the FY 2012 budget presented in February for VA health care by the Obama Administration relies on several "gimmicks" to reduce the real dollar appropriations provided by Congress, including a projected \$1.2 billion in savings from "operational improvements," \$500 million in carryover funding from FY 2011, an unexplained or justified reduction in non-recurring maintenance, and an approximate \$1 billion contingency fund for medical care that may or may not be released to VA. All of these assumptions have been built into VA's FY 2012 budget, thereby lowering the level of appropriations approved by Congress, yet there are serious questions about whether these "savings" will indeed reduce VA's need for direct funding.

Further straining VA's medical care budget, receipts from the Medical Care Collections Fund (MCCF) have been dropping. In February of this year, VA indicated that contrary to prior assumptions used to build the FY 2012 advance appropriation for medical care, MCCF receipts were expected to drop by \$600 million. Later in July, Secretary Shinseki reported to Congress that "MCCF collections are 8.5 percent below plan . . ." further reducing funding available to VA for FY 2012 medical care programs.

In July, the Secretary reported that implementation of the new caregiver programs would cost almost \$100 million more in FY 2012 than previously estimated. He also stated that VA's ". . . ability to achieve operational improvements . . . remains an element of risk to the sufficiency of the FY 2012 budget." In a report released in June, GAO raised these same concerns about the "operational improvements," citing similarities to "management efficiencies" proposed by VA in prior years that did not materialize and were never documented as having been achieved. In addition, GAO reported that in VA's FY 2012 medical care budget submission, funding for non-recurring maintenance had been lowered \$900 million below the level that VA's own Enrollee Health Care Projection Model (EHCPM) had already projected was needed to maintain its health care facilities.

Mr. Chairman, if we are to ensure that VA actually eliminates duplication, inefficiency and waste from its budget, rather than just cutting services for veterans, we must have an accurate and transparent budget process to measure whether savings are achieved. First, did the carryover funding from FY 2011 to FY 2012 actually take place? What is the current projection for MCCF in FY 2012? How will VA measure whether savings from proposed "operational improvements" actually materialize? Does VA anticipate requesting the funding designated for contingency purposes?

Moreover, as we work to find areas where real savings might actually be achieved, we must keep in mind that VA has significant underfunded needs that are essential to the integrity of the system itself, especially its health care infrastructure. VA's Strategic Capital Investment Planning (SCIP) process has estimated that VA space is over-utilized at 114 percent of its intended capacity. SCIP has identified at least 4,808 capital projects that should be completed within 10 years, at a cost estimated to be between \$53 and \$65 billion. Yet funding for major and minor construction has gone down, not up, and funding for non-recurring maintenance and equipment purchases are being cut below what VA's own actuarial model estimates is needed.

Although Congress has funded a significant number of new facilities in recent years, the vast majority of existing VA medical centers and other associated buildings are, on average, more than 60 years old. Aging facilities create an increased burden on VA's overall maintenance requirements. All facilities must be maintained aggressively so that their building systems—electrical, plumbing, capital equipment, etc.—are up to date and that these facilities are able to continue to deliver health care in a clean and safe environment.

Unless VA effectively responds to these needs, we fear that VA's capital programs and the significant effects on the system as a whole, as well as the veterans individually, will go unchanged; ultimately risking a diminution of the care and services provided by VA to sick and disabled veterans in substandard facilities. Older, out dated facilities do not only present patient safety issues, but from VA's perspective, older buildings often have inefficient layouts and inefficient use of space and energy. This means that even with modification or renovation, VA's operational costs will be higher than they would be in a more modern structure. For these reasons, we believe that if Congress is able to find true "savings" the first obligation must be

to use them to help fund the essential long-term maintenance needs of the VA health care system.

Mr. Chairman, I would also like to comment on one proposal to make “savings” that may be considered by the so-called “Super Committee:” to take back all or part of the cost-of-living-adjustment (COLA) increase for veterans disability compensation and survivors’ disability indemnification compensation (DIC) payments that Congress just approved. As you know, disabled veterans have not had a COLA increase since December 2009.

On October 19, it was announced that there would be a 3.6 percent COLA for Social Security recipients next year, and the Senate immediately and unanimously passed legislation (S. 894) to apply this same COLA increase to veterans disability compensation payments. On November 2, the House also passed this COLA legislation unanimously, just as it had done with companion House legislation (H.R. 1407) earlier this year. We expect the President will sign this legislation any day now. Mr. Chairman, we want to thank you and all members of this Committee for helping to pass this vital legislation. As you have stated, for the past “. . . 2 years, our veterans have not received an increase. This additional income will help them make ends meet in the coming year.”

However, we are distressed to hear that the “Super Committee” may consider a proposal to freeze, delay or cut this very COLA that Congress just passed without one dissenting vote. While we recognize it is difficult to make reductions in Federal spending, we believe it would be irresponsible to target cuts at those who have already sacrificed so much for their country. For many of these veterans, particularly those with severe and catastrophic disabilities, these payments may be their primary or even their only source of income.

For the past 2 years, disabled veterans have seen no COLA increases, and for many it has become increasingly harder to make ends meet. While the official COLA may have been zero for those years, it is important to understand that the CPI index upon which the COLA is calculated does not take into account increases in the cost of food or gasoline. In addition, as disabled veterans grow older, their needs may also increase due to declining health and increased morbidity. We agree with the sentiment that Mr. Filner expressed on the House floor when he said, “. . . [Congress] would be derelict in our duty if we failed to guarantee that those who sacrificed so much for this country are able to receive benefits and services that keep pace with their needs and inflation.”

Mr. Chairman, in this context, our veterans organizations have worked together to identify specific areas throughout VA where we believe the Committee could focus additional attention to find inefficiency, duplication and waste. Many of the ideas we developed were already on the Committee’s oversight agenda, so in our joint letter of April 4, we focused on nine additional areas that offered new opportunities for the Committee to consider. In the spirit of eliminating duplication and being efficient, my colleague from PVA will focus on the first five areas from our letter and I will focus on the last four.

#### ***Duplicative Surveys of State Veterans Homes***

Currently, State Veteran Homes must undergo regular evaluation by VA inspection teams. Many of these same veterans’ homes are also inspected by the Centers for Medicare and Medicaid Services (CMS). The CMS survey has approximately 185 criteria and is considered the more stringent survey. The VA survey has 158 criteria, 150 of which are already contained in the CMS survey. VA could quickly review its eight unique criteria as part of the CMS survey team or on its own, in order to cease such duplication of efforts. Such overlap in inspection regimes appears unwarranted and we understand that VA itself has been seeking to engage CMS to consider ways to eliminate this duplication, however so far they have been unable to make much progress. We urge the Committee to examine this overlap of efforts in order to reduce the administrative burden on both VA and State Veterans Homes and potentially achieve savings.

#### ***VBA Records Management and Shredding Practices***

In response to alarming instances of security lapses and the discovery of the destruction of veterans’ claims files by employees, VBA in recent years has instituted a number of new security protocols, including records management practices. While VBA absolutely needed to take corrective action to ensure that essential veterans’ records were never again destroyed in the future, we have heard credible reports that some VA Regional Offices (VARO) may have gone too far and spent too much time and resources on shredding non-essential paperwork. We understand each

VARO has designated a “Records Management Officer,” often at one of the higher GS levels, who spends an inordinate amount of time focused on the shredding of documents. We have been told that such records management practices have become overly complicated; in fact, some VAROs even have procedures for shredding Post-It notes, further burdening VBA employees struggling to properly adjudicate hundreds of thousands of pending claims. It is our understanding that VBA has made some changes over the past 6 months in this area, however, we would recommend that the Committee continue to investigate whether current records management practices are effective and appropriate to meet the requirements of protecting and preserving veterans’ records, without wasting precious VA resources.

***The Costs of Brokering VBA Claims Work***

Another area of the VBA claims process that needs scrutiny is the practice of brokering claims between and amongst VBA regional offices, and particularly the significant costs of transporting such brokered claims files. Brokering has become a standard practice in recent years as some VAROs have been overwhelmed with the sheer volume of work. VBA has created more than a dozen specialized Resource Centers at VAROs to handle brokered claims; four doing development phase work, eight doing rating, award and authorization work, and one “Tiger Team” that does all phases of the claims process on the oldest and most complex brokered claims. According to a VA Inspector General (VAOIG) report in September, the number of brokered claims has been rising in recent years, reaching 18 percent in FY 2010. Although that number has dropped over the past 18 months as these resource centers have been shifted to work on Nehmer claims, but as the Nehmer workload ends later this year the resource centers will once again start to receive large numbers of brokered claims.

While VBA is still awaiting a paperless solution to its claims processing problems, it must maintain and process virtually all claims using paper files, many of which contain hundreds of pages. It is our understanding that claims are transported using FedEx services in both directions. Furthermore, some claims are brokered twice: once from the home VARO to a resource center doing development, then after being returned to the home VARO, the claims file is sent to another resource center for the rating, award and authorization work, and then back again to the home VARO. The costs of transporting these claims using express delivery services must be quite substantial. In addition, the number of personnel involved in locating, organizing, delivering, receiving and distributing these paper files must also be quite substantial. The VAOIG report also found other areas of concern related to the timeliness and quality of the work done through this brokering process that the Committee needs to review.

We would recommend that the Committee examine the entire brokering system, particularly the paper-centric logistical demands of the current practices. We believe that VA should consider transitioning rapidly to digitizing all claims files that are to be brokered. If feasible, such a change could redirect spending from shipping paper files to digitizing files in anticipation of future paperless processing.

***Regular Use of Authorized Overtime***

One additional area in VBA that merits scrutiny by the Committee is the use of mandatory or “authorized overtime” as a regular practice to address increased workload. While VBA continues its myriad efforts to develop a new paperless, rules-based process for developing and adjudicating claims, it has relied on increased manpower to meet the current workload requirements. As the total number of claims filed has grown to over 1.2 million per year, VBA has hired several thousand new employees to try and keep pace. In addition, we understand that most VAROs have also increased the regular use of “authorized overtime” by employees in an attempt to meet production goals. We have concerns about whether sufficient and cost-effective productivity gains can be achieved through heavy reliance on overtime. More importantly, we have concerns about the effects on quality if employees are being mandated to work under the pressure and strain from extended hours. We recommend that the Committee examine VBA’s use of overtime and further examine whether VBA’s personnel projections and staffing models are accurately meeting their workload requirements.

Finally, I do want to add one comment about the issue of Senior Executive Service (SES) bonuses that was discussed in our joint VSO letter and in my colleague’s testimony today. While it is important for Congress and VA to consider whether it is appropriate to provide SES bonuses at a time when Federal employees are in the midst of a 2-year Federal pay freeze, we would not want to see VA put at a competi-

tive disadvantage to other Federal agencies. If Congress were to consider reducing or eliminating SES bonuses for any time period, it must do so across all Federal agencies, not just target VA. We must ensure that those dedicated men and women who choose work that serves our veterans are equally valued and compensated as those who work elsewhere in the Federal Government.

Mr. Chairman, as we have pledged to you previously, we will continue to work with this Committee and others in Congress to identify areas within VA where there may be duplicative, ineffective, inefficient or wasteful use of VA resources. We share your desire to ensure that the precious funding dedicated to the care of America's veterans, especially disabled veterans, achieve its intended purposes.

That concludes my testimony and I would be happy to respond to any questions you may have.

---

**Prepared Statement of Carl Blake, National  
Legislative Director, Paralyzed Veterans of America**

Chairman Miller, Ranking Member Filner, and Members of the Committee, Paralyzed Veterans of America (PVA) is pleased to be here today to discuss the ongoing debate about deficit and debt reduction and how that might affect the Department of Veterans Affairs (VA). This Committee has expressed an interest in this issue since the beginning of the year. In fact, as you know, PVA, along with AMVETS, Disabled American Veterans, The American Legion, and Veterans of Foreign Wars, addressed this issue in a letter provided to the Committee in April 2011. Today, we will address the various issues that were outlined in our letter to the Committee. Additionally, we will address the larger budget and appropriations process and ongoing activities within the VA related to this process.

Before discussing the ideas put forth by the five veterans service organizations represented here today, I would like to focus my comments on the current status of the budget and appropriations process. Once again, Congress has failed to fulfill its obligations to complete work on appropriations bills funding all Federal departments and agencies, including the VA, by the start of the new fiscal year on October 1, 2011. Fortunately, as has become the new normal, last year the enactment of advance appropriations shielded the VA health-care system from the political wrangling and legislative deadlock. However, the larger VA system is still negatively affected by the incomplete appropriations work. VA still faces the daunting task of meeting ever-increasing health-care demand as well as demand for benefits and other services.

Meanwhile, the VA is operating based on the parameters of P.L. 112-36, the "Continuing Appropriations Act for FY 2012." As we understand it, the VA has implemented an across-the-board reduction in all program spending of approximately 1.5 percent. As you know, one of the main reasons that Congress passed, and the President signed, legislation creating advance appropriations was precisely to allow the VA health care system to be able to function efficiently and without interruptions caused by budget showdowns and stop-gap continuing resolutions. That is why Congress included a full year FY 2012 advance appropriations for VA medical care in P.L. 112-10, the "Full Year Continuing Appropriations Act for FY 2011," passed in April 2011. For this legislation to be superseded or misinterpreted by short term CRs and result in a reduction of VA health care funding that was already approved is absolutely outrageous.

Moreover, we are particularly concerned about steps the VA has taken in recent years to generate resources to meet ever-growing demand on the VA health care system. In fact, the FY 2012 and FY 2013 advance appropriation budget proposal released by the Administration earlier this year includes "management improvements," a popular gimmick used by previous Administrations to generate savings and offset the growing costs to deliver care. Unfortunately, these savings were often never realized leaving the VA short of necessary funding to address ever-growing demand on the health care system. We believe that continued pressure to reduce Federal spending will only lead to greater reliance on gimmicks and false assumptions to generate funding. In fact, the Government Accountability Office (GAO) outlined its concerns with this budget accounting technique in a report released to the House and Senate Committees on Veterans' Affairs in June 2011. In its report, GAO states:

If the estimated savings for fiscal years 2012 and 2013 do not materialize and VA receives appropriations in the amount requested by the President, VA may have to make difficult tradeoffs to manage within the resources provided.<sup>1</sup>

This observation reflects the real possibility that exists should VA health care, as well as other programs funded through the discretionary process, be subject to spending reductions.

And yet, we are here today to further discuss savings that can be realized within the VA. As we outlined in our letter to the Committee earlier this year, the veterans service organizations are not so naïve as to think that cost-savings cannot be found within the VA, but the question remains: “To what end?” The context of this hearing is to identify savings within the VA that can be presumably returned to the Treasury for deficit and debt reduction. However, we believe the VA is already failing to meet the demands being placed on its health care and benefits systems. We would argue that any savings realized by the VA should be used to fill gaps in services now or be immediately reinvested into the system to make it function more efficiently and effectively. This is especially true when discussing the maintenance and modernization of the infrastructure necessary to deliver the benefits and services authorized under current law.

In response to your budget hearing questions posed after the release of the Administration’s budget request in February about “savings” and “waste” within VA, we presented our shared views on the need for Congress to conduct aggressive oversight of Federal veterans’ programs and services to ensure that they are providing maximum value to our Nation’s veterans. Like you, we are committed to working collaboratively to identify areas of inefficiency, duplication or waste so that the resources provided by Congress to the VA are effectively and efficiently used to deliver the benefits and services due to our Nation’s veterans. However, to simply cut spending across-the-board, in the absence of detailed justifications or evidence of savings, will likely result in the loss of accessibility, quality and safety of the services veterans depend on, rather than true deficit reduction. We believe such an approach will likely lead to additional, unnecessary and avoidable spending to “fix” problems created by underfunding essential services for veterans.

Within this context, we have worked together to identify specific areas throughout VA where we believe the Committee should focus its attention in efforts to find inefficiency, duplication and waste. Many of our ideas are already on the Committee’s oversight agenda. My comments will focus on the issues identified in our joint letter targeted at the administration of the VA and the health care system.

### **Growth of General Administration**

In recent years, increased scrutiny has been placed upon the administrative sections of the VA, most notably on General Administration. The VA’s General Administration budget request includes funding for the Office of the Secretary, the Board of Veterans’ Appeals, the General Counsel, and the Offices of Management, Human Resources, Policy and Planning, Operations and Security, Public and Intergovernmental Affairs, Congressional and Legislative Affairs, and Acquisitions, Logistics, and Construction. In FY 2012, the Administration recommended an 11.3 percent increase in funding for its General Administration accounts, the largest account increase within the VA. As we expressed, and as the Committee likewise emphasized, during the hearing held in conjunction with the release of the FY 2012 Budget Request in February, we have serious concerns that rising VA Central Office (VACO) management budgets and expanding personnel comprise a significant portion of FY 2012 budget growth. In fact, it was particularly troubling to our organizations that the Administration requested a considerable increase in funding for General Administration while simultaneously requesting a decrease in funding for the Veterans Benefits Administration.

The scale of the increases sought in General Administration do not appear reasonable and we have concerns about whether such bureaucratic growth is necessary during a time when veterans face delays in accessing medical care and proper claims adjudication. However, we would like to impress upon the Committee that some of the changes to administrative funding in the VA are the result of new requirements and programs authorized by Congress. It is not surprising that the VA might choose to direct more funding to its administrative functions in order to respond to the actions of Congress. Ultimately, when budgets are limited, it is essen-

<sup>1</sup>U.S. Government Accountability Office. (2011, June). GAO–11–622. Veterans’ Health Care Budget Estimate: Changes Were Made in Developing the President’s Budget Request for Fiscal Year 2012 and 2013.

tial that every penny reach the veteran at the ground level. We urge this Committee to scrutinize the General Administration account, including travel and meeting costs, and to limit funding increases only where necessary, and to redirect these funds to the services and programs that immediately impact veterans. Moreover, it is imperative that the Committee consider the ramifications of any new programs authorized or requirements placed upon the VA.

#### **Size of VISN Administrations**

Similarly, we are concerned about the size and growth of the VISN (Veterans Integrated Service Networks) bureaucracies within the Veterans Health Administration (VHA). When this new organizational model was developed, the plan called for VISNs to employ a small number of managers and support staff, perhaps a dozen or so, and any additional expertise needed would come from existing personnel at medical centers and other existing facilities. Today, however, some VISNs employ hundreds of administrative personnel and have built enormous buildings to serve as their permanent headquarters.

We understand that VA leadership is beginning to take steps that will better align the VISN administrative structure with the duties and responsibilities placed upon those offices. However, we hope that as the VA reorganizes its personnel alignment at the VISN level that these changes do not translate to simply administrative staff at a different location. Any change in VISN organization should have quality, timely health care delivery as its priority. Ultimately, while we believe there is certainly value in the regional network model that VHA employs, we urge the Committee to carefully examine the growth of VISNs and the increasing share of the budget that they currently consume.

#### **Funding “Hold Back” at VACO and VISNs**

Related to concerns about VACO and VISN growth is the manner in which Congressionally-appropriated funds for medical care are distributed to the field. In particular, we have concerns about the practice of “hold back”, by which VACO or VISNs may withhold medical care appropriations from being distributed to facilities as directed by the Veterans Equitable Resource Allocation (VERA) system. VERA determines the level of funding each facility should receive annually based upon the quantity and value of services provided in prior years, relative to the amount of medical care appropriations in the current budget. However, it has become a common practice that VACO “holds back” a significant amount of this funding and retains it to be distributed as it determines for special programs or projects, or to meet contingencies that may arise throughout the year. Similarly, VISNs “hold back” portions of the VERA funding they receive to fund their operations and for other programs and projects that they manage.

In fact, as we have already explained in this testimony, the VA is currently holding back approximately 1.5 percent of the advance appropriations (as well as other VA funding) for health care as a result of its interpretation of the current “Continuing Resolution.” Preventing funds from being disbursed to the field ultimately diminishes the care being provided. As we have already testified, all of our organizations have received credible reports from VHA facilities across the country in recent years that despite significant year-to-year increases for VA medical care, local facilities received only small or no increases.

This is particularly troublesome when we continue to hear about funding shortfalls occurring at medical centers around the country. Likewise, there continue to be reports everyday of the VA falling short in provision of various health care services. In fact, *The New York Times* recently reported on a survey of VA mental health professionals in an article on October 24, 2011:

Only 29 percent of respondents—272 psychologists, psychiatrists, nurses and social workers at dozens of hospitals and clinics—said their workplace had enough staff to meet demand. Nearly 40 percent said they could not schedule an appointment for a new patient within the 2-week window the veterans department requires. Nearly 70 percent said they lacked enough space. And nearly half said some patients were being denied care because no appointments were available outside regular office hours.

We regularly hear reports of hiring freezes that seem inconsistent with the growth of VA’s medical care appropriations. Several VA medical center (VAMC) directors have reported budget shortfalls that would preclude them from moving forward with hiring. In fact, the American Federation of Government Employees (AFGE) testified earlier this year that in the VAMC in Delaware, budget shortfalls

resulted in leadership leaving beds empty in emergency rooms and therefore limiting the ability to provide necessary care to the community's veterans. Last fall, the Director of the Indianapolis VAMC, in a newsletter to his staff, informed them that the facility expected to be \$28 million short of the resources required for FY 2011; this despite VA having received a significant funding increase through advance appropriations. And yet, the VACO response has been that directors "want" more money than they "need." We would beg to differ with this assertion. We urge the Committee to examine how VA "holds back" medical care appropriations from being distributed through VERA, how VISNs do similar "hold backs," and whether such practices are properly using medical care funding, including focusing on the growth of administrative personnel and "special projects."

Additionally, we must reemphasize that often the VA is forced to withhold funding to VISN and local levels in order to address new program requirements created through Congressional authorization.

### **SES Bonuses**

Another area that has drawn significant scrutiny in recent years is the distribution of bonuses to the Senior Executive Service (SES) employees at a time when there are serious questions about management performance, particularly in an environment where Federal funding is constrained. For example, last year the Veterans Benefits Administration (VBA) distributed \$417,152 in bonuses to 30 SES employees while veterans wait interminably long periods to receive their proper disability benefits. During 2010, the backlog of compensation and pension entitlement claims pending over 125 days (VBA's standard) rose from just less than 180,000 to over 290,000 claims. Furthermore, a March 2010 GAO report found that accuracy as noted by VBA's own STAR program had not increased, but fallen from 86 percent accuracy to below 84 percent accuracy. When every metric of VBA's performance drops, it appears unreasonable that management should be rewarded.

Given that the VA's workforce has dealt with a pay freeze for all Federal employees for the last 2 years, the payment of bonuses seems completely unjustified. Overall, focused solely on bonuses paid to the SES employees, last year VA paid out over \$3.4 million dollars to 238 SES employees with an average SES Performance Bonus exceeding \$14,000. This is nearly half of the Bureau of Labor Statistics estimate of the average American salary of \$32,708 for 2010.

We understand that executive bonuses serve an important purpose. In order for the VA to be competitive in the marketplace for senior executive leadership, it must be able to provide financial incentives to candidates and employees. However, given the tight fiscal situation facing the VA, rather than taking \$3.4 million dollars to reward senior executives of VA, we believe this funding might be better directed to ensure essential programs are funded to assist those who have fought to defend our Nation. We urge Congress to scrutinize the bonus practices within VA, particularly while a Federal pay freeze is in effect. Additionally, we believe Congress should not limit its scrutiny of SES bonuses to the VA, but to all other Federal agencies which you have oversight authority over in other committees.

### **Care Coordination for VA Fee-Based Care**

Another area we urge the Committee to address is the lack of coordination of non-VA purchased care and the process of referring veterans to local providers. A veteran who is approved for fee-based care is not currently provided a list of providers who are certified, licensed, or accredited to practice. Furthermore, VA does not identify local providers in the veteran patient's community that accept VA's payment rate. VA's General Counsel has indicated that this "identification and referral" process may not adhere to full and open competition requirements as well as other quality oversight issues. Failure to adopt such an identification and referral process can lead to veterans being unable to find qualified providers. It can also lead to VA paying higher rates than necessary because savings could have been achieved if VA would identify and contract with local networks or providers at lower rates. We urge Congress to conduct oversight of non-VA purchased care to ensure coordination of care and to avoid improper payments.

### **Joint Select Committee on Deficit Reduction**

Ultimately, discretionary spending in the VA accounts for approximately \$62.0 billion. Of that amount, nearly 90 percent of that funding is directed towards VA medical care programs. As the Joint Select Committee addresses the possibility of reductions in discretionary spending across the entire Federal Government, including the VA, it is important to emphasize that any cuts to VA spending will have a direct



impact on the delivery of health care services and benefits to veterans and their families.

We are concerned that in the event that the Joint Select Committee fails to agree to a bipartisan solution or the House or Senate fails to approve the Committee's recommendations, an automatic "trigger" would occur that would immediately cut an additional \$1.2 trillion in Federal spending. The triggers would target two principle areas of the Federal budget—national security spending and all other domestic spending. For FY 2012 and FY 2013, the VA would be included in the national security category along with the Department of Defense, Department of Homeland Security, Department of State, and similar agencies. While we believe all VA programs are excluded from automatic cuts by P.L. 111–139, The "Statutory Pay-As-You-Go Act of 2010," questions remain about whether or not VA health care spending in particular could be included in broader discretionary spending reductions. In fact, Section 11 (Exempt Programs and Activities) of P.L. 111–139 specifically states:

(b) VETERANS PROGRAMS—The following programs shall be exempt from reduction under any order issued under this part:

"All programs administered by the Department of Veterans Affairs."

We believe this language is crystal clear in outlining the priority that Congress has placed on funding for VA programs, even in the face of pressure to reduce the deficit.

The VA is the best health care provider for veterans. Providing primary care and specialized health services is an integral component of VA's core mission and responsibility to veterans. Across the Nation, VA is a model health care provider that has led the way in various areas of medical research, specialized services, and health care technology. The VA's unique system of care is one of the Nation's only health care systems that provide developed expertise in a broad continuum of care. Currently, VHA serves more than 8 million veterans, and provides specialized health care services that include program specific centers for care in the areas of spinal cord injury/disease, blind rehabilitation, traumatic brain injury, prosthetic services, mental health, and war-related polytraumatic injuries. Such quality and expertise on veterans' health care cannot be adequately duplicated in the private sector. Any reduction in spending on VA health care programs would only serve to degrade these critical services.

In the end, it is easy to forget, that the people who are ultimately affected by wrangling over the budget are the men and women who have served and sacrificed so much for this Nation. We hope that you will consider these men and women as you continue to investigate areas for potential savings within the VA budget.

This concludes my testimony. I will be happy to answer any questions you may have.

#### **Information Required by Rule XI 2(g)(4) of the House of Representatives**

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding Federal grants and contracts.

##### ***Fiscal Year 2011***

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation—National Veterans Legal Services Program—\$300,000 (estimated).

##### ***Fiscal Year 2010***

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation—National Veterans Legal Services Program—\$287,992.

##### ***Fiscal Year 2009***

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation—National Veterans Legal Services Program—\$296,687.



**Prepared Statement of W. Todd Grams, Executive in  
Charge for the Office of Management and Chief Financial  
Officer, U.S. Department of Veterans Affairs**

Good morning, Chairman Miller, Ranking Democratic Member Filner, and Members of the Committee. I am accompanied today by Mr. William Schoenhard, FACHE, Deputy Under Secretary for Health for Operations and Management, Veterans Health Administration and Ms. Diana Rubens, Deputy Under Secretary for Benefits for Field Operations, Veterans Benefits Administration.

I am pleased to be here with my colleagues and to share this forum with representatives of the Department of Veterans Affairs (VA) Office of Inspector General (OIG). I also want to recognize as our partners and friends, the Veterans Service Organizations (VSO). They serve as tireless advocates for Veterans and support, in so many ways, VA's mission to serve Veterans across the array of health care, disability compensation, memorial benefits and other services they have richly earned. The VSOs also provide VA with useful observations on VA's performance, from their own professional staff as well as their members.

This hearing is centered on a joint VSO letter sent to you, Mr. Chairman, on April 4, 2011, spurred by your questions at the budget hearings earlier this year. Their letter states our central challenge very well: how do we provide the maximum value and excellence of service to Veterans, at the same time we are becoming more efficient, reducing waste, and respecting every dollar entrusted to us by the taxpayer? The letter also explains why this has to be a careful and studied exercise to avoid taking actions that, while appearing to be fiscally responsible, would "likely result in the loss of accessibility, quality, and safety of the services Veterans depend on" and actually could lead to additional avoidable spending. It is clear this Committee is—and has been—committed to taking a careful and deliberate path, as we strive to achieve fiscal discipline while improving quality and access for those returning Servicemembers and for Veterans of all eras—as well as their families and survivors.

We set out in this testimony some of our more significant initiatives that are already delivering better services to Veterans and cost savings. While acknowledging our successes, we must also recognize that in an organization with missions as large, complex, and varied as VA, there are times when these operations and systems need improvement or correction. In those circumstances we must take action. The Congress, the VSOs, and our OIG are important contributors in our efforts to always learn and improve, as they provide an outside view of how we are living up to the commitments the Nation makes to Veterans.

The hearing invitation asked VA to testify on the recommendations made in the VSO letter. We would like to do so in the context of speaking to the Department's broader transformational efforts that are central to both improving our benefits and services and using resources wisely. The Secretary began these efforts after taking over the helm of VA when he focused the Department to be "people-centric, results-driven, and forward-looking." It is hard to overstate how important the 'people-centric' element is in the work we do. We live necessarily in the world of systems, processes, organizations, and policies—but they all exist—and we all at VA are here—to serve Veterans. This personal dedication is exhibited every day in extraordinary ways by our employees. Being a People-centric organization means having our leadership, management, and systems be as good as our individual employees—to empower that sense of mission, and not frustrate it.

Being results-driven means that we do more to measure our performance and hold ourselves accountable. We will be measured by our accomplishments, not by our promises. VA's leadership has been developing systems and processes to better measure the results we are securing for Veterans. And being forward-looking means modernizing VA's business practices and using technology to its fullest advantage. We will seek out opportunities to deliver the best services with available resources, continually challenging ourselves to do things smarter and more effectively.

**VA Efficiencies and Savings through Transformation—Office of Management**

With those principles in mind, I will first highlight those transformation efforts I am responsible for as VA's Chief Financial Officer (CFO). These are not issues in the VSO letter, but it is important for the Committee to know that these significant improvements in financial management systems and integrity serve as a foundation in securing efficiencies and savings across the Department.

Shortly after joining VA in November 2009, I led the CFO team in establishing a set of top priorities for VA financial management. It has been my pleasure to brief

this Committee's staff of the status of these initiatives on a quarterly basis. Our priorities included fixing long-standing issues in financial management, which have been concerns for VA and this Committee. These included material weaknesses in our financial systems as well as a lack of adequate internal controls over \$14 billion in spending categorized as miscellaneous obligations. VA's independent auditor certified at the end of fiscal year (FY) 2010, we had remediated our three material weaknesses related to financial management. In terms of internal controls and financial integrity, this was a major accomplishment. It has been over a decade since VA had no financial management material weaknesses. We have also dramatically reduced the number of financial issues the auditors categorize as significant deficiencies. Since 2008, VA has reduced those significant deficiencies from sixteen to two.

Internal controls related to 'miscellaneous obligations' have been a long-standing issue of concern to this Committee, VA's OIG and the Government Accountability Office (GAO). About 18 months ago, I made this a top priority for VA financial management. With a comprehensive plan and the dedication of our VA team, we have increased compliance in this program dramatically from 49 percent in 2009 to nearly 100 percent today. And we can account and report on how these funds are being spent across the VA system.

There are many other improvements we have been able to make in financial management, including a thorough revision and standardization of VA financial policies, and improved financial management training.

Today, our Financial Services Center processes over 1 million payments annually to commercial vendors. Payment timeliness, measured by the amount of interest penalties paid per million dollars disbursed for late payments in accordance with the Prompt Payment Act, dramatically improved from \$48 per million in FY 2008 to just \$18 per million in FY 2011. At the same time, VA earned \$5.1 million in discounts for prompt payment (nearly 97 percent of the discounts offered by vendors)—savings that we are able to use to provide additional funding for Veterans programs. This past fiscal year 23 percent of the vendor payments VA processed used data obtained from electronic invoices, which improved both the timeliness and accuracy of our payment process.

VA continues to aggressively use the Government-wide purchase card program as a cost effective method of acquiring goods and services. We processed nearly 7 million purchase card transactions valued at \$3.6 billion during FY 2011 compared to 4.8 million transactions worth \$3.0 billion during FY 2008. We pay our credit card provider daily for credit card purchases, allowing VA to maximize the bank rebate offered for prompt payment. As a result, during FY 2011 VA earned \$73.8 million in purchase card rebates, a dramatic increase over the \$49.4 million earned in FY 2008. The benefit of those rebates goes directly to Veterans programs.

VA aims to save even more by essentially eliminating all paper check payments to vendors by the end of FY 2012. We made a significant down payment towards that goal. Over 97 percent of commercial vendors now receive payment by electronic funds transfer (EFT). We are reducing check payments to our medical providers supporting the fee basis and Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) programs. Our outreach to medical providers helped these programs improve EFT usage by 20 percent this year and eliminated 1.5 million checks VA-wide.

We are proud of these achievements in financial management, but realize there is always more we can do to be more effective and efficient across the Department.

The VSO letter raised questions about recent staff increases in some offices. Many of these increases in staffing are tied to the very transformation efforts to modernize VA, and are items that the VSOs have historically supported. For example, staff increases enhanced VA's outreach to Veterans and tribal governments as well as improved VA's ability to manage costs and programs that deliver services to Veterans, their families and survivors. Other staff office increases are tied to meeting the needs of Congress for extensive and significantly expanding information requirements to conduct oversight, formulate policy, and serve individual constituents. Especially now, taxpayers need to be assured that staffing levels are justified as a good return on investment for Veterans.

I would also like to address the issue of travel and conferences, a subject of Congressional interest that has been in the news for VA as well as other agencies. For a Department with many different and complex missions, and with facilities throughout the country, travel and conferences provide important opportunities to train and conduct a range of other essential activities to include: share best practices, maintain critical clinical skills and readiness, conduct oversight and compliance inspections, increase professional certification of our employees, and provide opportunities for our employees to establish and enhance their professional contacts

and relationships within the VA and with other Federal, state and local agencies as well as private sector stakeholders. These all are important to activities that enable VA to provide high quality care and services to Veterans. The role of conferences is too important for us to treat casually—that is why VA requires a very strong business case supporting each conference. Since FY 2009, the VA has mandated VA Chief of Staff review and approval for all conferences involving 100 or more VA employees. For FY 2012, the VA Chief of Staff issued guidance requiring his office's pre-approval of any conference involving 50 or more employees. His directive calls for maximizing teleconferencing, and for managers to challenge the assumption that an event needs to occur, including making a business case analysis of the benefits of a meeting, and consideration of alternatives that might serve the same purpose. We would be glad to share with your staff the scrutiny that proposed conferences and travel receive and welcome VSO and Congressional staff analysis of what reductions could be taken without adverse impact to the programs and proficiency we seek in the delivery of care and benefits.

For the past 3 years, spending for Senior Executive Service (SES) bonuses has been reduced, as well as the number of outstanding ratings issued. VA understands the need for fiscal restraint, and is following the Secretary's guidance, as well as Office of Personnel Management and Office of Management and Budget limitations. Mr. Chairman, VA has detailed to you in a letter dated October 14, 2011 what it has done to ensure the integrity of the performance awards process. We emphasized in that letter the importance of VA being able to attract and retain the most talented leaders and managers from within the Federal workforce and from the private sector. We are especially wary of restrictions on performance awards that would not be undertaken as a government-wide policy—in that case VA would be specifically disadvantaged with respect to other Federal employers, weakening our ability to compete for and retain the talent we need to best manage VA and serve our Nation's Veterans.

#### **VA Efficiencies and Savings Through Transformation—Veterans Health Administration**

VHA is undertaking its most significant transformation since the 1990's by realigning the organization to focus and target resources on delivering clinically appropriate, quality care for eligible Veterans when they want and need it. These efforts are supporting our goals of improving access and quality of care. Systems Redesign is one of the key tools we are using to achieve these goals—it involves multiple strategies that address transportation, options for Veterans to improve access, use of advances in medical technology, and local partnerships.

Complementing the Systems Redesign initiatives, we are instilling a culture throughout our system that pursues continuous improvement and empowers staff members to solve problems at the front line or at any point in the health care system. As a result of these steps, VHA is improving efficiency and reducing costs by consolidating data, analytic, and reporting systems, and using the power of our electronic health record to collect clinical performance measures using fully automated processes.

VA is using telephone care, telemedicine, secure messaging, My HealthVet, and traditional postal mail to reduce the need for additional clinic visits concerning relatively simple matters. Telehealth is a particularly critical area where VHA is identifying significant potential for cost savings. Home Telehealth provides non-institutional care and chronic care management services. It is predicated upon proactively intervening when a patient's symptoms, behavior, or lack of knowledge about his or her conditions places them at a high risk for hospital admission or institutional care. Home Telehealth helps to reduce unnecessary hospital bed days of care and provides Veterans with additional support at home.

Clinical video telehealth (CVT) provides services through clinical video conferencing between VA medical centers (VAMC) and community-based outpatient clinics (CBOC) or other VAMCs. VA has established that use of CVT reduced the total number of hospital bed days of care for patients needing mental health by more than 20 percent. Telehealth not only improves the quality of care available to Veterans but also reduces the cost to VA for providing such care. For Veterans living in rural areas, expanded telehealth services improve their access to high quality specialty care services previously only offered at major medical centers.

Moreover, the infrastructure that supports telehealth also supports the training and education needs of our staff; for example, specialists can more easily provide ongoing medical education to primary care staff about the management of Veterans with complex needs. We are also gaining additional value from this allied infrastruc-

ture by using it to deliver training to administrators, analysts, and users of our IT systems through video-conferencing.

Another critical technology to improve care and reduce costs is an integrated electronic health record (iEHR) between VA and DoD. The two Departments are already in the process of jointly modernizing our respective EHR systems, but an integrated joint system will allow both Departments to achieve economies of scale. It will enable us to acquire needed functionality and reduce future sustainment costs, increase the amount of patient information shared through the use of national data standards, and improve the delivery of health care and services to more than 15 million VA and DoD patients.

VA operates a world class pharmacy program that excels in several key areas: Clinical pharmacy practice, pharmacy automation, medication safety, drug formulary management and the strategic sourcing of pharmaceuticals. In several of these areas, VA is an innovator and benchmark within the pharmacy profession. VA's pharmacy activities have yielded many billions of dollars in savings over the past 15-plus years. While aggressively pursuing savings, VA's customer service performance remained excellent, as evidenced by an independent customer survey conducted by J.D. Powers and Associates. This survey ranked VA's Consolidated Mail Outpatient Pharmacy (CMOP) as "Among the Best" in 2009; for 2010 and 2011. VA's CMOPs scored higher than any other mail order pharmacy in the country. Based on customer feedback from 20 industries and 800 brands, in 2011 CMOP was one of only 40 brands designated as Customer Service Champions by J.D. Powers.

Effective earlier this year, VHA adopted the Centers for Medicare and Medicaid Services (CMS) payment methodologies for outpatient services. This aligned VHA with standard Federal payment methodologies and ensures all payments from VA utilize the same structure. VA estimates that this change will result in savings of almost \$1.5 billion over FYs 2011–2015. Veteran care will remain uninterrupted, and existing contracts will not be affected. We are using the savings from this change to reinvest into our health care system and provide more accessible and better quality care to America's Veterans.

VA's Consolidated Patient Account Center (CPAC) business model is designed to enhance VHA billing and collection activities by consolidating traditional revenue program functions into seven regionalized centers of excellence. Four CPACs are already operational, and the final three CPACs will be activated in FY 2012. By standardizing and improving business processes, VA has improved key revenue metrics from FY 2010 to FY 2011. The average number of days to bill for the Nation declined by 3.5 (8.3%), while the percentage of accounts receivable greater than 90 days was reduced 3.3 percent. However, VHA has not seen the same level of collections recently for a variety of reasons—an increase in the number of hardship waivers and copayment exemptions connected to the condition of the economy, a reduction in third party "collections to billings" ratios, and movement of Veterans from lower Priority Group enrollment categories to higher levels. An aging Veteran population receiving coverage from Medicare, which becomes the primary insurance provider when a Veteran becomes 65 years old, has also significantly reduced the amount of funds VA can collect. Even with these challenges, VHA's improved business practices are capturing available collections more efficiently. Continued improvements are a necessity to maximize this critical piece of our medical care budget.

The VSO letter raised issues relating to VA's purchase of fee-basis care. VA provides care to Veterans directly in a VA medical center, or indirectly, through either fee-basis care or through contracts with local providers. This strategic mix of in-house and external care provides Veterans the full continuum of health care services covered under our benefits package. VHA provides Veterans care within VA's health care system, whenever feasible. When VA is unable to provide care within the system, the VA medical center director first considers sending patients to another VA medical center. Contracting for necessary services is considered only if these options are inappropriate or not viable. If contracting for services is required, VA's first option is to use a competitive bid. This step ensures that taxpayer funds are used to the greatest effect.

VA appreciates Congress' support of the use of fee-basis care as a complement to VA services; the Department has been able to provide services closer to Veterans' homes as a result of a number of congressionally mandated programs and directives intended to improve the management and oversight of fee-basis and to expand access to care for Veterans in rural areas.

Earlier this year, VA conducted a pilot program that used standardized templates for purchasing care, ensured more consistent assessment of other VA options, and resulted in better control over and management of the care we purchased. We have instituted controls to track timeliness of initial approvals for non-VA care, appoint-

ments, and return of clinical information. Pilot results have seen positive improvements in each of these areas. For example, pilot sites document initial approvals for use of non-VA care at 4 days, appointments made within 8 days and return of clinical information within 20 days.

VA will realize approximately \$200 million in savings for fee basis care in FY 2012 through the use of electronic re-pricing tools, contract and blanket ordering agreements, reduced duplicate payments, and other efforts. We are also consolidating contracting for multi-facility, Veterans Integrated Service Networks (VISN) or regional contracts, increasing the use of competitive contracts, bringing back contracted functions in house, reutilizing existing VA property, and related measures.

We would also like to address the role of VISNs in ensuring Veterans receive top quality health care in the most efficient way possible. The VISN structure encourages innovation and has been the basis for many of the significant advances within VHA over the last 15 years. The responsibilities of VISNs have grown, which has necessitated corresponding staffing adjustment. This increase in the number of employees is mostly the result of a consolidation of functions previously performed at the facilities within the Network to achieve economies of scale. For example, some VISNs have created service lines dedicated to either specialty care areas or to administrative functions that provide support to all VHA facilities within the Network. This approach more effectively utilizes our resources and allows us to achieve efficiencies not otherwise possible. For example, by consolidating equipment purchasing at the VISN level, some Networks have saved millions of dollars by negotiating high volume contracts with low per unit prices and saved money on maintenance costs while improving the consistency of quality of care through equipment uniformity.

One of VHA's most important tools in ensuring the fair distribution of resources is the Veterans Equitable Resource Allocation (VERA) model, which helps VA provide equitable access to care for the Nation's Veterans. In short, VERA ensures we put the money where the work is. VERA has been assessed positively in independent reviews by PricewaterhouseCoopers, the RAND Corporation, and the Government Accountability Office (GAO).

VERA addresses the many complexities of Veterans' health care by recognizing differences in patients (those who use some health care but are less reliant on VA care exclusively, those who seek routine care from VA, and those with special or complex health care needs), variations in costs of care across the country, movement of Veterans across the country, research and education demands, and the need for investments in non-recurring maintenance. The system must also account for differences in the types of funds—including general purpose funds, which are allocated based on patients treated, and specific purpose funds, which are allocated to comply with statutory or programmatic requirements.

After VISN Directors receive the Network's allocation, they are responsible for making the allocations to their facilities. In 2011, VA implemented a standard VISN work-performed allocation model to ensure VISNs provided resources to facilities in a consistent, timely, and efficient manner. This enables the VISN Director to hold a portion of the allocation for such requirements as central equipment purchases, central management of non-recurring maintenance (NRM) projects, and for changing workload requirements among facilities. VISN Directors have the discretion to make appropriate adjustments to that model to reflect local realities, such as the activation of new CBOCs and changes in patient demand.

To help ensure the Department achieves its financial and program performance goals, VA conducts monthly reviews that include metrics that measure financial performance, workload, and access. These reviews provide data for risk analysis and serve as a warning system to highlight potential operational or funding problems. VHA facility and VISN directors also maintain frequent oversight of their budgets and communicate with VHA Central Office to provide timely information to ensure necessary resources are available. The Secretary also meets with each VISN Director at least twice during the year to ensure each VISN has sufficient resources to provide services consistent with the needs of Veterans.

The VSO letter cites reports of local budget shortfalls or "hiring freezes." VA will be glad to discuss any of these specific reports with the Committee or with our VSO partners.

#### **VA Efficiencies and Savings through Transformation—Veterans Benefits Administration (VBA)**

VBA is committed to achieving the Secretary's 2015 strategic goals of completing all rating-related compensation and pension claims within 125 days at a 98 percent accuracy level. VBA has embarked on a wide-scale Transformation Plan to achieve new efficiencies, greater effectiveness, improved quality and consistency, and a

workplace that is recognized as an “employer of choice.” Our transformation strategy builds on VA’s strategic plan, goals, and integrated objectives. Initiatives that help improve our business processes are encouraged. Ideas are solicited from employees and other internal and external stakeholders including VSO’s, state and county service officers, industry partners, as well as Veterans themselves.

Our plan incorporates an integrated approach to people, process, and technology solutions, including a strong focus on a career-ready military transition program, national training standards, paperless rules-based systems, case management, and automated capability to process an increased number of claims and a greater number of complex conditions per claim—all at a high quality level for our Veterans, their families, and survivors. Best practices in claims processing are being tested at regional offices to validate the potential of the initiatives to help us achieve our 2015 strategic goals. The effective implementation of this transformation plan is driving VBA to achieve standardization among all regional offices and a methodology for governing implementation. Our implementation strategy includes effective communications and change management, detailed implementation planning, and effective and measurable training, ensuring that new ideas are sustainable for the future.

A primary focus of our plan is managing our relationships with Veterans throughout their lives—from the day they join the military service, and well into their transition to Veteran status and beyond. Seventy-three percent of our Veterans seek new “on-line” ways of engaging with VA to facilitate their claims and benefits. In September 2011, VA and DoD, in a collaborative partnership, registered its one-millionth user on eBenefits, the one-stop shop that provides information about military and Veterans benefits and serves as the client-services portal for lifelong engagement.

Today, the eBenefits portal provides an on-line capability to check the status of a claim, an appeal, the history of VA payments, request and download personnel records, secure a certificate of eligibility for a VA home loan, and numerous other benefit actions. In the next 6 months, Veterans will be able to file a claim online in a “Turbo Claim” like approach, where claims data can be entered by prompting software that self-checks for data errors, and upload supporting claims information that feeds our paperless claims process. Every 3 months, VA and DoD release additional eBenefits functionality that provides new ways for our Veterans, their families, and survivors—with support if they choose from their representatives—to conduct self-service benefit actions at a time and place of their choosing.

VBA’s organizational transformation will be deliberate, sweeping, and multifaceted. Specific initiatives incorporated in the transformation plan include:

- The Veterans Benefits Management System (VBMS), a holistic and integrated technology solution delivering paperless processing capability in 2012 to support our business process transformation. Combining a paperless processing system with improved business processes is key to providing Veterans with timely and high-quality decisions.
- The Veterans Relationship Management (VRM), an initiative to expand eBenefits access and self-service capabilities, improve VBA call center technology, increase initial call resolution, and establish life-long relationships with our Veterans.
- Rules-based calculators for automated adjudication of basic compensation, pension, and dependency claims. These calculators will guide decision makers through the process with intelligent algorithms similar to tax-preparation software.
- New evidence-gathering tools, known as Disability Benefits Questionnaires, which allows VBA to bring new efficiencies to the collection of medical information needed for claims decisions.
- An 8-week national Challenge training program for recently hired claims processors, as well as refresher training for more experienced staff, that ensures intense, high-quality and standardized training of the VBA workforce.
- Simplified rating decisions and notification letters to more effectively communicate with Veterans and streamline the decision-making process.
- Systemic Technical Accuracy Review STAR-trained local Quality Review Teams to conduct “in-progress” quality checks and regular end-of-month reviews.
- Cross-functional teams (case management) of cross-trained raters, co-located to increase knowledge transfer, speed, and accuracy.
- Specialized processing “lanes” based on claims complexity and priorities (“Express Lane” for less complex work; “Core Lane” for the majority of the workload; and “Special Operations Lane” to case manage special missions, such as former prisoners of war and military sexual trauma cases).

- Intake Processing Centers for quick, accurate triage of claims.

These major transformations will be implemented using multi-year timelines. Changes in people, processes, and technology will be rolled out in a progressive, intentional sequence that enables efficiency gains while minimizing risks to performance.

We would like to address the three VBA management issues mentioned in the VSO letter: records management, cost of brokering of claims work, and use of authorized overtime.

The VSO letter notes concern that, “too much time and resources are now being devoted to the protection and/or shredding of non-essential paperwork.” Based on findings from VA’s OIG in 2008, VBA took action to ensure that Veterans’ records are protected, maintained, and disposed in accordance with Federal regulations, statutes and policies. While VA’s policy was initially based on OIG findings, updates have been made to incorporate lessons learned. In FY 2011, VBA established the Records Management Technician (RMT) position. The RMT position has enabled VBA to reduce the supervisory review and approval process to “claims-related material only,” providing the supervisors more time to facilitate increased claims productivity. The RMT assists the Records Management Officers (RMO) in managing, maintaining, and properly disposing of Veterans’ records and personally identifiable information. The duties of RMOs and RMTs are absolutely vital in protecting Veteran, employee, and other sensitive information.

A second VBA area of concern identified in the VSO letter is the cost of brokering claims. For a number of years, VBA has pursued this strategy to allocate additional resources to regional offices that perform at a higher level. This strategy is intended to increase VBA organizational performance and capacity by assisting regional offices experiencing workload challenges and performance difficulties. To do this, claims are brokered for processing to Resource Centers at 13 high-performing offices throughout the country.

This past fiscal year was challenging because VBA utilized our Resource Center brokering capacity to readjudicate previously denied claims for newly established Agent Orange presumptive conditions (B-cell leukemia, Parkinson’s disease, and Ischemic heart disease). Due to the complexity of readjudicating these claims, they are all being processed at VBA’s Resource Centers. Our Resource Centers were therefore temporarily unavailable for brokering work during FY 2011.

VA recognizes that transporting paper claims is neither ideal nor sustainable. VBMS will significantly reduce our reliance on the receipt, movement, and storage of paper. By eliminating the dependence on paper, VBA will be better positioned to make use of available resources, regardless of geographic location.

The third VBA area of concern noted in the VSO letter is the use of authorized overtime. While VA works to transform the delivery of benefits and services, overtime funding is essential to manage claims workload and put VA on a path to achieve our ultimate goal of having no Veteran wait longer than 125 days to receive a quality rating decision. Although VBA has significantly increased the numbers of primary decision makers through internal promotions and external recruitment actions to address the growing workload, the normal training time for these positions is 18 to 24 months. While in training status, these individuals are not fully productive and often require 100 percent review of their cases by a more experienced employee with greater technical knowledge. Overtime is a necessary tool to allow VBA to maintain production as we continue to work to increase our productive capacity and ensure thorough training.

VBA’s workload continues to dramatically increase due to the unprecedented volume of disability claims being filed. This growth is driven by a number of factors, including our successful outreach efforts, improved access to benefits, the growing number of returning Veterans from 10 years at war, the aging Veteran population, economic conditions prompting Veterans to pursue the benefits they earned during military service, and presumptive disabilities for Veterans who were exposed to Agent Orange or other herbicides during military service.

In FY 2011, VBA received nearly 230,000 additional claims as a result of the approval of three new Agent Orange presumptive conditions (B-cell leukemia, Parkinson’s disease, and Ischemic heart disease) based on the latest evidence of an association between those illnesses and exposure to herbicides. Of the over 180,000 Agent Orange claims processed last year, approximately 93,000 were covered by the *Nehmer* court settlement requiring readjudication of previously denied claims. Pursuant to a court order from the U.S. District Court for the Northern District of California in *Nehmer v. U.S. Department of Veterans Affairs*, C.A. No. C-86-6160 TEH (N.D. Cal.), VA provides retroactive benefits to certain *Nehmer* class members (Vietnam Veterans and their survivors) who filed claims for the three new presumptive



conditions during the period from September 25, 1985, to the effective date of the VA regulation establishing a presumption of service-connection for these diseases. These claims are very complex and take more than twice the resource levels to complete, which significantly slowed production in 2011. As we have nearly completed processing *Nehmer* claims, overtime funding related to claims processing will be reduced.

We continue to devote significant resources, including overtime resources, to processing claims for our wounded, ill, and injured Servicemembers separating from active duty through the Integrated Disability Evaluation System (IDES). Overtime resources are essential if we are to meet our processing goal of 100 days for IDES claims. Additionally, overtime allows our regional offices to increase production while VBA's pilot initiatives are tested, enabling us to determine which concepts are suitable for nationwide deployment.

Overtime funding is also critical to the delivery of education benefits in all of the education programs VA administers. Because of the fluctuations in workload inherent in the processing cycles associated with school enrollment periods, it is essential that we continue to make effective use of overtime funds to ensure our Veteran-students and their schools timely receive their benefit payments. With full automation of Post-9/11 GI Bill enrollment processing through the Long Term Solution, we anticipate that our need for overtime funds in the education program will be reduced.

### **Closing**

VA appreciates this opportunity to have this exchange with the Committee, with the participation of the VA OIG and our VSO partners. As noted at the beginning of the testimony, the key question is an important one: how does VA provide the maximum value and excellence service to Veterans, at the same time we are becoming more efficient, reducing waste, and respecting every dollar entrusted to us by the taxpayer? VA is committed to keep this question foremost across every administration and office, in Washington and at medical facilities, regional offices, and national cemeteries in every area of the Nation.

---

### **Prepared Statement of Belinda J. Finn, Assistant Inspector General for Audits and Evaluations, Office of Inspector General, U.S. Department of Veterans' Affairs**

Mr. Chairman and Members of the Committee, thank you for this opportunity to testify on the potential for budgetary savings within the programs and operations of Department of Veterans Affairs (VA). We read the recommendations made by Veterans Service Organizations (VSOs) for budgetary savings within VA with great interest and can comment on VA's performance in several of these areas. My testimony today will highlight a broad range of programs and issues where we have identified possible cost savings, recoveries, better uses of funds, and opportunities for VA to achieve economies and efficiencies.

### **VA FEE CARE PROGRAM**

Of the many issues raised by the VSOs, improved management and oversight of medical care provided outside of VA facilities, commonly known as fee care, offers the greatest opportunity for savings. Under the program, VA medical centers authorize veterans to receive treatment from non-VA health care providers when certain services are unavailable at VA facilities; cannot be economically provided in the veteran's geographic area; or in emergencies when delays may be hazardous to life or health. The cost for fee care has increased from \$1.6 billion in fiscal year (FY) 2005 to \$4.4 billion in FY 2010. This amount is expected to increase further in future years as both the demand and cost of health care rises. We have issued four audit reports related to fee care since August 2009.

In August 2009, we reported that the Veterans Health Administration (VHA) improperly paid 37 percent of outpatient fee claims, resulting in \$225 million in overpayments and \$52 million in underpayments in FY 2008 and an estimated \$1.1 billion in overpayments and \$260 million in underpayments over a 5-year period. Also, serious weaknesses in the processes for authorizing outpatient fee care resulted in 80 percent of payments lacking proper justification. Clinicians typically documented the diagnosis and treatment plan but no rationale for using fee care. Fee staff did not conduct required cost analyses to determine if lower cost alternatives, such as transporting patients to other VA facilities, were available. In August 2010, we reported that VHA improperly paid 28 percent of inpatient fee claims, resulting in net

overpayments of \$120 million in FY 2009 and an estimated \$600 million in improper payments over a 5-year period. Between these two audits of inpatient and outpatient medical care, we estimated potential improper payments of \$1.5 billion through FY 2015 could be avoided by more effective policies and procedures to oversee and manage fee care services. (*Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program*, August 3, 2009, and *Veterans Health Administration—Audit of Non-VA Inpatient Fee Care Program*, August 18, 2010)

During the audit of inpatient claims, we found the Fee Program's inadequate payment processing system, Veterans Health Information Systems and Technology Architecture (VistA) Fee, contributed to the high rate of payment errors. VHA was aware of the shortcomings of VistA Fee and has fielded an integrated claims processing and management system. Further, the average cost per claim for the Fee Care Program was \$9.96 compared to \$2.55 for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), a difference of \$7.41 per claim. In addition, sites that processed fee payments for a single VA medical center (VAMC) had an average cost per claim of \$10.78. Consolidated sites, which processed claim payments for multiple VAMCs, had an average cost per claim of \$6.85, or about one-third less. As a result, we conservatively estimated that current claims processing inefficiencies cost VHA \$134 million through FY 2015 and recommended VA evaluate alternative organizational models and payment processing options, which they agreed to do.

Consolidation of processing activities is one solution to lowering the average cost per claim, but not the only alternative. Commercial claims processing organizations already process claims for Federal Government agencies, such as Medicare and TRICARE. Since our first audit in 2009, VA has adopted Medicare payment methodologies for common services such as ambulatory surgery, anesthesia, dialysis, and the payment of professional services. With business changes, VA may be able to leverage competition for the claims processing services. In response to our recommendation, VA contracted with the National Academy of Public Administration to study organizational alternatives, including consolidation or contracting out for services.

We also evaluated VHA's controls to prevent and detect fraud and reported VHA had not identified fraud as a significant risk to the Fee Care Program. Health care industry experts have estimated that 3 to 10 percent of all claims involve fraud and we see VA facing similar risks. We estimated that VA could be paying between \$114 million and \$380 million annually for fraudulent claims and recommended VA establish a fraud management program with data analysis and high-risk payment reviews, system flags for suspicious payments, employee fraud awareness training, and fraud reporting. (*Veterans Health Administration—Review of Fraud Management for the Non-VA Fee Care Program*, June 8, 2010)

In the 2½ years since our 2009 report on the Fee Care Program, VHA has made many changes to the program. However, fundamental controls are still problematic, as illustrated by our recent report, *Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System* (November 8, 2011). We reported the medical facility mismanaged fee care funds and experienced a budget shortfall of \$11.4 million, which was 20 percent of the health care system's FY 2010 fee care program funds. One cause of the shortfall was the lack of effective pre-authorization procedures, the same problem we reported in 2009. In fact, the facility processed about \$56 million in fee claims without adequate review to ensure services were medically necessary.

Our most recent national audit on VA's fee care program reported VHA missed opportunities to bill third-party insurers for 46 percent of billable fee care claims, reducing third-party revenue by \$110.4 million annually or by as much as \$552 million through FY 2016. VA bills third-party health insurers for nonservice-connected medical services provided by VA or non-VA care as part of the Medical Care Collection Fund (MCCF) Program, which supplements VA's medical care appropriations. In FY 2010, the MCCF Program collected approximately \$1.9 billion in total third-party revenue, which was about 69 percent of the total \$2.8 billion revenue. The potential for third-party revenue from the Fee Care Program is expected to increase in future years due to increased demand for care and increased health care costs. (*Audit of Veterans Health Administration's Medical Care Collection Fund Billing of Non-VA Care*, May 25, 2011)

## CLAIMS BROKERING

The VSOs noted the potential inefficiencies of the Veterans Benefits Administration's (VBA) claims brokering process. We have testified several times on the many challenges that VBA faces to improve the accuracy and timeliness of disability

claims decisions, managing an ever-increasing inventory of claims, and maintaining efficient VA Regional Office (VARO) operations. One of the steps VBA has taken to address these challenges is to establish 13 resource centers that process compensation claims brokered from other VAROs. VBA believes effectively shifting claims from one VARO to another allows VBA to better align workload with available staffing resources and reduce claims backlogs by expediting claims processing.

Our nationwide audit of the brokering process identified opportunities for VAROs to improve brokering effectiveness (*Audit of VBA's Compensation Claims Brokering*, September 27, 2011). We evaluated the overall effectiveness of claims brokering and reviewed available documentation on the costs of transporting hardcopy claims folders from one location to another. VBA and VAROs do not consistently track or report the costs of transporting brokered claims between VAROs. In fact, only one of seven audited VAROs was tracking the costs of transporting brokered claims. During 1 year, this VARO spent about \$40,000, or approximately \$2.00 per claim, for the one-way transportation of approximately 18,500 brokered claims folders. Based on the one VARO's cost information, we estimated that VBA could have spent almost \$740,000 to transport brokered claims using express delivery services during FY 2009.

We also reported VBA can improve brokering effectiveness by addressing ineffective practices such as untimely brokering of claims by the original regional office, reducing excess inventories of unprocessed claims at resource centers, brokering to separate facilities for development and rating, and brokering claims to resource centers with lower claim processing accuracy rates than the original office. For nearly 171,000 brokered claims completed during FY 2009, we projected the average processing time of 201 days would have been 49 days less, or 152 days, if VBA had avoided the claims-processing delays identified during the audit. VBA agreed it can improve the overall effectiveness of brokering. We will monitor the implementation of the recommendations.

VBA could eliminate transportation costs associated with brokering claims and improve claims processing timeliness by digitizing claims folders. We caution that even digitized claims will require infrastructure and management controls to ensure VAROs consistently and accurately maintain documents to allow claims processing personnel complete and timely access to veterans' claims folders documents.

## **VA EMPLOYEE COMPENSATION ISSUES**

The VSOs noted concerns with general administrative costs and overly generous employee bonus programs. We have issued several reports dealing with retention incentives that identified consistent themes regarding where VA falls short in its administration of this program.

Retention incentives are a valuable tool to retain quality and critical employees. VA uses retention incentives to retain employees in hard-to-fill positions and employees who possess high-level or unique qualifications that VA does not want to lose. Our review of retention incentives at the VA Medical Center in Providence, Rhode Island, concluded that for 17 (85 percent) of 20 cases, justification for retention incentive awards was not available or was inadequate, resulting in approximately \$179,000 in questioned costs annually and over \$895,000 over the next 5 years (*Review of Retention Incentive Payments at VA Medical Center, Providence, Rhode Island*, January 20, 2011). In response to our report recommendations, VHA outlined actions to accomplish a 100 percent review of Providence employees' retention incentives, establish controls to ensure incentives meet VA policy, develop standard operating procedures, and establish a system for maintaining this information.

In FY 2010, VA paid nearly \$111 million in retention incentives to 16,487 employees. In a nationwide audit of VHA and VA Central Office (VACO) retention incentives that was recently issued, we questioned the appropriateness of 96 (80 percent) of 120 VHA incentives, and 30 (79 percent) of 38 VACO incentives, totaling approximately \$1.06 million during FY 2010. (*Audit of Retention Incentives for Veterans Health Administration and VA Central Office Employees*, November 15, 2011)

As with the Providence review, we determined VHA and VACO approving officials did not adequately justify and document retention incentive awards. This occurred because VA lacked clear guidance, oversight, and training to effectively support the program. Also, VA did not effectively use the Personnel and Accounting Integrated Data system to generate timely incentive re-evaluation notices and did not always stop retention incentives at the end of set payment periods. VHA and VA officials agreed with our report recommendations and outlined corrective actions to address the issues identified.

## VBA OVERTIME

The VSOs' letter raises concerns about VBA's use of overtime to meet claims production goals. In 2010, the OIG conducted a review to assess VBA's efforts to meet its hiring goals and the impact of VBA's increased workforce on Compensation and Pension (C&P) claims workload. We found that VBA could not assess the impact of overtime on its capacity to complete claims and recommended that VBA collect data on the number of overtime hours worked to assess the capacity of its current workforce and project future workforce needs. VA agreed and have reported to us that they have implemented a plan to address this issue. (*Review of New Hire Productivity and the American Recovery and Reinvestment Act Hiring Initiative*, February 18, 2010)

## OTHER AREAS FOR POTENTIAL SAVINGS

In addition to the potential improvements identified by the VSOs, VA can reap substantial benefits by improving its processes in several areas: acquisition, delivery of health care and compensation benefits, information technology system development, and workers' compensation for employees injured on the job.

### Acquisition Process

VA purchases goods and services in excess of \$10 billion annually. In November 2009, the Secretary reported to the Office of Management and Budget that he had established a 2-year departmental goal of \$958 million in acquisition savings by FY 2011. We have identified issues with processes at all levels and all phases of the procurement process—planning, solicitation, award, and administration.

Historically, problems in VA procurement have led to inadequate competition for many contracts and a general lack of assurance that VA has obtained fair and reasonable prices or the best value for goods and services. In the past, only about 50 percent of VA's contract awards were competitive. We strongly believe competition is a proven strategy to achieve better value for the Government. For example, VA originally planned to contract for approximately 940 non-recurring maintenance projects with its \$1 billion in American Recovery and Reinvestment Act (ARRA) funds. VA reported that as they executed the ARRA program, it competed approximately 98 percent of these contracts, which resulted in cost savings that allowed VA to fund almost 1,125 projects, a 19 percent increase in projects to improve VA medical facilities. We validated the completion rate in our report, *ARRA Oversight Advisory Report Review of VHA's Efforts to Meet Competition Requirements and Monitor Recovery Act Awards*, (September 17, 2010).

VA can achieve savings by fully leveraging its buying power and improving the administration of contracts. The following examples highlight opportunities where VA can strengthen the integrity of its contracts and realize significant acquisition-related cost savings over 5 years:

- Savings of about \$22 million by procuring aortic valves, coronary stents, and thoracic grafts through consolidating requirements using national contracts and blanket purchase agreements instead of making open market purchases. (*Audit of the Acquisition and Management of Selected Surgical Device Implants*, September 28, 2007)
- Savings of about \$41 million through improved acquisition planning and oversight processes to increase the use of the Federal Supply Schedules for the purchase of medical equipment and supplies. (*Audit of Veterans Health Administration Open Market Medical Equipment and Supply Purchases*, July 21, 2009)
- Savings of about \$60 million through improved clinical sharing agreement monitoring and negotiation practices when using noncompetitive clinical sharing agreements for professional medical personnel. (*Audit of Veterans Health Administration Noncompetitive Clinical Sharing Agreements*, September 28, 2008)
- Savings of about \$38.5 million in health care staffing costs through increased competition, better price evaluations, and improved ordering practices. (*Review of Federal Supply Schedule 6211—Professional and Allied Healthcare Staffing Services*, June 7, 2010)
- Reduce unsupported costs and improper payments by about \$16.8 million by strengthening contract administration practices in VHA's Home Respiratory Care Program. (*Audit of Veterans Health Administration's Home Respiratory Care Program*, November 28, 2007)
- Preventing \$85.3 million in overpayments by effectively competing, awarding, and administering patient transportation contracts. (*Veterans Health Administration—Audit of Oversight of Patient Transportation Contracts*, May 17, 2010)

### **Management of Rural Health Initiatives**

In addition to identifying potential savings, we also evaluate how funds are managed and used to meet a program's intended outcomes. In FYs 2009 and 2010, VA's Office of Rural Health (ORH) received \$533 million in funds designated for improving access and quality of care for veterans residing in rural areas. We reported ORH lacked reasonable assurance that its use of \$273 million of the \$533 million improved access and quality of care for veterans residing in rural areas. For example, ORH provided \$200 million of rural health funds to VISNs to cover fee expenditures for rural veterans through a project called the Rural Health Fee Usage Plan. ORH's goals for the use of these funds were to improve the percentage of fee care dollars spent on rural veterans and the percentage of rural patients utilizing VHA services. However, the health care facilities were unable to demonstrate that the use of these funds improved access to care for rural veterans. For example, one VAMC received \$3.2 million of Fee Usage Plan funds. The VAMC transferred \$3 million of these funds to their general account then used the funds without any restrictions. By the end of FY 2010, the VAMC's overall planned fee care expenditures increased only about \$252,000.

We also noted concerns with the project review and selection process used to select projects for execution in FYs 2010 and 2011. In addition to improved organizational and management controls, we recommended that VA reassess ORH's FY 2012 budget requirements to align planned use of resources to their greatest rural health needs. As a result of our report, the Government Accountability Office recommended to the Appropriations Committees that ORH's budget resources for FY 2012 be restricted. VA has taken our recommendations seriously and strengthened its controls to provide increased oversight and transparency to ensure that future funds will be used as intended.

### **Temporary 100 Percent Disability Evaluations**

Veterans' disability compensation payments are not usually an avenue for cost savings. We have, however, identified one area where a systemic problem leads to veterans receiving long-term payments to which they are not entitled. VBA grants veterans a temporary 100 percent disability evaluation for service-connected disabilities requiring surgery, convalescence, or specific treatment. At the end of a mandated period of convalescence or cessation of treatment, VA staff are required to review the veteran's medical condition to determine whether to continue the temporary evaluation. If a medical exam shows a change in the veteran's condition, and VARO staff determines that a reduced benefit is warranted, then VBA staff initiate action to reduce benefits. In January 2011, we issued a report detailing our concerns with VBA's processing of temporary 100 percent disability evaluations. We projected that regional office staff did not correctly process claims of about 27,500 (15 percent) veterans with temporary 100 percent evaluations and that since January 1993 VBA overpaid these veterans a net amount of about \$943 million. Without timely corrective action, we conservatively projected that VBA will overpay veterans \$1.1 billion over the next 5 years.

The primary message in our report is that VBA paid veterans a temporary 100 percent benefit without adequate medical evidence. Further, VBA rarely attempts to recover any monies paid to the veteran in error and once a temporary 100 percent rating has been in place for 20 years, VBA cannot reduce the rating unless the veteran committed fraud in obtaining the benefits. The then Acting Under Secretary for Benefits did not agree with the projected overpayment amounts, but agreed to implement the recommendations we made. We stand behind our statistical projection as a reasonable and conservative estimate of overpayments and potential future overpayments based on our review of compensation records available at the time of the audit. We monitor VBA's actions to correct this condition during the OIG's VARO Benefits Inspections program and we continue to find claims files without suspense dates for reexaminations. VBA has just recently started work to identify veterans who need reexamination, and to establish suspense dates to drive timely examinations.

### **Information Technology Issues**

Information technology (IT) is critical to support VA in accomplishing its mission of providing benefits and services to veterans. For FY 2012, VA requested approximately \$655 million for new product development out of a total budget of \$3.2 billion for IT systems and support. If managed effectively, these IT capital investments can significantly enhance operations and increase efficiency in a range of VA programs, from medical care to compensation and pensions.

However, IT management at VA is a longstanding high-risk area. VA experienced significant challenges in managing its IT investments, including cost overruns, schedule slippages, performance problems, and in some cases, complete project failures. For example, VA spent over 14 years and \$308 million developing the Veterans Services Network (VETSNET) to consolidate compensation and pension benefits processing into a single system. Although VETSNET has now achieved most of the planned functionality, VA has yet to identify a date for migrating all claims and decommissioning the legacy system, which costs about \$7 million a year to maintain.

Also, VA has tried twice to develop an integrated financial management system. In 2004, after 6 years and spending more than \$249 million, VA halted the Core Financial and Logistics System (CoreFLS) project due to significant project management weaknesses. In 2005, VA began work on the Financial and Logistics Integrated Technology Enterprise (FLITE) program, comprised of an accounting system, an asset management system, and a data warehouse component—all scheduled for deployment by FY 2014 at an estimated cost of approximately \$609 million. In July 2010, VA cancelled two FLITE components, partly because of the same project management issues that had plagued CoreFLS. In October 2011, VA cancelled the remaining component after spending more than \$127 million on the entire FLITE program.

VA recently began planning for a new financial system. Reviewing and applying the lessons learned from the previous failed attempts will be crucial to any future success. In September 2009, we reported VA needed to better manage its major IT development projects, valued at that time at over \$3.4 billion, in a more disciplined and consistent manner (*Audit of VA's System Development Life Cycle Process*, September 30, 2009). In general, we found that VA's processes were adequate, but VA's Office of Information Technology (OI&T) did not communicate, comply with, or enforce its mandatory requirements.

In June 2009, OI&T implemented the Program Management Accountability System (PMAS) to proactively manage VA's IT projects to complete system development efforts on time and within budget. PMAS was designed as a performance-based management discipline that provides incremental delivery of IT system functionality—tested and accepted by customers—within established schedule and cost criteria. In September 2011, we reported OI&T had not established key management controls to ensure PMAS data reliability, verify project compliance, and track project costs. Until these issues are addressed, VA will risk cost overruns, schedule slippages, and poor performance in future efforts to deliver the systems essential to accomplishing the Department's missions and programs.

### **Workers' Compensation Program Case Management**

Ineffective workers' compensation program (WCP) case management leads to potential program fraud, as well as increased costs to VA. Over the past two decades, VA's WCP costs have increased 57 percent to approximately \$182 million; VHA comprises 93 percent of these total costs.

We recently reported that VHA could reduce WCP costs by an estimated \$264 million over the next 5 years through improved program case management oversight. (*Audit of VHA's Workers' Compensation Case Management*, September 30, 2011) While VHA submitted employee compensation forms timely, it often lacked the medical evidence necessary to support the employee's continued disabilities. VHA also missed opportunities to return able employees to work. Overall, we attributed these issues to a lack of oversight to ensure compliance with WCP statutory requirements.

We recommended that VHA provide oversight and assign dedicated resources to control costs and reduce the potential for future waste and abuse. The Assistant Secretary for Human Resources and Administration and the Under Secretary for Health agreed with our findings and recommendations and plan to complete all corrective actions by December 31, 2011. We will assess and monitor the implementation of corrective actions.

We also recommended that VA support legislation currently pending to convert claimants 65 years of age or older to more appropriate benefit programs. VA responded that they will contact the Department of Labor in support of its proposed change in legislation.

### **WORK IN PROGRESS**

The VSOs expressed concerns about the size and growth of Veterans Integrated Service Networks (VISN) in VHA. We have ongoing audit work to examine VISN management structures and fiscal operations. Although our work is not yet com-

plete, we believe the VSOs have raised valid concerns. When VHA created the VISNs in 1995, VHA specifically decentralized budgetary, planning, and decision-making functions to the Networks to promote accountability and improve oversight of the daily operations of its medical facilities. VHA estimated the overall size of the original 22 VISNs would range between 154–220 FTE with total operating costs of about \$26.7 million annually. Today, we estimate the existing 21 VISNs employ at least 1,098 staff at an annual cost of over \$165 million.

We also have concerns about the existence of national and regional fiscal controls and data that would allow VHA to effectively evaluate and compare the reasonableness of VISN staffing levels and costs. Strong financial management and fiscal controls would provide VHA the opportunity to identify inefficiencies in VISN operations and possibly reallocate funds back to direct patient care.

While not referenced in the VSOs' letter, we also have ongoing projects in several areas that could potentially result in cost savings. We are currently examining the extent to which the MCCF program effectively bills third-party health insurers for VA provided medical care. VHA is currently centralizing MCCF billings and collections processes nationwide, however medical centers are continuing to perform some MCCF functions. Although our work is ongoing, VHA continues to miss opportunities to increase MCCF revenue by not billing third-party insurers for billable fee care services provided. We expect to issue a final report by the spring of 2012.

We are also evaluating the effectiveness of VHA's acquisition and management practices used to purchase prosthetic limbs. Our preliminary results show that VA is paying more for prosthetic limbs than the agreed upon prices in the contracts in place. VA can reduce its risks for paying excessive prices by strengthening its oversight and controls with actions to ensure the review of vendor quotes, purchase orders, and to verify the costs of items billed on invoices match agreed upon prices in the associated contracts. We expect to issue a final report on this early in 2012.

## **CONCLUSION**

As an agency whose primary mission is to deliver benefits and services, it is a challenge to achieve meaningful cost savings but it is not insurmountable. The suggestions from the VSOs are a good starting point for the discussion but we believe the Committee and VA should consider other areas, including those we have raised. The VA OIG is committed to continue reviewing VA programs and operations to ensure that they function economically, efficiently, and effectively. We will continue to put forth recommendations that not only produce savings but more importantly provide better services to our Nation's veterans.

Mr. Chairman and Members of the Committee, this concludes my statement today. I will be pleased to answer any questions you may have.

**MATERIAL SUBMITTED FOR THE RECORD**

**Deliverables from House Committee on Veterans' Affairs  
Hearing on *Potential Budgetary Savings within VA:*  
*Recommendations from Veteran Service Organizations*  
November 15, 2011**

Below are VA's responses to questions asked during the November 15, 2011 HVAC hearing on potential budgetary savings within the Department of Veterans Affairs.

**Question 1:** Please provide a legal conclusion from OMB on the application of sequestration to VA.

**Response:** This question will be addressed in VA's responses to the post-hearing questions stemming from this hearing.

**Question 2:** Please provide the trend in the number of conferences over the past several years.

**Response:** Leadership of the Department has centralized the approval process for all conferences involving more than 50 employees, and applied much greater scrutiny to them, requiring a strong business case to show a clear purpose and desired outcomes from the proposed conference, as well as encouraging wider use of teleconferences. When there is a case made for an in-person conference, there is a strong push for more economical venues and ensuring the number of participants is appropriate. The future trendline for both conference expenditures and the number of conferences will be downward. With regard to the request on historical information, however, an accurate, reliable figure on the number of conferences is not available.

**Question 3:** Please provide a side-by-side review of CMS and VA survey questions for State Homes for certification.

**Crosswalk—38 CFR 51 VA's State Veteran Home (SVH) Survey Areas with Centers for Medicaid & Medicare Services (CMS) SVH Survey Standards (38 CFR 483)—(8) eight areas of difference:**

**11-18-11**

Below are the 8 areas identified by Ascellon *which differ between the VA's SVH Survey Standards and those of CMS*. Each of these (8) eight areas are discussed and provided below.

**1. VA area—Administration**

**38 CFR 51.210 Notification of change of administration to Geriatrics and Extended Care**

Compliance with Section 504 of the Rehabilitation Act 1973, Annual Certification of Drug Free workplace, Annual Certification r/t lobbying, Annual certification compliance with Title VI of Civil Rights Acts, percentage of Veterans, State employee if contract out management of SVHs.

These are VA specific with no correspondence in CMS.

**2. VA area—Credentialing and Privileging (C&P)**

**38 CFR 51.210 j. Credentialing and Privileging.**

VA Specific area—no corresponding Credentialing & Privileging process in CMS.

Specific to VA is (38 CFR 51.10); the CMS SVH survey regulation 38 CFR 483 does not identify a C&P process, it simply states: *"The facility must operate and provide services in compliance with applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility."*

**3. VA area—Basic Per Diem**

**Basic Per Diem 51.41**

VA Specific area—no corresponding CMS area

**4. Per Diem and drugs and medicines: 38 CFR 51.42 & 43 (all VA specific)**

VA—specific—no corresponding CMS area.

**5. Social Worker qualifications**

VA's qualifications are more comprehensive than those of CMS as described below:



**VA Social Work Qualifications****38 CFR 51.100 (h) Social Services.**

- (1) The facility management must provide medically related social services to attain or maintain the highest practicable mental and psychosocial well-being of each resident.
- (2) A nursing home with 100 or more beds must employ a qualified social worker on a full-time basis.
- (3) Qualifications of social worker. A qualified social worker is an individual with—
  - (i) A bachelor's degree in social work from a school accredited by the Council of Social Work Education (Note: A master's degree social worker with experience in long-term care is preferred), and
  - (ii) A social work license from the State in which the State home is located, if offered by the State, and
  - (iii) A minimum of 1 year of supervised social work experience in a health care setting working directly with individuals.
- (4) The facility management must have sufficient support staff to meet patients' social services needs.
- (5) Facilities for social services must ensure privacy for interviews.

**CMS Social Work Qualifications:****§ 483.15 Quality of life.**

“(3) *Qualifications of social worker.* A qualified social worker is an individual with—

- (i) A bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and
- (ii) One year of supervised social work experience in a health care setting working directly with individuals.”

**6. Registered Nursing Services Coverage—VA more specific than CMS in required coverage****VA Nursing Service Standards—38 CFR 51.130 Nursing services**

- “(b) The facility management must provide registered nurses 24 hours per day, 7 days per week.
- (d) The facility management must provide nursing services to ensure that there is direct care nurse staffing of no less than 2.5 hours per patient per 24 hours, 7 days per week in the portion of any building providing nursing home care.
- (e) Nurse staffing must be based on a staffing methodology that applies case mix and is adequate for meeting the standards of this part. (Authority: 38 U.S.C. 101, 501, 1710, 1741–1743).”

**CMS Nursing Service:****38 CFR 493 483.30**

States that: “facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hr basis to provide nursing care to all residents in accordance with resident care plans,” ***with waivers to this requirement by the State*** for a variety of reasons-ex. when the state determines that doing so will not endanger the health of the residents, when the facility has been unable to recruit appropriate personnel, etc.

**7. Issue: Nursing Services: Issue of designation of a supervising nurse for each tour of duty—****VA more specific than CMS****VA Nursing Service Standards****§ 51.130 Nursing services.**

“Facility must designate a supervising nurse for each tour of duty.”

**CMS Nursing Service Standard**

See Item #6 above for CMS Nursing Service—38 CFR 493.30 states a facility must designate a licensed nurse to serve as a charge nurse on each tour of duty except when waived.

**8. Nursing Services Issue: VA's Hours Per Patient per 24 Hours (HPPD) of no less than 2.5 hours:**

**VA more specific than CMS**

**VA Nursing Service Standards****38 CFR § 51.130 Nursing services.**

“(d) The facility management must provide nursing services to ensure that there is direct care nurse staffing of no less than 2.5 hours per patient per 24 hours, 7 days per week in the portion of any building providing nursing home care.”

**See Item #6 for CMS Nursing Service standards**—does not specify hours of nursing care per patient.

**Question 4:** Please provide a complete cost to implement paperless claims.

**Response:** The Veterans Benefits Management System (VBMS) lifecycle cost estimate (as revised in the September 2011 E300A submission) is \$934,795,000. This cost estimate consists of VBMS development, technology, operation and maintenance (O&M), and government full time employees from fiscal year 2010 through 2017. The top cost and schedule drivers are development, technology, and O&M.

**Development:** The major cost driver is the Workflow and Business Rules development costs. Man-hours required to interpret the vast set of business rules surrounding Workflow and Workload management will be more extensive than any other functional component of the system. This is where the most “custom” code development will most likely be incurred. Another major driver is the security required for a HIGH system accreditation. The development activities surrounding these controls and the additional documentation will be a larger cost than most systems incur.

**Technology:** By far, the largest cost driver is the Document Repository (FileNET) and associated technology required for the image-processing. Scanning and, more to the point, back-scanning of image data will be a large cost. The physical requirements to store and transmit this data, operationalize in a performant manner and deliver end capability will be a major long term cost and initial operationalizing cost. The network connectivity required along with the associated hardware and software are all major drivers for cost.

**O&M:** Scanning will also be one of the larger cost drivers along with data storage. VA 6500 and Legal requirements to store data within accessible means impact long term storage requirements and transmission needs. Licensing and repeated incurring costs to support the document management will be an operational cost.

---

**Questions and Responses for the Record**  
**Questions for Joseph A. Violante, National Legislative**  
**Director, Disabled American Veterans and Carl Blake,**  
**National Legislative Director, Paralyzed Veterans of America:**  
 November 30, 2011

Joseph A. Violante  
 National Legislative Director  
 Disabled American Veterans  
 807 Maine Avenue, SW  
 Washington, DC 20024

Dear Joe:

In reference to our full Committee hearing entitled, “Potential Budgetary Savings Within the U.S. Department of Veterans Affairs: Recommendations from Veterans’ Service Organizations,” that took place on November 15, 2011, I would appreciate it if you could answer the enclosed hearing questions by the close of business on January 11, 2012.

In an effort to reduce printing costs, the Committee on Veterans’ Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore,

it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Carol Murray at *Carol.Murray@mail.house.gov*, and fax your responses to Carol at 202-225-2034. If you have any questions, please call 202-225-9756.

Sincerely,

BOB FILNER  
*Ranking Democratic Member*

---

**Questions for the Record**  
**November 15, 2011**  
**Questions for Joseph Violante, National Legislative**  
**Director, Disabled American Veterans**

**Question 1:** Out of the nine recommendations discussed in your testimony, please tell the Committee your top three issues that you believe the Committee should focus on in order of priority.

**Question 2:** Does your organization generally support the VISN structure or do you think it is time to take another look at how the provision of medical care is organized and managed? If you are generally supportive of the current VISN structure, do you believe that the present VISN boundaries are optimally drawn or do you have suggestions as to how to better draw these boundaries to reflect local needs and national centralization?

---

**Letter to Carl Blake, National Legislative Director,**  
**Paralyzed Veterans of America**  
November 30, 2011

Carl Blake  
National Legislative Director  
Paralyzed Veterans of America  
801 18th Street, NW  
Washington, DC 20006

Dear Carl:

In reference to our full Committee hearing entitled, "Potential Budgetary Savings Within the U.S. Department of Veterans Affairs: Recommendations from Veterans' Service Organizations," that took place on November 15, 2011, I would appreciate it if you could answer the enclosed hearing questions by the close of business on January 11, 2012.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Carol Murray at *Carol.Murray@mail.house.gov*, and fax your responses to Carol at 202-225-2034. If you have any questions, please call 202-225-9756.

Sincerely,

BOB FILNER  
*Ranking Democratic Member*

---

**Questions for the Record**  
**November 15, 2011**  
**Questions for Carl Blake, National Legislative Director,**  
**Paralyzed Veterans of America**

**Question 1:** Out of the nine recommendations discussed in your testimony, please tell the Committee your top three issues that you believe the Committee should focus on in order of priority.

**Question 2:** Does your organization generally support the VISN structure or do you think it is time to take another look at how the provision of medical care is organized and managed? If you are generally supportive of the current VISN structure, do you believe that the present VISN boundaries are optimally drawn or do you have suggestions as to how to better draw these boundaries to reflect local needs and national centralization?

---

***Responses from Joseph A. Violante, National Legislative Director, Disabled American Veterans and Carl Blake, National Legislative Director, Paralyzed Veterans of America:***

**Question 1:** Out of the nine recommendations discussed in your testimony, please tell the Committee your top three issues that you believe the Committee should focus on in order of priority.

**Answer:** On behalf of The American Legion, AMVETS, Disabled American Veterans, Paralyzed Veterans of America and Veterans of Foreign Wars: Ranking Member Filner, our organizations believe it is imperative that the funding provided to VA must be efficiently and effectively spent in order to care for our Nation's veterans. Every dollar that is misspent or wasted is a dollar that cannot be used to provide benefits or services to veterans in need. For this reason, we worked jointly to identify a number of areas that the Committee might examine as possible ways to reduce waste and achieve savings within certain VA programs. In both our letter to the Committee dated April 4, 2011, and in our subsequent testimonies offered on November 15, 2011, we stressed the overriding importance of maintaining sufficient funding for VA health care and infrastructure remediation, each of which requires significant focus by the Committee over the coming year.

***Health Care Funding***

Our organizations have worked with you and your colleagues for a number of years to gain sufficient, timely and predictable funding for VA's many programs. One extraordinary success was the passage of the Veterans Health Care Budget Reform and Transparency Act, Public Law 111-81, an Act that created the advance appropriations process to govern VA health care funding. That Act was designed to allay the Veterans Health Administration's (VHA) chronic annual anxiety about the availability of funds on the first day of a fiscal year, and has begun to change management behaviors in a very positive way for the betterment of health care for veterans.

However, as detailed in our testimony, the Administration and the Office of Management and Budget continue to introduce budget variables and make individual decisions irrespective of VA's internal Enrollee Health Care Projection Model and the advance appropriations process, actions that undermine our joint efforts to stabilize VHA funding. We have grave concerns about a number of budgetary "gimmicks" that were proposed by the Administration and accepted by the Congress. Moreover, the entire benefit of advance appropriations was recently overridden by Congress itself when a provision in the short-term continuing resolutions approved at the beginning of FY 2012 forced VA to spend less than Congress had previously provided to VHA through the advance appropriations process.

Thus, we believe a clear priority for the Committee's time and resources in the new Session and the next Congress should be allocated to the Administration's VA budget formulation practices, with oversight of any new variables, "management improvements," or other budget gimmicks that may threaten the advance appropriations process—which functions optimally when based on honest and transparent actuarial forecasting. Therefore, we believe this must be the Committee's top oversight function for the foreseeable future.

***Maintaining and Improving VA's Physical Plant***

VA's capital infrastructure is another top concern of our organizations. Diminution of VA through neglect and attrition of capital infrastructure, whether in the health or benefits systems, will over time reduce the quality and quantity of services for veterans. Without properly functioning buildings and major building systems, VA cannot sustain quality programs. Without these investments, VA will experience steadily increasing inefficiencies and ever-greater difficulty attracting talented people to work within the VA system.

Over the past two decades (with the partial exception of seismic improvements), no Administration or Congress has adequately funded VA's infrastructure needs. While VA buildings today are still serviceable, they and their component parts need to be maintained, renovated, replaced and kept contemporary in order for VA facilities to remain viable institutions for veterans who need services and for the staffs who work in them. We believe that it is a major responsibility of Congress and, more specifically, this Committee, to ensure that VA receives adequate funding to keep its infrastructure safe and functional. Congress has reserved to itself the sole power to approve and authorize appropriations for major medical facility construction on a per-project basis, and provides oversight on minor construction and VA's maintenance and repair accounts. We believe this critical area of VA weakness and lack of resources warrants much closer attention and leadership by the Committee.

While all the recommendations discussed in our testimony are important, these two items are a priority.

**Question 2:** Does your organization generally support the VISN structure or do you think it is time to take another look at how the provision of medical care is organized and managed? If you are generally supportive of the current VISN structure, do you believe that the present VISN boundaries are optimally drawn or do you have suggestions as to how to better draw these boundaries to reflect local needs and national centralization?

**Answer:** VA's adoption of VISNs as a regional health care organization was derived from the geographic service area concept of the 1991 VA Commission on the Future Structure of Veterans Health Care, a Federal advisory commission chartered by then-VA Secretary Edward J. Derwinski to make recommendations for organizational, structural, quality, safety and cultural improvement in VA health care, among other aims. VA considered the Commission's recommendations for 3 years before implementing this one as a part of VHA's 1995 administrative reorganization. Initially, 22 VISNs were established but two of them—the smallest in terms of patient workload, staff and funding—were not independently viable and were consolidated, so that today 21 networks remain, covering the continental U.S., Hawaii, Puerto Rico and U.S. possessions.

We supported the VA's decision to restructure the VA health care system, the principal benefit being a regionalization of health care delivery, coordination of leadership and decentralization of decision-making with a corresponding reduction of VA Central Office's involvement in local health care management matters. Like Congress, we believed that health care decisions were best left to local VA facility managers and clinicians, while VA Central Office should focus on national strategy and policies, program development, practices and standards-setting. The idea was simple: policy is set at the top; implementation occurs at the local level.

Recent testimony before the Senate Committee on Veterans Affairs suggested VA facility managers are "gaming the system" to meet goal numbers established by the VISNs, rather than providing needed care to veterans as provided for by law and is also one of our concerns. We receive much anecdotal information from our members and VA employees that is consistent with such allegations—although these troubling reports are difficult to prove in any systematic way. The Committee's recent oversight hearing on chronic problems at the Miami VA Medical Center is illustrative of how such challenges can fester undetected because of lack of adequate public reporting and the general unavailability of documentary data.

A second concern and one about which we wrote you in our April 2011 letter and testified at your November 15 hearing, is the number of staff now assigned to the VISNs. When the networks were formed, VA asserted that they would be staffed by network directors with small cadres of staff. Management functions that exceeded this staff's ability to perform them were to be accomplished by working groups composed of VAMC staffs on temporary assignments. Over the past 15 years, however, the network offices have grown dramatically, and have morphed into 21 permanent mini-central offices, staffed with full-time professional staffs focused on operations, clinical care, human resources, quality, safety, internal and external review, media, press, public affairs, budget, academic affairs, and numerous other functions.

Perhaps the most worrisome concern with the VISN organization is the enormous administrative overhead that is being incurred by these seemingly bloated numbers of staff. We believe thousands of VA permanent, full time staff may now be assigned to VISN offices (but exact numbers are elusive due to lack of publicly available information). Within VA these network positions are popular because they represent opportunity for career mobility, professional advancement, and promotion of local VA employees. We believe a large number are clinicians who in their network assignments no longer provide clinical care to veterans. While we believe that clinical

leadership is a strength of VA health care, we believe that the size and complexity of the current VISNs depart from the recommendations of the Commission's report, and from the original vision of those who implemented the geographic service area recommendation. Not only are clinical staff members being taken away from front line positions but also valuable technical and administrative staff have been drained from medical centers to VISN offices.

Many of the additional positions were VACO-mandated to respond to the "crisis of the day" phenomena. Instead of developing thoughtful solutions for recognized problems, previous Administrations simply added new mandatory positions, functions or new offices.

Our third concern with the networks deals with the geographical boundaries of VISNs. With the exception of the one major consolidation change mentioned above, no adjustment of VISN boundaries has occurred in the 15-plus years of the life of this organizational model. The original VISN geographic boundaries were drawn based on VA patient-referral patterns and delivery systems from well over 20 years ago; these may well have changed. Also, some historical anomalies of the VISN map seem to cry out for review, for example, the small state of West Virginia remains subdivided into parts of four VISNs; the western Panhandle of Florida is part of the eight-state VISN 16, while the remainder of the large state of Florida is in VISN 8. We see other examples in the current VISN map that raise questions as well.

Another concern is the allocation of appropriated medical care funds below the level of the network offices. VA's VERA system is a risk-adjusted capitation model that allocates Congressional appropriations to the networks rather than the facilities. Theoretically, this model enables regional coordination and funding of highly specialized, scarce medical resources, while the facilities remain the major delivery systems and serve as VHA's basic building blocks to formulate VHA's annual budget request. VHA's appropriations have grown dramatically over the past several years—yet VA facilities often indicate to us that they are significantly underfunded and must ration spending for numerous categorical needs across the operating year. We believe the resource allocation model or the systems being employed by the VISN offices to allocate resources to the VAMCs might need scrutiny and possibly re-balancing for their effects on local operations.

With these thoughts in mind, we would recommend the Committee commission an independent, outside review of the VA network concept, subsequent implementation and current status, with recommended changes that may be warranted by review findings. We believe the time has come for a critical review of the organization, functions, operations, and budgeting process at the VISN and VAMC levels. We recommend the review be conducted by the Institute of Medicine (IOM) rather than by VA or a private contractor. Involving the IOM would ensure a thoroughgoing, apolitical and unbiased review. In addition to examining the current referral patterns, the analysis should account for future demand, changes in veteran and family expectations, and the changing trends in health care delivery.

Also, we would recommend that the IOM's review and analysis be comprehensive to include a review of the VHA Central Office organization. This evaluation should address a value-based analysis of those programs that are optimally managed and funded at a national, VISN or VAMC service level.

While the IOM's report should be made to the Committee, VA should be permitted to comment on the report. We would also recommend the Committee hold hearings on the results of this review to include testimony from this community and other interested parties. The IOM reviewers should be carefully instructed as to the goals of the study, which we believe should focus on ways to improve health care quality, safety, satisfaction, consistency and access. The study should focus on delivery of comprehensive, patient-centered care to today's veterans that builds on the obvious progress VA has made over the past 16 years. The IOM's work on this project should be closely monitored by the Committee as the process occurs to ensure your goals are met.

We thank the Ranking Member for your questions, and we would be happy to furnish any additional information that might be of use to the Committee as it conducts its oversight of VA programs.

---

**Letter from Hon. Jeff Miller, Chairman, Committee on  
Veterans Affairs to Hon. Eric Shinseki, Secretary,  
U.S. Department of Veterans Affairs**

November 30, 2011

The Honorable Eric K. Shinseki  
Secretary  
U.S. Department of Veterans Affairs  
810 Vermont Avenue, NW  
Washington, DC 20420

Dear Mr. Secretary:

In reference to our full Committee hearing entitled, "Potential Budgetary Savings Within the U.S. Department of Veterans Affairs: Recommendations from Veterans' Service Organizations," that took place on November 15, 2011, I would appreciate it if you could answer the enclosed hearing questions by the close of business on January 11, 2012.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Bernadine Dotson at [bernadine.dotson@mail.house.gov](mailto:bernadine.dotson@mail.house.gov). If you have any questions, please call 202-225-3527.

Sincerely,

JEFF MILLER  
*Chairman*

---

**Post-Hearing Questions for the Record  
Submitted by Chairman Jeff Miller  
Hearing on Potential Budgetary Savings Within the  
U.S. Department of Veterans Affairs: Recommendations  
from Veterans' Service Organizations  
November 15, 2011**

1. According to the VA IG testimony, VHA estimated in 1995 that the original size of all 22 VISNs would range between 154 to 220 with total operating costs of about \$26.7 million annually. The IG now estimates the existing 21 VISNs employ at least 1,098 staff at an annual cost of over \$165 million.
  1. Please detail what is being done to assess this growth in VISN staffing levels.
  2. What is the FTE range of VISN headquarter staff nationwide?
  3. Is there a correlation between a growing headquarter staff and VISNs meeting key performance measures?
2. Please provide information on newly hired employees in the VHA positions of Medical Center Director, Associate Network Director, and Network Director for the years 2008 through 2011, broken down by year and the Pay Grade and Step at which these individuals were hired.
3. Please provide information on the number of VA employees, broken down by Administration, whose work-related business activities permit such employee to receive reimbursement for travel and other expenses incurred for having a temporary duty location (basically having two residences) and the cost to the Department as a result of payments for air fare; per diem; or mortgage, interest, property taxes and utility costs for purchasing a home at the temporary duty location.
4. The IG testimony stated that fundamental controls continue to be problematic for the fee care program. Why is that? What is being done about it?
5. How many individual fee-basis care contracts does VHA have? Would consolidation of contracts into larger networks of providers (similar to a Tricare model) be more economical and improve care coordination? Has there been any analysis of the feasibility of moving to a Tricare-like model for VA's fee-basis program? What about moving to a larger network model for only certain kinds of care, e.g., mental health?

6. In the past year the VA IG has uncovered instances of fraud in VA's beneficiary travel program. In essence, veterans who lived only a few miles from a medical center claimed residences that were over 100 miles away, then obtained a travel reimbursement based on the fictitious residence.
  1. What methods does VA have to guard against this kind of fraud? Are veterans' addresses matched against other government records to ensure valid residences are reported?
  2. What oversight is conducted on individual medical centers' beneficiary travel offices in terms of correct determinations being made regarding a veteran's eligibility for travel reimbursement?
  3. How much money is spent annually on VA's beneficiary travel program? How much is spent administering the program? Has any thought been given to consolidating the beneficiary travel function (similar to a CPAC model) to improve efficiency and promote consistent decision-making?
7. Do VA employees ever fly business class to conferences or other VA-sponsored travel destinations?
8. Please provide the Administration's position regarding whether VA programs are exempt from sequestration. Please provide the Office of General Counsel legal opinion/recommendation to the Office of Management and Budget regarding whether all VA-administered programs, including VA medical care, are exempt from sequestration.
9. In the November 14, 2011 IG report regarding VA retention incentives, Dr. Petzel committed to a 100 percent review of all SES/SES Equivalent retention incentives by November 30, 2011. Please provide the Committee with the results of that review.

**Questions for the Record**  
**Chairman Jeff Miller**  
**House Committee on Veterans Affairs**  
**Potential Budgetary Savings within the**  
**U.S. Department of Veterans Affairs:**  
**Recommendations from the Veterans' Service Organizations**  
**November 15, 2011**

**Question 1:** According to VA IG testimony, VHA estimated in 1995 that the original size of all 22 VISNs would range between 154 to 220 with total operating costs of about \$26.7 million annually. The IG now estimates the existing 21 VISNs employ at least 1,098 staff at an annual cost of over \$165 million.

1. Please detail what is being done to assess this growth in VISN staffing levels.
2. What is the FTE range of VISN headquarter staff nationwide?
3. Is there a correlation between a growing headquarter staff and VISNs meeting key performance measures?

**Response:**

1. Please detail what is being done to assess this growth in VISN staffing levels.

In 1995, VHA began a reorganization that included the establishment of 22 VISNs. Staffing began with each VISN having ten core staff. Over time, staffing has grown commensurate with increased VISN responsibilities. In August 2011, VHA conducted a preliminary review of VISN management variation and staffing data, and determined that a more detailed analysis was necessary. VHA established work teams to examine the following sub-areas:

- VISN Role and Function
- VISN Core Staff
- VISN Regional Variations
- VISN Strong Practice Sharing
- Structured Business Reviews of VISNs

**Expected deliverables**

*VISN Role and Function.* Since the mid-1990s, the VISN's role has evolved into that of a fundamental operating unit of VHA. VISNs have been charged with increased oversight responsibilities and programmatic implementation, which vary according to complexity of care, specialized services, staff sizes and other local factors. A specific and comprehensive definition of the role and functions of the VISN Net-



work Office will be developed, to ensure that the VISN Network Office role relative to operation, oversight and implementation of programs within facilities is adequately covered.

*VISN Core Staff.* VHA has increasingly come to rely on VISNs to provide “reach” into the field, for added oversight and operational direction for the Deputy Under Secretary for Health for Operations and Management (DUSHOM), program office implementation efforts and VHA leadership. A work team will formally match this and other responsibilities into the broader VHA organizational structure. As form follows function, the organizational structure (form) will be mapped to the explicit roles and functions of the VISN. The work team will generate a document that maps the VISN role and function to an organization structure. The structure will include a breakdown of types of positions (core/leadership, mandated, discretionary, etc.).

*VISN Regional Variations.* Develop a methodology to identify and monitor positions that provide (direct) support to facilities through coordinated regional effort for those positions or services that do not meet the criteria for core VISN staff.

*VISN Strong Practice Sharing.* Develop a process (to include expected outcomes) for VISN identification, validation (measurement) and sharing of strong practices in the VISN.

*Structured Business Reviews of VISNs.* Develop a management agenda that will serve as the DUSHOM (10N) structured business review of the VISNs.

Work teams comprised of VISN and VHACO leadership are expected to report the results of their efforts to the Office of the DUSHOM during the first quarter of calendar year (CY) 12.

2. What is the FTE range of VISN headquarter staff nationwide?

VISN staffing ranges between a high of 104 fulltime-equivalent employees (FTEE) and a low of 38. A November 2011 survey of VISNs indicates there is a direct correlation between the complexity of the VISN (number of campuses) and the number of Veterans the VISN serves (coverage area).

3. Is there a correlation between a growing headquarter staff and VISNs meeting key performance measures?

As VHA undertakes new and expanded initiatives, the variance in interpretation and assignment of functions and personnel assigned to the VISN has increased. Compounding this situation, the escalating role of the VISN in the oversight and implementation of programs and policies has led to substantial variation in VISN structure.

While geographic and Veteran population differences provide for valid reasons for some level of variation among VISN structures, the incremental expansion of VISN mission, coupled with variation in structures, creates variations in both the functions performed by VISNs and interpretation about the purpose of the VISN. While it is desirable that VISN structure and function are evaluated and standardized to disseminate strong practices across all VISNs that align in mission, VHA’s current efforts to assess VISN staffing will accommodate those geographic and population differences that are found among the Networks.

A corollary to VHA’s VISN staffing assessment will be the identification of candidate reporting sources for use in the development of a balanced view of VISN performance. VHA anticipates that structured business reviews will guide the integrated outcome, process and associated measurement framework to incorporate the following traditional dimensions of a balanced scorecard: client, process/quality, financial, operational efficiencies and employee/learning. A team was formed to develop this complementary activity, whose timeline for completion is also first quarter CY 12. A significant factor in VHA’s VISN staffing assessment is the finding that the appropriate VISN-level FTEE to provide leadership and expertise has contributed to better performance at the VAMC-level in such areas as mental health, geriatrics, prosthetics and patient safety.

**Question 2:** Please provide information on newly hired employees in the VHA positions of Medical Center Director, Associate Network Director, and Network Director for the years 2008 through 2011, broken down by year and the Pay Grade and Step at which these individuals were hired.

**Response:** Please see attached.

**Question 3:** Please provide information on the number of VA employees, broken down by Administration, whose work-related business activities permit such employee to receive reimbursement for travel and other expenses incurred for having a temporary duty location (basically having two residences) and the cost to the De-

partment as a result of payments for air fare; per diem; or mortgage, interest, property taxes and utility costs for purchasing a home at the temporary duty location.

**Response:** VA does not have access to records that identify individuals who own a second home at the TDY location. Under that scenario, the traveler should not claim lodging costs for the period of travel. Also, there would be no lodging receipt for review/approval by the supervisor as required by travel regulations. The travel voucher should reflect no lodging costs.

However, such travelers could receive a Travel Savings Award. These incentives are not exclusively provided to individuals who own a home in a temporary duty location and could include situations where travelers stayed with friends or stayed in lower cost accommodations as well. VA's Travel Savings Award policy can be found at: <http://10.222.13.221/scan/jobs/13320/DC-260-80B7761018.pdf>

VA records show that in 2011 a total of \$59,795 was paid out to 105 employees as "Travel Savings Awards."

**Question 4:** The IG testimony stated that fundamental controls continue to be problematic for the fee care program. Why is that? What is being done about it?

**Response:** VHA has been developing and implementing initiatives to resolve program issues. Most significant issues center on the manual nature of the program and variability in business practices. VHA's Chief Business Office for Purchased Care has taken several steps to improve this program, focusing in several areas. The program has been supported by manual processes; key changes described below are underway to standardize, reduce or eliminate manual processes supporting the program.

**Technology Improvements:** *Fee Basis Claims System (FBCS):* The VistA Fee package was developed more than 20 years ago and was not designed for the sophistication and volume of claims that the VA is now processing. As a result, VA has implemented an interim automation system, FBCS, to support and improve the Purchased Care claims management operations. VA has seen improvements in payment accuracy and timeliness since this implementation began in October 2009, with significant reductions in the manual work required to manage this program. In addition, enhancements are underway that will address the top audit findings, reducing the significant manual processes currently supporting the program. These are planned to be implemented in late calendar year 2012.

*Program Integrity Tools:* VA has implemented an aggressive Fraud/Waste/Abuse (FWA) Program with specific awareness and training efforts accomplished in FY 2011 through the creation of the VHA CBO Program Integrity Department which combats fraud, waste and abuse using various system safeguards, detailed auditing and the development of fraud detection and awareness training classes. During FY 2011, quarterly Fraud, Waste and Abuse training sessions were conducted through Live Meeting presentations, which covered: code gaming, ambulance upcoding, "bundled" billable claims, common fraud schemes, and detection and prevention of health care fraud. In addition, VA has developed routine monthly reporting that provides detailed information on FWA cases to each facility for review; if payment errors are validated, these results are included in the quarterly High Dollar Overpayment report to the Office of Management and Budget (OMB). Finally, VA has procured industry standard technology tools that utilize known health care industry algorithms to identify potential fraudulent or erroneous claims. VA will implement these tools by the end of calendar year 2012 which will consist of the following:

- Claims Scoring Tool
- Data Repository
- Data Integration/Extraction, Transform and Load (ETL) tool, and
- Reporting Tool

**Business Process Changes:**

*Non-VA Care Coordination:* VHA is implementing the following standardized business processes to reduce variability and inefficiency across all program areas including:

- Consult/Referral review: initial decision point for use of Non-VA Care.
- Appointment Management: control and oversight of the Non-VA appointments.
- Clinical Documentation Management: assure appropriate clinical information is received in a timely manner.
- Emergency Care: assure appropriate oversight and management of emergent care provided at Non-VA facilities; assure claims associated with emergent care are adjudicated in a standardized manner.

- Appeals Management: assure timeliness and quality standards are met when Veterans appeal benefit decisions.

These standardized business processes are scheduled to be fully deployed throughout all 21 VISNs by the end of FY 2012. Early results have seen positive progress in the timeliness of approvals and appointments for non-VA care, and the receipt of clinical documentation for these non-VA care visits.

*Site Assessment Visits:* VA's Chief Business Office has expanded its Non-VA Care Field Assistance Program to provide enhanced assistance visits designed to assist with site specific process improvements and assessment of key business practices supporting the program. In FY 2011, 30 site assistance visits were performed, which included providing staff guidance and training to approximately 180 Fee field facility staff. The site assistance visits also included an extensive analysis of the clinical utilization review aspect of Fee care, proper authorizations, obligations of funds, staff understanding of payment methodologies and the Fee Basis Claims System (FBCS) and an overview of management controls within the Fee office. Upon conclusion of the visit, a final report and extensive action plan for process improvement is shared with the facility leadership and follow-up conducted to ensure that action plan findings are implemented.

*Training and Education:* The Fee Academy is the primary training program provided to VISN and VAMC Non-VA Care (Fee) employees nationwide. The Fee Academy is organized into a four-tiered, progressive level of curriculums designed to improve performance, enhance internal controls and be in compliance with program policies—461 employees completed this training in FY 2011. The Fee Academy is augmented by 'just in time' mini-courses delivered via LiveMeeting on myriad topics concerning new or changed processes—over 13,000 employees attended 60+ mini-courses in FY 2011. Future efforts will include a link to core competencies and associated mandatory training requirements.

*Non-VA Purchased Care Claims Audit Contract (CCAC):* This external contract conducts post-payment reviews and analysis that identify errors in payment methodologies and procedures for Non-VA Care (Fee) claims processing. In FY 2011, 12 VISNs were audited, addressing findings at 24 VA facilities. Each VISN prepared an action plan specific for their findings. In addition, the findings from audits have been utilized to prioritize technology and business process changes required to support overarching program improvement initiatives.

*Recovery Audit:* The Purchased Care Business Line (PCBL) manages the national contract for an external audit of non-VA care inpatient payments. These audits have been in place since 2002, with recoveries exceeding \$100 million. In March 2011, PCBL expanded the recovery audit to include outpatient services. To date, this audit has identified approximately 1,800 cases with the potential for \$557,000 in collections to the government. The results will be used to reinforce training and field communications and develop additional audit and corrective actions plans.

**Question 5:** How many individual fee-basis care contracts does VHA have? Would consolidation of contracts into larger networks of providers (similar to a Tricare model) be more economical and improve care coordination? Has there been any analysis of the feasibility of moving to a Tricare-like model for VA's fee-basis program? What about moving to a larger network model for only certain kinds of care, e.g. mental health?

**Response:** On a national basis, VA currently has fee-basis care national contracts for Dialysis/End Stage Renal Disease (ESRD) services and pilot contracts in select VISNs for Project HERO (medical, surgical, and dental care), mental health services, and Project ARCH (Access Received Closer to Home) pilot program. Also, within VA Medical Centers, specific contracts do exist on a limited basis and they are developed, awarded and managed at the local level based on need. Approximately 30 percent of Non-VA Care (Fee) payments are covered under a contract or local agreement. VA facilities also issue individual authorizations, which serve as contracts once accepted by non-VA providers. The Project HERO pilot, while different than TRICARE, has some similarities to the broader model of contracting with larger networks of providers.

VA will be moving to a larger network model of contracts for health care services with awards anticipated in late calendar year 2012 and operations beginning in the mid-year 2013. These contracts utilize lessons learned from Project HERO and other pilot efforts and the effort is referred to as Patient-Centered Community Care (PCCC). This new effort seeks to connect VA with networks of providers across the country through centrally supported health care contracts. The contracts will leverage economies of scale to provide community-based care that is coordinated, timely and of high clinical quality. The requirements for the contract are in development

and are based on lessons learned from Project HERO and other Purchased Care pilot programs, such as:

- Standardize business processes;
- Require medical documentation return;
- Include timeliness and access standards to ensure best possible access to care;
- Ensure provider quality by requiring they meet credentialing, licensure and board certification standards; and
- Establish performance measures and objectives.

**Question 6:** In the past year the VA IG has uncovered instances of fraud in VA's beneficiary travel program. In essence, Veterans who lived only a few miles from a medical center claimed residences that were over 100 miles away, then obtained a travel reimbursement based on the fictitious residence.

1. What methods does VA have to guard against this kind of fraud? Are Veterans' addresses matched against other government records to ensure valid residences are reported?
2. What oversight is conducted on individual medical centers' beneficiary travel offices in terms of correct determinations being made regarding a Veteran's eligibility for travel reimbursement?
3. How much money is spent annually on VA's beneficiary travel program? How much is spent administering the program? Has any thought been given to consolidating the beneficiary travel function (similar to a CPAC model) to improve efficiency and promote consistent decision-making?

**Response:**

1. What methods does VA have to guard against this kind of fraud? Are Veterans' addresses matched against other government records to ensure valid residences are reported?

VA acknowledges that the Beneficiary Travel Program (BT) is a high risk area. Veterans in accordance with BT regulations at 38 Code of Federal Regulations (CFR) 70.30 (b) may receive travel benefits for travel from either their residence or other point travel initiated; however, payment cannot exceed the amount payable from the Veteran's residence. Also, current Health Insurance Portability and Accountability Act (HIPAA) laws provide for an individual to have a mailing address that does not reflect their residence. In addition, some rural residences do not have an established street address.

VA currently does not have address-matching capabilities with other Federal agencies. However, for reasons noted above, another agency's address on file may or may not reflect where the Veteran currently resides or initiated travel. Therefore, such matching could be of limited value. As such, when a questionable address is identified by the local VA Medical Center, program office guidance has been for the VA Medical Center, in accordance with 38 CFR 70.20 (e), to request from the Veteran a document, generally a utility bill, in his or her name indicating current residence. If the Veteran does not have such a document, a notarized letter from an individual where the Veteran is staying may be requested. VA is also exploring the use of web-based services which provide automated real time verification of residence. This may include use of HHS or SSA address verification tools.

In addition, VA released to the field in June 2011, a tool that provides the ability to analyze BT mileage reimbursement data at the facility or Network (VISN) level to determine: total and average cost per patient; total and average cost per zip code; different patient populations according to total number (count) of payments made and total amount paid (sum); total and average number of claims per clerks; and patient behavior and clinic usage trends. As such, stations can identify: clinic and patient population outliers by sum and count; total amount paid in mileage reimbursement within pre-determined parameters; how efficiently travel clerks are performing; geographic travel trends; and possible patient behavior trends. Feedback obtained from VHA field staff is that this tool has proven extremely beneficial in identifying potential BT issues for further evaluation and appropriate action by the using station. VA is also currently in the final production test of a "BT Dashboard" tool that will allow field stations to more effectively and efficiently process beneficiary travel claims. The tool will expedite claims process to reduce waiting time for patients and increase accuracy of mileage determinations through system-wide use of a standardized mileage calculator and creation of a detailed clinical inventory for surrounding facilities and VISNs.

2. What oversight is conducted on individual medical centers' beneficiary travel offices in terms of correct determinations being made regarding a Veteran's eligibility for travel reimbursement?

VA is currently in the final stages of implementing internal controls for the BT program by both descriptive/deductive and inductive modeling through 6 identified Veteran behaviors relating to BT reimbursement. Behaviors describe Veterans who:

1. "Unbundle" appointments by scheduling them on multiple days even though they could be scheduled on the same day; and drop-in for medical services without a scheduled appointment.
2. Provide incorrect income information, which may render them eligible for BT benefits irrespective of their service-connected (SC) rating; have a SC disability rating of less than 30 or have a non-service-connected (NSC) disability; and have an annual income higher than the VA pension level.
3. Frequently change their addresses in order to increase their BT payments.
4. Choose a VA facility for care that is further than the closest VA facility providing the same care; and Veterans receiving care at multiple facilities concurrently or sequentially; some of these Veterans may have been denied BT benefits at some of the facilities; moreover, the care sought may be similar at each facility.
5. Travel together (in the same vehicle) but file BT claims separately.
6. File for BT benefits for multiple visits occurring on the same day. Improper BT payments may occur when the time needed to travel roundtrip is longer than the time between the appointments.

Behaviors are to be run against national VA data and then distributed to VISNs on a monthly basis for review, action and reporting back to the program office to track, trend, and provide national level reports regarding results. Information will also assist the program office to identify potential deficiencies for review and take corrective action, if required. Development is anticipated to be completed by the end of January 2012 with first reporting expected in March 2012.

3. How much money is spent annually on VA's beneficiary travel program? How much is spent administering the program? Has any thought been given to consolidating the beneficiary travel function (similar to a CPAC model) to improve efficiency and promote consistent decision-making?

While BT is generally thought of as mileage reimbursement, Title 38 United States Code (U.S.C.), § 111, "Payments or allowances for beneficiary travel" as regulated in 38 CFR Part 70 authorizes VA to pay for special mode (ambulance, wheelchair, van, etc.) and common carrier (plane, bus, train, ferry, etc.) transportation of certain eligible Veterans and other beneficiaries. VA can provide or reimburse for the actual cost of bridge tolls, road tolls, tunnel tolls, parking, and in case of air transport luggage costs, when supported by a receipt. The actual cost for meals, lodging or both, not to exceed 50 percent of the amount allowed for government employees may also be provided in limited circumstances. As such, VA tracks costs via three cost centers which are:

- Inter-Facility Travel (Budget Object Code (BOC) 2112): Travel costs associated with the transfer of a patient from one facility to another when the transfer is necessary for the continuation of care. The transfer may occur between VA facilities, non-VA facilities or any combination as long as the treatment is at VA expense;
- Other than Mileage (BOC 2119): All beneficiary travel charges, except mileage. This includes special mode transport and certain eligible associated costs of travel: lodging, meals; and
- Mileage (BOC 2120): Mileage reimbursement and associated costs: road, bridge, tunnel tolls, parking.

Obligations for the past three Fiscal Years (FY) are:

Type	FY 2009 (000)	FY 2010 (000)	FY 2011 (000)
Inter-Facility	\$69,910	\$71,752	\$63,201
Other Than Mileage	\$244,275	\$242,045	\$276,803
Mileage	\$314,754	\$431,518	\$484,829
Total	\$628,939	\$745,315	\$824,833

VA has previously given consideration to consolidating certain aspects of the BT program; however, because of the eligibility requirements of the program, unique

clinic needs, physical layout of medical center and associated community based outpatient clinics and available resources at each facility (as well as unique local resources), program operations and functions are better suited for local implementation. VA, is however, currently evaluating several options to increase oversight, and this may lead to centralizing certain aspects of the BT program. The Chief Business Office has estimated FY 2012 administrative costs for managing the Beneficiary Travel program to be \$645,263. In addition, during FY 2012, the Chief Business Office expects to award an analytics support contract for BT program, at an estimated cost of \$624,000. Total FY 2012 administrative costs for the program office are estimated to be \$1,269,263. These figures do not include the costs incurred at VA health care facilities for administering the program.

**Question 7:** Do VA employees ever fly business class to conferences of other VA-sponsored travel destinations?

**Response:** Yes, but only on a very infrequent basis. The Federal Travel Regulations (FTR) and VA travel policy permit employees, under certain circumstances, to use business or first class "other-than-coach" (OTC) class travel with proper justification and approval. OTC travel is always to be the exception, and approval is strictly limited. VA recently tightened the authorization process for obtaining such approval. VA employees are required to exercise the same care in incurring expenses that any person would exercise if traveling on personal business and consider the least expensive class of travel that meets his or her needs. Authorization for OTC travel may be justified as a result of a traveler's medical condition, properly documented by a medical authority; a total flight time in excess of 14 hours (business class, but not first class); or other reason allowed under the FTR. Approved use of OTC travel entails authorization by the employee's direct supervisor, a senior approving official, the respective Under Secretary or Assistant Secretary, and VA's Chief Financial Officer. Otherwise, if OTC travel does not fall within one of the exceptions to the FTR, the only way an employee could fly OTC is using personal funds to pay for the upgrade.

**Question 8:** Please provide the Administration's position regarding whether VA programs are exempt from sequestration. Please provide the Office of General Counsel legal opinion/recommendation to the Office of Management and Budget regarding whether all VA-administered programs, including VA medical care, are exempt from sequestration.

**Response:** This issue remains under Administration legal review.

**Question 9:** In the November 14, 2011, IG report regarding VA retention incentives, Dr. Petzel committed to a 100 percent review of all SES/SES Equivalent retention incentives by November 30, 2011. Please provide the Committee with the results of that review.

**Response:** In September 2011, the Under Secretary for Health established a VHA Retention Incentive Technical Review Board (RITRB) to review all proposals for retention incentives for SES and SES Equivalent employees. All VHA entities were directed to review retention incentives currently in place and determine if all requirements were met for the retention incentives to be continued. If all criteria were not met, the retention incentives were to be terminated. Requests for continuation of retention incentives were to be submitted for RITRB review by October 31, 2011. The RITRB completed their review by November 30, 2011.

The RITRB reviewed all submissions and made recommendations. The Under Secretary for Health has also made his recommendations to the Department, which are now under consideration.

---

**Follow-up to Questions for the Record**  
**Chairman Jeff Miller**  
**House Committee on Veterans Affairs**  
**Potential Budgetary Savings within the U.S. Department of Veterans**  
**Affairs:**  
**Recommendations from the Veterans' Service Organizations**  
**November 15, 2011**

**Question:**

A question was asked to Mr. Grams at the Nov. 15 hearing regarding the date VA sent its legal review/recommendation to OMB on the sequestration issue. We still need VA's response to that question. Further, a request was made for the Com-

mittee to receive a copy of VA's review/recommendation. That request was repeated in Chairman Miller's post-hearing questions as part of question 8. That was not responded to as well.

Understanding that the broader question on sequestration is still under legal review (according to the responses to Mr. Miller's post hearing questions), we still await responses on the two issues above. Since Mr. Grams spoke of a review that had already been completed and submitted, I suspect letting the Committee know of its contents and date submitted shouldn't take any time at all.

**Response:**

The Administration continues to believe that balanced deficit reduction, not across-the-board sequestration, is the way to put the Nation on the path to fiscal stability.

The President's Budget includes a comprehensive and balanced deficit-reduction proposal. Congress should enact that proposal and then halt the sequestration scheduled to take place on January 2, 2013.

If Congress does not Act on the President's deficit-reduction proposals, the Administration will provide guidance on the implementation of the sequestration. It is committed to doing so well in advance of January 2, 2013, to facilitate orderly planning.

---

**Letter to Hon. Eric Shinseki, Secretary, U.S.  
Department of Veterans Affairs from Hon. Bob Filner,**

NOVEMBER 30, 2011

The Honorable Eric K. Shinseki  
Secretary  
U.S. Department of Veterans Affairs  
810 Vermont Avenue, NW  
Washington, DC 20420

Dear Mr. Secretary:

In reference to our full Committee hearing entitled, "Potential Budgetary Savings Within the U.S. Department of Veterans Affairs: Recommendations from Veterans' Service Organizations," that took place on November 15, 2011, I would appreciate it if you could answer the enclosed hearing questions by the close of business on January 11, 2012.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Carol Murray at [Carol.Murray@mail.house.gov](mailto:Carol.Murray@mail.house.gov), and fax your responses to Carol at 202-225-2034. If you have any questions, please call 202-225-9756.

Sincerely,

BOB FILNER  
*Ranking Democratic Member*

---

**Questions for the Record  
November 15, 2011**

***Questions for W. Todd Grams, U.S. Department of Veterans Affairs***

**Question 1:** Your written testimony states that VA is "instilling a culture throughout our system that pursues continuous improvement and empowers staff members to solve problems at the front line or at any point in the health care system." Please provide the Committee with the specific policies or procedures VA has implemented or issued, Since January 1, 2011, to achieve this change in culture. Which specific policies or procedures can you point to as being of primary importance in instituting this change? In what other ways are you "instilling" this culture?

**Question 2:** In February, Secretary Shinseki testified regarding the VA's reliance on "carryover" funding, or funding not obligated in the previous fiscal year. For

many years, a small portion of VA's medical care budget was provided in the form of 2-year authority to better enable the VA to manage its resources. Arguably, the need for 2-year authority for a portion of the VA's medical care budget is not as strong in the era of advance appropriations. The continued reliance of the VA on carryover funding may provide a perverse incentive at the local level not to obligate funds in order to provide VA Central Office with carryover funding to plug funding gaps in the next fiscal year. What specific steps has VA Central Office taken to negate this incentive? What specific steps has VA Central Office taken, and communicated to the VISN level, to ensure that funds are obligated when needed and on a timely basis?

**Question 3:** VAOIG audits and reports have identified hundreds of millions of dollars in potential savings through better management of VA programs. Please explain to the Committee why these savings and improvements were not identified by VA prior to being identified by VAOIG audits or reports. What specific steps has the VA taken to improve day-to-day internal management in order to proactively identify program deficiencies? Does VA feel confident that it is better able today to identify future problems?

**Question 4:** According to your testimony, earlier this year VA "conducted a pilot program that used standardized templates for purchasing care, ensured more consistent assessment of other VA options, and resulted in better control over management of the care [VA] purchased." What was the impetus behind starting this pilot program, and why wasn't this degree of standardization implemented in the past?

**Question 5:** VAOIG testified that improved management and oversight of the Fee Basis program offers the greatest opportunity for savings. VAOIG also states in testimony that the Fee program, still lacks fundamental controls. Please explain what VA is doing to tighten up the pre-authorization process and management controls? What has VA done proactively that will prevent the same mistakes happening in the future?

**Question 6:** VAOIG evaluated the Veterans Health Administration's controls to prevent and detect fraud. VHA had not identified fraud as a significant risk to the Fee Care Program. Health care industry experts have estimated that 3 to 10 percent of all claims involve fraud. What is your progress on the VAOIG's recommendations from the *Veterans Health Administration—Review of Fraud Management for the Non-VA Fee Care Program*, June 8, 2010 report that VA should establish a fraud management program with data analysis and high-risk payment reviews, system flags for suspicious payments, employee fraud awareness training, and fraud reporting?

**Question 7:** VSOs have raised concerns with the VA's practice of holding back medical care appropriations from being distributed to the field. Particularly they mention VA is currently holding back 1.5 percent of the advance appropriations for health care. Please explain the policy rationale for this practice.

**Question 8:** In testimony, the VAOIG listed several other areas for potential savings. One of these areas was the management of rural health initiatives. In FYs 2009 and 2010, the VAOIG reported that the Office of Rural Health (ORH) lacked reasonable assurance that its use of \$273 million of the \$533 million it received improved access and quality of care for veterans. Please provide the Committee with a progress report on the six recommendations listed by the VAOIG in the report *Veterans Health Administration—Audit of the Office of Rural Health* dated April 29, 2011

**Question 9:** According to a *New York Times* article dated September 12, 2011, entitled "Government Pays More in Contracts, Study Finds," a study, conducted by the Project on Government Oversight "found that in 33 of 35 occupations, the government actually paid billions of dollars more to hire contractors than it would have cost government employees to perform comparable services." In what areas is VA currently studying the differences in contracting costs comparable to providing services in house? In those areas where the VA has contracted out services in the past, has the VA undertaken any follow-up studies to ascertain if projected savings were indeed realized?

**Question 10:** It is our understanding that the Veterans Benefits Administration has recently awarded a contract to ACS, Inc. It is also our understanding that VBA is training this company on how to develop claims and that at some time next year, ACS employees will be charged with developing 190,000 claims. Please provide the Committee with details of the contract, including cost, and the policy rationale for contracting this function out.



**Question 11:** According to the National Academy of Public Administration's white paper entitled "Veterans Health Fee Care Program," dated September, 2011, "VA's Fee Care Program expenditures have grown 275 percent since [FY] 2005. There are now approximately 2400 Full Time Employees (FTEs) working in the program. Paid claims rose from \$3 billion in FY 2008 to \$4.4 billion in FY 2010 (46 percent increase), while the number of unique patients served increased from 820,000 to 952,000 (16%) in the same period. NAPA also reported that in "recent years, Fee Care has been increasingly used to meet patient wait-time standards. That is, when a medical service cannot be provided at a VA facility within wait-time performance standards, VA Medical Centers (VAMCs) often use the Fee Care Program.

Please detail why paid claims increased 46 percent while the number of unique patients served increased only 16 percent. How much of this 46 percent increase in paid claims is attributable to VA attempts to meet patient wait-time performance standards? Please provide the Committee with wait-time reports from FY 2008 to the present, and a detailed breakdown, by VISN, of Fee Care Program expenditures since FY 2008 and the amount expended, by VISN, since FY 2008 of Fee Care Program expenditures utilized to meet wait-time performance standards.

**Question 12:** The NAPA white paper recommended that substantial changes be made in the VA Fee Care Program and that a strategic change management plan be developed as quickly as possible. Does VA agree that substantial changes should be made in the Fee Care Program? Is the VA developing, or planning on developing, a strategic change management plan? What is the specific timetable for changes that have been identified as needed in the Fee Care Program to be implemented?

**Question 13:** The NAPA white paper states that "[g]iven the significant organizational and productivity challenges within the Fee Care Program, VHA has a limited understanding of the services it is procuring through its program and their cost. The Fee Care Program does not appear to have been well managed at any level of VA. VHA provides limited VISN-wide executive oversight of its purchased care program, and the program lacks clearly defined operational objectives or goals, and it is not guided by a coherent strategy for managing program expenditures." Does VA believe the Fee Care Program has been well managed? Does VA believe that there is sufficient level of VISN-wide executive oversight? Does VA believe that the Fee Care Program has clearly defined operational objectives and goals and a coherent strategy for managing program expenditures?

**Question 14:** The NAPA white paper states that the "Chief Business Office estimates the error rates (that is, erroneous payments) at 12 percent per year, which equates to approximately \$500 million in FY 2011. By contrast, TRICARE has a reported error rate of 0.42 percent. Productivity varies across operating sites by nearly ten folds between the most and least efficient sites [footnotes omitted]." Please provide a detailed explanation to the Committee as to why the VA experiences such a high error rate compared to TRICARE and why there is a divergence across the VA system in the level of error rates. What policies or procedures are currently in place, or have been in place previously, that contribute to this high error rate and divergence, and what specific policy and procedural steps is the VA taking to address this high error rate and divergence?

**Question 15:** During the hearing, VA stated that it was going to roll-out Project HERO nationwide. What are the detailed policy rationales behind implementing this program nationwide? Please provide the Committee with a detailed plan on the proposed nationwide roll-out including detailed time frames, benchmarks, and costs associated with the roll-out. In addition, please provide the Committee with any detailed cost studies that have been prepared estimating any cost-savings, by VISN, that VA will achieve with Project HERO. If VA has not prepared detailed cost estimates, please provide the Committee with estimates regarding these proposed savings.

**Questions for the Record**  
**Ranking Democratic Member Bob Filner**  
**House Committee on Veterans Affairs**  
**Potential Budgetary Savings within the**  
**U.S. Department of Veterans Affairs:**  
**Recommendations from the Veterans' Service Organizations**  
**November 15, 2011**

**Question 1:** Your written testimony states that VA is “instilling a culture throughout our system that pursues continuous improvement and empowers staff members to solve problems at the front line or at any point in the health care system.” Please provide the Committee with the specific policies or procedures VA has implemented or issued, since January 1, 2011, to achieve this change in culture. Which specific policies or procedures can you point to as being of primary importance in instituting this change? In what other ways are you “instilling” this culture?

**Response:** The creation and nurturing of a culture of continuous improvement and organizational learning is a multifaceted organizational imperative in health care. The Veterans Health Administration (VHA) understands that drivers of sustained change include the organizational impetus to change over time, leadership commitment and support of the change, improvement initiatives that actively engage staff in meaningful problem solving, alignment from the top to bottom to achieve consistency of organizational-wide goals with resource allocation and actions, and integration to bridge traditional intra-organizational boundaries between individual components.

VHA is moving forward with a variety of organizational initiatives and training efforts to influence culture in a way to harness its power to speed the capacity for the provision of safe, high quality care characterized by continuous improvement and learning. VHA's Offices of Quality, Safety, and Value (QSV), Workforce Services, Office of Patient Centered Care & Cultural Transformation, and Nursing Services are key partners in these efforts. The functions and activities of all of these offices are fundamental to the success of efforts to facilitate cultural transformation as these functions draw upon the belief that culture is related to organizational performance.

*Quality, Safety, and Value*

VHA has had a long history of commitment to, and development of a culture of safety through the establishment of the National Center for Patient Safety (NCPS) in 1999. This culture of safety provides the foundation of improvement and learning. Over the years since NCPS was established, and with the support of VHA, the elements of a culture of safety have been developed and expanded. These include the following:

- *Just Culture*—a just culture is the lynchpin of any safety culture and is one in which human error is recognized as an inevitable product of highly complex processes. With the 2011 establishment of the Office of QSV, VHA has clearly re-committed to the continued support and expansion of the just culture.
- *Understand Complexity*—human error occurs because of the complex environment in which individuals operate. To improve the safety of this environment, a deep understanding of why errors occur must be developed so that improved systems may be created. Because people have difficulty discussing the errors they make, it is imperative for a *just culture* to exist so that people may admit to, and discuss, the errors they have made without fear of retribution. Only with such a culture may health care professionals and staff completely understand the systems issues that lead to medical errors. VHA leadership has fully supported NCPS in developing and training VA staff and leadership in the concepts of a *just culture* and this has helped improve the willingness of front line providers to report errors when they see them. NCPS conducts a Safety Culture Survey to track perceptions of patient safety at the facility and Veterans Integrated Service Network (VISN) level over time.
- *High Functioning Teams*—because of the inherent complexity of medical systems, it is difficult for even the most intelligent and diligent individual to catch all possible failures that may occur. Highly functioning teams are imperative to improve patient outcomes. To this end, VHA strongly supported NCPS in the development of programs to enhance team performance. Medical Team Training (MTT) focuses on enhancing the performance of teams in high risk areas such as intensive care units (ICU), operating rooms, and emergency departments.

The face-to-face training sessions have been running since 2005 and help develop the skills that improve team functioning. In 2011, the program was expanded to other areas of VHA where well defined teams must interact together such as dental, podiatry, and orthopedic clinics. The training results in improved safety attitudes, higher morale, and reduced staff turnover. A key outcome of VHA's training has been reductions in risk-adjusted surgical mortality rates (VA's findings were published in JAMA 2010; 304 (15); 1693). Another team program, Clinical Crew Resource Management (CCRM) has recently been added to focus on the more informal teams that interact at the ward level. This training focuses on the empowerment of the multidisciplinary front line staff that come together to care for patients at the ward level. Over 800 people have been trained since the pilot in 2010 and as of 2011 the program will be introduced in an additional 5–7 sites. Results pre- and post-training note improved average teamwork scores as well as improvement in the error reporting culture. This strongly suggests that people feel more comfortable in discussing errors when a *just culture* exists. This training has also resulted in reductions of unit acquired pressure ulcers, medication errors per patient day, hyper- and hypoglycemic events, and failure to rescue.

- *Engaged Leadership*—as part of any team training that a facility undertakes there must be leadership support and engagement. NCPS ensures that facility leadership understands that for a culture of safety to be fully developed leadership must engage in walk rounds so that they may hear about safety and quality concerns from front line providers and show them that their concerns have been heard. VHA leadership has supported such training and with the 2011 reorganization has specifically created an arm within VHA that focuses on QSV—concepts of teamwork and leadership have been reinforced in vision and mission of the new Office of QSV.

Additional initiatives focusing on a culture of safety and continuous improvement include:

- Select executive leadership teams have participated in a variety of site visits to non-Department of Veterans Affairs (VA) health care entities. These medical organizations (Virginia Mason, ThedaCare, Henry Ford, Baptist Health care, Barnes-Jewish, et al.) have been nationally recognized for successfully navigating change management and commitment to knowledge sharing. Eight Veterans Integrated Service Networks (VISNs) have participated, and site visits will continue to all remaining Networks.
- In support of VA's transformational initiatives, senior leaders from all VISNs are participating in customized *Leading Organizational Improvement* workshops. These workshops include an organizational assessment of the existing leadership structure and function, and then combine didactic training with real-time strategic planning to facilitate cultural transformation towards a culture of continuous improvement. To date, 10 of 21 VISNs have completed the workshop. More than 90 percent of the FY 2011 workshop participants rated the materials, instruction, and exercises as "Good to Excellent."
- In July 2011, VHA leaders participated in a conference entitled "VHA Culture of Improvement" to thoughtfully develop action plans to help change the culture.
- The *Enhancing a Culture of Continuous Improvement Guidebook* will be piloted in early 2012 with plans for widespread deployment later that same year. VHA's Systems Redesign function within the QSV Office is developing the guidebook with the assistance of a multidisciplinary committee of field-based and national experts (Systems Redesign Leadership Committee). The guidebook focuses on how to change organizational culture to foster a culture of continuous improvement.
- Approximately 25 hospital teams per year participate in training academies in order to learn and apply systems redesign and operations management techniques to leadership-identified strategic priorities. Academy sessions focus on outpatient access, inpatient flow, and systems redesign methodologies that include the application of systems engineering principles.
- Veteran Engineering Resource Centers conduct Rapid Process Improvement Workshops (RPIWs), which enable facility-based teams to apply improvement principles to real projects. More than 300 staff attended RPIWs in FY 2011.
- VHA continues to use Learning Collaboratives to engage and train facility based teams in achieving patient-centered, continuously improving, team-based care in a data driven health care delivery organization.
- Patient Aligned Care Teams (PACT) improved access, care coordination, and re-designed practices;

- The Human Resources (H.R.) Recruitment Community of Practice initiative built upon the FY 2008–FY 2009 H.R. Recruitment Collaborative to continue support, training, and sharing of information and strong practices in improving recruitment and hiring of skilled health care workers;
- The FIX/Flow Collaborative is transforming inpatient ward care and building cohesive care teams through innovative improvements in quality, safety, nurse and physician communication, and work efficiencies;
- The Patient Flow Collaborative focuses on management of hospital flow, communications, and coordination, and incorporation of the deployment of the electronic bed management system within VA medical centers.
- The Transitioning Levels of Care Collaborative improved and smoothed the transitions of patients between levels of care. The main focus was on movement from acute care to lesser acuity settings such as home, long term care, etc.
- Ensuring Correct Surgery (ECS) continues to be offered to facility teams. This training program was developed in 2011 in collaboration with Surgical Service and resulted in a series of virtual training modules available to all operating room/procedure area staff. While this training is still new, VISN leadership in surgery and anesthesia have all been trained in this high-risk area.
- QSV is aggressively pursuing implementation of the International Standards Organization (ISO) 9001 quality standards. ISO 9001 is the preeminent international standard for quality management systems that ensure reliable delivery of services and products. These standards are created, updated, and sustained through the International Organization for Standardization (ISO). Starting with the reprocessing of reusable medical equipment, VHA is one of the few health care organizations bringing non-health care industry rigor and discipline to the execution of scope cleaning processes.
- VHA is successfully changing the culture in primary care practices to include patient-centered, team-based primary care. PACT aims to improve patient access to appointments with health care providers, enhance access to providers through the telephone, secure messaging, group visits and home telehealth, and engage patients more aggressively in care for chronic disease to keep more patients out of the emergency department and hospital.
- The Office of QSV is leading the revision of VHA's "Framework for Excellence" overarching policy on quality functions.

VHA partners with the Office of Inspector General (OIG) on numerous actions that result in reported change and continual improvement. Specifically, OIG has verified organizational improvement for more effective operations in areas specific to procurement; improvement in how the Workers Compensation Program is managed and monitored to maximize savings and efficiencies; implementation of significant controls over the payment of executive retention incentives; and reduction in the number of improper payments with new monitoring processes involving VHA Finance.

#### *Workforce Services*

VHA's Office of Workforce Services is another fundamental component of instilling a culture of continuous improvement and empowering staff to solve problems in the health care system. The primary function of Workforce Services is managing and developing human capital, supporting organizational health, and transforming VA into a learning organization. Achievements in 2011 encompass four core themes: improved recruitment and appointment processes, transformation and system redesign, ensuring a sense of workplace psychological safety and engagement, and development of the future clinical workforce.

Recruitment and appointment processes:

- In FY 2011, VA implemented a new WebHR system in response to enterprise-wide assessment and modernization of processes and systems to enhance recruitment, management, and retention of VA's 300,000-person workforce and to support VA's human capital investment. The WebHR application has been identified as foundational in VA's overall human capital management systems modernization initiative by providing a singular point of automatic document creation. WebHR provides a starting point, via the information contained in the SF-52, for many key H.R. functions. WebHR and the Form SF-52 are common to all VA H.R. components, with the result of centralizing and facilitating management of information across VA for applicants, trainees (including affiliates), and employees.
- The Under Secretary for Health granted authority to VISN Directors to approve leadership positions prior to review by the Leadership Management & Succession Board (LMSB). This new process has accelerated the selection and place-

ment of Executive Career Field senior leadership positions at Medical Centers throughout VHA.

- Professional clinical recruiters were hired and placed in each VISN to engage local H.R. staff and clinical hiring managers in a concerted effort to resolve long-term staffing issues. Over 1,700 qualified candidates were referred, and over 350 selections were made in the past 18 months.

Transformation and system redesign:

- VHA is transforming to provide health care excellence for the 21st century, and in doing so, more than 30 percent of the programs, products, and services delivered in FY 2011 were related to transformational initiatives.
- Employee Education Service (EES) manages the clinical training needs of fifteen major VHA health care transformational initiatives. For example, in FY 2011, EES conducted 132 Center of Excellence trainings resulting in PACT education of 8,087 participants.
- A strategic partnership with VHA's Office of QSV to implement critical organizational improvement initiatives was developed. As detailed above, these initiatives included improving access to care, improving inpatient flow, and implementation of PACT.
- Significant training has been provided to VHA leadership on improvement principles and how to create a culture of improvement throughout the organization.

Psychological safety and engagement in the workplace:

- VHA offers on-site executive coaching expertise to current and developing leaders within the organization, including the creation of personal development plans, and offers on-site consultation and assistance. In 2010, the National Center for Organizational Development (NCOD) provided executive coaching to 630 VA clients. In 2011, NCOD provided one-time executive coaching to 223 VA clients and ongoing executive coaching to 116 VA clients.
- Civility, Respect, and Engagement in the Workplace (CREW) was initiated in 2005. As of 2011, over 1,000 workgroups at 109 VA Medical Centers have participated in CREW. Each cohort of CREW has reported statistically significant improvements in civility as a result of the CREW intervention. CREW is now available to Veterans Benefits Administration (VBA), National Cemeteries Administration (NCA), and VA Central Office (VACO) staff as a Human Capital Investment Plan initiative.
- The VA All Employee Survey (AES) has been administered annually to all VHA employees from 2006. In 2010, the AES was expanded to all VA employees across all VA administrations (VACO, VHA, VBA, and NCA).
- In FY 2010, NCOD provided 360-Degree Assessment reports to 1,800 VA employees, including 560 VA executives, and provided 180-Degree Assessment reports to 1,000 VA employees. In FY 2011, it is projected that NCOD will provide 360-Degree Assessment reports to 1,500 VA employees, the Executive 360-Degree Assessment reports to 550 VA employees, and the 180-Degree Assessment reports to 900 VA employees.
- In 2011, NCOD provided ongoing, intensive consultation services to 67 VA organizations (including VISN offices, Medical Centers, VA program offices, VBA, and NCA). Additionally, NCOD experts provided focused, one-time consultative services to 106 VA organizations (including VISN offices, Medical Centers, VA program offices, VBA, and NCA).
- In FY 2011, VHA developed an executive team model to support the provision of services that are Veteran-centric, evidence-based, and delivered by engaged, effective, collaborative teams in an integrated environment that supports learning, discovery, and continuous improvement. To date, a total of 162 executive teams, including 704 executives from medical centers and network offices in the field, have completed a new Executive Team Assessment. The Executive Team Assessment is currently being administered to all executive teams in VHA Central Office.

Development of the future clinical workforce:

- One of the primary missions of VA is to have the leadership in place today to lead us into the future. But it is equally important to educate health care professional trainees for practice in the 21st century health care workplace.
- In FY 2011, VHA stood up five Centers of Excellence in primary care education with the goal of transforming care delivery and the education of VA's future clinical workforce.

- In FY 2011, VA also expanded the size of the Chief Residents in Quality and Safety program, which is designed to introduce the foundational principles of patient safety and quality improvement to medical residents.

#### *Nursing Services*

The Office of Nursing Services (ONS) is implementing the Clinical Nurse Leader role (CNL), a new master's prepared general RN provider at the point of care. The CNL will coordinate and deliver complex clinical care; improve clinical and cost outcomes, and provide continuous quality and safety improvements at the Micro-systems level; translate and apply research findings at the point of care; and enhance staff competence and empowerment to solve problems at the front line. Since 2009, VHA has demonstrated significant positive CNL outcomes related to quality, safety, value, cost savings, cost avoidance and innovative clinical practice. CNL practice aligns with both the Patient Aligned Care Team and Specialty Care Transformation, thereby creating an efficient, transparent, and collaborative health care environment. As of December 2011, ONS has made significant progress implementing the CNL role throughout the entire VA health care system.

#### *The Office of Patient Centered Care & Cultural Transformation*

The Office of Patient Centered Care & Cultural Transformation was created in January 2011. A vision, strategy, and implementation plan has been formulated, and many presentations have taken place at all levels of our system (National Leadership Council, VISN, Medical Center, program offices) to communicate this plan and engage the organization. Nine Centers of Innovation have been identified and established to pilot new models of care and approaches to enrich the Veteran's experience. Since August 2011, Field Based Implementation Team members have been hired and are undergoing intensive training. As a result, the Office has a framework and strategic plan established to implement this significant cultural transformation.

#### *Health Equity*

Following a multidisciplinary work group meeting in August, 2011, the Under Secretary for Health committed to support for a new initiative to champion the advancement of health equity and reduction of health disparities for our Veterans. This initiative will position VHA as a national leader in achieving equity in health care and outcomes among disadvantaged patient populations and lead efforts to address health disparities by promoting and providing education/training, communications and information to Veterans and our workforce. VHA will coordinate programs, projects and other activities to bring synergy within the organization. Representatives from the work group will represent VA and VHA to serve as liaison to other governmental and non-governmental organizations working to achieve health equity. They will capitalize on the existing network of Minority Veteran Coordinators, Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Coordinators, Women Veterans Program Managers, Homeless Veterans Coordinators, Center for Faith-based and Neighborhood Partnerships, Office of Rural Health, Office of Diversity and Inclusion, Office of Patient-Centered Care and Cultural Transformation and other key partners to coordinate efforts to advance health equity.

This initiative will be implemented using the framework provided in the National Stakeholder Strategy for Achieving Health Equity, using five VHA goals for a Veteran-centric approach. These goals include:

- *Leadership*—Strengthen and broaden the ability of VA leadership to address health inequalities and reduce health disparities through operations, policy oversight and research.
- *Awareness*—Increase awareness of the significance of health inequalities and disparities, their impact on the Nation and the actions necessary within VHA to improve health care and health outcomes for disadvantaged populations.
- *Health Outcomes*—Improve health and health care outcomes for Veteran sub-populations experiencing health disparities.
- *Diversity and Cultural Competency of the Workforce*—Improve cultural and linguistic competency and the diversity of the VA workforce involved in advancing the health and well-being of Veterans.
- *Data, Research and Evaluation*—Improve the availability, coordination and utilization of data and the diffusion of research and evaluation outcomes in order to track progress towards the achievement of health equity.

**Question 2:** In February, Secretary Shinseki testified regarding the VA's reliance on "carryover" funding, or funding not obligated in the previous fiscal year. For many years, a small portion of VA's medical care budget was provided in the form of 2-year authority to better enable the VA to manage its resources. Arguably, the need for 2-year authority for a portion of the VA's medical care budget is not as strong in the area of advance appropriations. The continued reliance of the VA on carryover funding may provide a perverse incentive at the local level not to obligate funds in order to provide VA Central Office with carryover funding to plug funding gaps in the next fiscal year. What specific steps has VA Central Office taken to negate this incentive? What specific steps has VA Central Office taken, and communicated to the VISN level, to ensure that funds are obligated when needed and on a timely basis?

**Response:** The Department of Veterans Affairs (VA) Central Office allocates all available funds, including funds carried over from the previous fiscal year, at the beginning of each year. The exception is a small National Reserve that is used to fund emerging requirements during the fiscal year.

In previous years, Congress has provided a small portion of each VA Medical Care appropriation (Medical Services, Medical Support and Compliance, and Medical Facilities) as being available for two fiscal years. This has allowed VA to accommodate unanticipated delays in implementation of new programs, acquisition delays, activation of new facilities that have experienced construction delays, and other activities that have crossed fiscal years. This has enabled VA to ensure that the funds appropriated by Congress are used for purposes that best enhance health care for Veterans, rather than for items that can be obligated by the end of the current fiscal year.

In Fiscal Year 2011, VA implemented a new resource allocation process called the VA Medical Center Allocation System that includes a standardized model for VISNs to use in allocating funding to their medical facilities. The model was designed to provide consistency in the allocation process across VISNs but still allow necessary flexibility to make adjustments to medical facility allocations.

**Question 3:** VAOIG audits and reports have identified hundreds of millions of dollars in potential savings through better management of VA programs. Please explain to the Committee why these savings and improvements were not identified by VA prior to being identified by VAOIG audits or reports. What specific steps has the VA taken to improve day-to-day internal management in order to proactively identify program deficiencies? Does VA feel confident that it is better able today to identify future problems?

**Response:** VA is committed to mitigating risk, ensuring compliance, and improving the identification of program deficiencies. While an Office of the Inspector General (OIG) review may identify issues that are not already being addressed by program offices and leadership, many issues identified in these reports are those that the Department has already begun to address prior to the review.<sup>1</sup>

VA action plans to address OIG recommendations and findings often indicate efforts that VA has proactively taken to address self-identified concerns. A good example is the recent response to the OIG Report "Audit of Veterans Integrated Service Network Contracts" that noted a number of actions VHA had already taken to address concerns such as:

- creation and implementation of the Acquisition Quality Compliance Audit Program;
- creation of Quality Assurance (QA) positions at the Network Contracting Activity (NCA), Service Area Office (SAO) and National levels; and
- implementation of a Responsibility Determination Standard Operation Procedures (SOP).

<sup>1</sup>For example, the VHA response to the OIG report "Review of Sole-Source Contracts with Affiliated Institutions" indicated:

It is important to note that the Veterans Health Administration has within the last year, after also identifying significant concerns about health care contracting and spending with affiliates for health care services, taken aggressive action to address these issues. Steps include:

- Bolstering leadership and employment in the Medical Sharing Office;
- Instituting new processes and procedures for tracking this health care contracting and spending;
- Improving training;
- Beginning to develop updated standard operating procedures for acquisition planning, establishment of backup plans for alternate sources for services, additional scrutiny of sole source justifications, and implementation of new checklist processes.

Also, OIG reviews often help to accelerate those processes that have already begun. Throughout this review, VHA was able to identify how VHA had already identified areas for improvement and solutions that were underway. In a collaborative effort, the OIG auditors advised VHA officials about their views of what VHA was doing or planned to do. In the end, the solutions were improved.

The recent establishment of the Office of QSV is a proactive way to identify and address concerns sooner, rather than later. QSV enhances the quality, safety, reliability, and value of VHA's clinical and business systems by enabling innovative, enterprise-wide approaches to compliance, risk awareness, and continuous improvement. QSV is currently implementing educational and consultative resources for the deployment of the ISO 9001 Quality Management System standard. The deployment provides a framework in which VHA may implement and sustain consistent quality management systems.

VA must also continue its efforts to identify efficiencies, seek improvement, and strengthen day-to-day internal management in order to proactively identify program deficiencies. To this end, several steps have been initiated. VA recently engaged a system-wide review of existing programs, structures, and skill sets that support the development of an Enterprise Risk system. Building upon the background research provided from this overview, the Under Secretary for Health asked the Office of QSV to introduce the concept of Enterprise Risk Management (ERM) to VHA leadership. Following this introduction, QSV has been further educating VHA leadership on the ERM concepts. The education process will be followed by a roll-out of the operational details that may help guide implementation of ERM at the VISN and hospital levels.

ERM is broadly understood to be a practice that helps organizations understand their risks so as to better identify, analyze, mitigate, monitor, and evaluate those risks. Thus, the benefits of ERM include more effective strategic planning and understanding of risk exposures. ERM represents an opportunity for VHA to begin to better manage risks across the organizational structure and function, rather than within an individual office or facility. While ERM is in the early roll-out phase in VHA, it has been well received by much of the VISN leadership, and interest in how such the ERM process will work across the VISNs has been high.

As is the case with VHA, VBA officials work closely with the Office of Inspector General and value its critical role and diligence in helping to meet that commitment to mitigate risk, ensure compliance, and improve the identification of program deficiencies.

VBA partners with OIG through all phases of its audits. OIG reports identify specific areas in need of process and/or systemic improvements, as well as compliance issues. At the regional office level, the OIG Benefits Inspection reports identify compliance issues and important areas where additional training is needed.

Often, issues identified in OIG reports are already in the process of being addressed by VBA program offices. The OIG reviews also have the benefit of looking at the administration of our programs retroactively. For all reports, VBA provides action plans addressing OIG recommendations and quarterly status updates for OIG validation and ultimate closure. Each VBA business line performs regular site visits to regional offices to review compliance with policy and procedures as well as to provide assistance and training where necessary.

VBA's ongoing transformation efforts also focus on improving decision quality, mitigating risk, and strengthening day-to-day internal management. For example, VBA has developed rules-based calculators for automated adjudication. Calculators will guide decision makers through the process with intelligent algorithms similar to tax-preparation software. VBA has also started to use new evidence-gathering tools, known as Disability Benefits Questionnaires, which allow us to bring new consistency to the collection of medical information needed for claims decisions. Additionally, local Quality Review Teams are being implemented to conduct "in-process" quality checks as well as regular end-of-month reviews. Throughout our change management efforts, we will identify risks up front and build in necessary controls and procedures to avoid potential deficiencies. Proactive risk management, recurring quality reviews, and compliance inspections will enable VBA to avoid potential program deficiencies.

VA is committed to building compliance and risk management into every process, policy, and procedure before implementation. We must identify risks and ensure compliance proactively, not rely on inspections after something is implemented. Inspections have a role, and we need to review lessons learned and then retool what we are doing when we do identify an ongoing concern. By ensuring enterprise risk management, building in compliance, and appropriately inspecting and measuring success, VA can and will be a system of continuous improvement.



**Question 4:** According to your testimony, earlier this year VA “conducted a pilot program that used standardized templates for purchasing care, ensured more consistent assessment of other VA options, and resulted in better control over management of the care [VA] purchased.” What was the impetus behind starting this pilot program, and why wasn’t this degree of standardization implemented in the past?

**Response:** The Non-VA Care Coordination (NVCC) initiative was established in October 2010 in response to findings from the Managing Variation Workgroup which identified organizational weaknesses and variations in both business and clinical areas. Non-VA Care was identified as one of several focus areas and included in the Health Care Efficiency Transformational Initiative. The Non-VA Care Coordination model was developed to reduce and/or eliminate variations and inefficiencies among Fee programs nationally. Prior efforts to standardize the program focused on back-end claims processing. This 2010 effort was a natural progression of the many programmatic changes previously underway for improving this program.

The pilot resulted in positive improvements in business processes, including improved controls in the timeliness of initial approvals for Non-VA Care, appointments for these services, and return of clinical information. Examples include improving initial approvals for Non-VA Care within 4 days, appointments made within 8 days and return of clinical information within 20 days.

Due to these positive results, VHA has initiated deployment of these standardized business practices in FY 2012. Deployment has been completed at the champion sites in VISNs 11, 18 and 16. Deployment will continue at all sites with completion prior to the end of FY 2012.

**Question 5:** VAOIG testified that improved management and oversight of the Fee Basis program offers the greatest opportunity for savings. VAOIG also states in testimony that the Fee program still lacks fundamental controls. Please explain what VA is doing to tighten up the pre-authorization process and management controls. What has VA done proactively that will prevent the same mistakes happening in the future?

**Response:** The objective of the national deployment of the Non-VA Care Coordination initiative is to establish standardized business processes and tools within all Fee programs across VA, with a strong focus on the pre-authorization process. A primary goal is to reduce or eliminate program variations and inefficiencies, thereby providing consistent and equitable delivery of Fee services to eligible Veterans. These changes will provide much greater management controls over this key programmatic component. This will be accomplished by facilitating and coordinating the Veteran’s Fee care, and following up by ensuring care was rendered and supporting documentation is returned to VA, and appropriate follow-up is scheduled that returns the Veteran to VA health care. VA is currently deploying this initiative across all Veterans Integrated Service Networks (VISNs), with full implementation expected prior to the end of FY 2012. These significant efforts to standardize the program will provide VA with more stringent controls over the entire program scope.

**Question 6:** VAOIG evaluated the Veterans Health Administration’s controls to prevent and detect fraud. VA had not identified fraud as a significant risk to the Fee Care Program. Health care industry experts have estimated that 3 to 10 percent of all claims involve fraud. What is your progress on the VAOIG’s recommendation from the Veterans Health Administration—Review of Fraud Management for the Non-VA Fee Care Program, June 8, 2010 report that VA should establish a fraud management program with data analysis and high-risk payment reviews, system flags for suspicious payments, employee fraud awareness training, and fraud reporting?

**Response:** VA has implemented an aggressive Fraud/Waste/Abuse (FWA) Program with specific awareness and training efforts accomplished in FY 2011. Within VHA’s Chief Business Office, this new FWA Program works with all stakeholders to identify and mitigate health care fraud, waste and abuse, provide training, research fraud cases, and assist in the development of process solutions to prevent and recover all improper payments. The program provides detailed fraud, waste, and abuse training to all Purchased Care personnel, VA Compliance Business Integrity staff, and other VA stakeholders. Prevention strategies include publications, VA and Medicare conferences, numerous training opportunities, employee orientation, and national conference calls. In addition, VA has developed routine monthly reporting that provides detailed information on potential FWA cases to each facility for review; if payment errors are validated, these results are included in the quarterly High Dollar Overpayment report to the Office of Management and Budget (OMB).

Finally, VA has a contract with IBM to implement a “state-of-the-art” Program Integrity Tool, which will evaluate medical claims data and provide pre-payment notifications to aggressively monitor improper payments. This is a significant improvement and will eliminate the need for “pay and chase” activities and identify providers that engage in fraud, waste, and abuse. VA anticipates implementing these tools by the end of 2012.

**Question 7:** VSOs have raised concerns with the VA’s practice of holding back medical care appropriations from being distributed to the field. Particularly they mention VA is currently holding back 1.5 percent of the advance appropriations for health care. Please explain the policy rationale for this practice.

**Response:** The Veterans Equitable Resource Allocation (VERA) methodology is used by VA Central Office to fund each of VA’s 21 Veterans Integrated Service Networks (VISNs). VERA does not allocate funds to the medical centers. VERA ensures that the funds are equitably distributed based on the number of Veterans who use the health care system. Its objectives are to provide health care to the greatest number of Veterans having the highest priority for health care, and provide for special health care needs. VERA makes adjustments for VISN variances in the case-mix/complexity of care provided, labor and contract costs, research support, education support, equipment, non-recurring maintenance (NRM), and high-cost patients.

In Fiscal Year 2011, VA implemented a new resource allocation process called the VA Medical Center Allocation System that includes a standardized model for VISNs to use in allocating funding to their medical facilities. The model was designed to provide consistency in the allocation process across VISNs but still allow necessary flexibility to make adjustments to medical facility allocations.

VISNs retain some resources allocated to them by VERA for centrally managed VISN activities and initiatives and for ensuring that medical facilities meet their mission requirements. This includes, but is not limited to, start-up costs for new VISN initiatives to reduce non-VA care costs; the funding of consolidation of services shared across the Network; and up to a maximum of 1.5 percent of the total allocation amount for a contingency reserve. The contingency reserve is used for unanticipated medical facility costs, such as increased patient workload for a non-declared natural disaster or high-cost non-VA care patients, and is normally all allocated to the medical facilities during the course of the year to provide health care services to Veterans.

**Question 8:** In testimony, the VAOIG listed several other areas for potential savings. One of these areas was the management of rural health initiatives. In FYs 2009 and 2010, the VAOIG reported that the Office of Rural Health (ORH) lacked reasonable assurance that its use of \$273 million of the \$533 million it received improved access and quality of care for Veterans. Please provide the Committee with a progress report on the six recommendations listed by the VAOIG in the report *Veterans Health Administration—Audit of the Office of Rural Health* dated April 29, 2011.

**Response:** VA’s Office of Rural Health (ORH) successfully completed the six recommendations listed by the VAOIG in the report *Veterans Health Administration—Audit of the Office of Rural Health* (ORH) dated April 29, 2011. ORH developed and deployed a robust set of financial and program controls and measures to monitor continuously and trend ORH performance and outcomes. These measures are evaluated proactively to ensure effective and efficient operations, cost savings and positive health care outcomes for Veterans served in rural and highly rural areas. Please see Attachment 1—the ORH report to the Appropriations Committees, dated November 17, 2011, which provides a status update of all six VAOIG recommendations.

**Question 9:** According to a *New York Times* article dated September 12, 2011, entitled “Government Pays More in Contracts, Study Finds,” a study, conducted by the Project on Government Oversight “found that in 33 of 35 occupations, the government actually paid billions of dollars more to hire contractors than it would have cost government employees to perform comparable services.” In what areas is VA currently studying the differences in contracting costs comparable to providing services in house? In those areas where the VA has contracted out services in the past, has the VA undertaken any follow-up studies to ascertain if projected savings were indeed realized?

**Response:**

1. In what areas is VA currently studying the differences in contracting costs comparable to providing services in-house?

The Consolidated Appropriations Act of 2010 required civilian Federal agencies to complete an annual inventory of their service contracts for review and analyze that information to understand how contracted services are being used and whether contractors are being used in an appropriate manner. In compliance with this Act, VA submitted its fiscal year (FY) 2010 annual service contract inventory to the Office of Management and Budget (OMB) in December 2010.

VA is actively participating in the government-wide OMB led effort to “buy less” and “buy smarter.” Toward this end, VA is actively working on several initiatives to improve acquisition practices and avoid inefficiency and waste. These initiatives are as follows:

- *Reduction of High Risk Contracts:* OMB challenged agencies to reduce the use of contracts which, if not managed appropriately, can result in excessive cost increases to the government. Contracts considered high risk are sole source, competitive one bid, cost reimbursement, and Time and Material/Labor hours. Since FY 2010, VA has been able to reduce contracting in each high risk category.
  - *Review of Management Service Contracts:* OMB noted a government-wide increase in the use of service contracts over the past decade. Of particular concern is the use of professional and management services contracts. These functions were identified by OMB for heightened management consideration, based on concerns of increased risk of losing control of mission and operations. VA is currently conducting an extensive review of the need for all management service contracts.
  - In July 2009, the VA Office of Human Resources and Administration in conjunction with the Office of Information and Technology (OI&T) conducted a pilot study in accordance with OMB memorandum M-09-26, *Managing the Multi-sector Workforce*, which required all agencies to develop a pilot study on insourcing. OI&T was selected for the pilot due to the high ratio of contractors to Federal employees and their interest in changing the ratio. This study found that the average salary for contractors was 29 percent more expensive than the Federal employee. As a result of the study OI&T was able to transition 9 contracting positions to government FTE.
2. In those areas where VA has contracted out services in the past, has VA undertaken any follow-up studies to ascertain if projected savings were indeed realized? Yes. However, VA has not converted any functions from in-house to contract via a standard or streamlined A-76 study since 2003 when the Veterans Benefits Administration converted their property management function from in-house to contract under an A-76 “standard competition,” due to a legal prohibition for conducting cost comparisons that can be found in appropriations law. VA was required by Section 647(b) of Division F of the Consolidated Appropriations Act, FY 2004, Public Law 108-188, to report savings from the conversion to contract for 5 years after the conversion.

**Question 10:** It is our understanding that the Veterans Benefits Administration has recently awarded a contract to ACS, Inc. It is also our understanding that VBA is training this company on how to develop claims and that at some time next year, ACS employees will be charged with developing 190,000 claims. Please provide the Committee with details of the contract, including cost, and the policy rationale for contracting this function out.

**Response:** VBA identified a temporary need for claims processing support following the Secretary’s decision to add three new Agent Orange presumptive conditions (Parkinson’s disease, ischemic heart disease, and chronic B-cell leukemia) for Veterans who were exposed to herbicides used in the Republic of Vietnam during the Vietnam era. The influx of new claims for these conditions significantly increased VBA’s claims workload and backlog. More than 1.3 million claims were received in FY 2011, including over 230,000 claims for the new Agent Orange presumptive conditions. To assist VBA in addressing the dramatic growth in the pending inventory and claims backlog, VBA decided to pursue a one-time professional services contract to assist with claims development. This contract was funded in FY 2011. ACS was awarded a 1-year contract on September 12, 2011. The total cost of the contract is \$18.6M.

This services contract includes expedited development of evidence to support certain types of claims, including claims for increase, original compensation claims, original pension claims, and dependency verification. The required development also includes providing an evidence summary and medical index, and return of the claims development package electronically in OCR readable format (paperless) for decision by VBA. The contractor performs claims development activities only—all

claims decisions remain the responsibility of VA employees. Having the contractor gather the needed evidence will allow VBA claims processors to focus on review of the claims and increasing decision output. If full contract volume is achieved, ACS will develop 300,000 claims.

Additional components to the contract include:

- Veteran self-service communications plan/outreach for increased enrollment in eBenefits (level II) self-service portal—target goal is 805,000 new enrollees.
- Process improvement (Lean Six Sigma based) capture and presentation to VBA stakeholder/leadership.
- Transformational training—2,400 hours of process improvement/change management training for field staff.

These additional services complement our plan to reduce the backlog.

**Question 11:** According to the National Academy of Public Administration's white paper entitled "Veterans Health Fee Care Program," dated September 2011, "VA's Fee Care Program expenditures have grown 275 percent since [FY] 2005. There are now approximately 2400 Full Time Employees (FTEs) working in the program. Paid claims rose from \$3 billion in FY 2008 to \$4.4 billion in FY 2010 (46 percent increase), while the number of unique patients served increased from 820,000 to 952,000 (16%) in the same period. NAPA also reported that in "recent years, Fee Care has been increasingly used to meet patient wait-time standards. That is, when a medical service cannot be provided at a VA facility within performance standards, VA Medical Centers (VAMCs) often use the Fee Care Program." Please detail why paid claims increased 46 percent while the number of unique patients served increased only 16 percent. How much of this 46 percent increase in paid claims is attributable to VA attempts to meet patient wait-time performance standards? Please provide the Committee with wait-time reports from FY 2008 to the present, and a detailed breakdown, by VISN, of Fee Care Program expenditures since FY 2008 and the amount expended, by VISN, since FY 2008 of Fee Care Program expenditures utilized to meet wait-time performance standards.

**Response:** Numerous changes have occurred over this time frame to include new clinical treatment/technology tools, our aging population (requiring complex specialty treatment), additional services for returning OEF/OIF/OND Veterans, expanded authority for payment of emergency claims, expanded initiatives within the Women's Health arena including coverage for newborn care (up to 7 days), a significant number of initiatives to improve claims processing timeliness, and other key initiatives to assure key controls are in place to manage and monitor the program. Payment files likely include prior year payments and are not always correlated to patients treated. VA's desire to provide Veteran centric care closer to home (such as our Rural Health initiatives) and increased use of home health services are focused on providing the right care in the right location. These efforts to provide Veteran centric care result in additional Non-VA costs. VA is analyzing options to assure the right care is provided at the right time—standardization of the initial decision points to utilize non-VA care is a major initiative to improve this area.

In addition, VA saw increases in billed charges during this time frame. In certain areas, VA addressed this issue by developing contracts to stabilize pricing. In addition, VA recently published regulations that permit VA in certain situations to utilize the same payment methodology as Medicare, resulting in significant cost avoidance in this program.

Please see spreadsheets listed as Attachment 2 for more details on Fee Data and Attachment 3 for more details on Wait Times.

**Question 12:** The NAPA white paper recommended that substantial changes be made in the VA Fee Care Program and that a strategic change management plan be developed as quickly as possible. Does VA agree that substantial changes should be made in the Fee Care Program? Is the VA developing, or planning on developing a strategic change management plan? What is the specific timetable for changes that have been identified as needed in the Fee Care Program to be implemented?

**Response:** VA does agree that substantial changes are needed in the health care claims processing systems as pointed out by NAPA. A work group, formed and represented by senior members of VHA, is in place to study the issues, identify and recommend a solution to health care claims processing for VA. The complexities of such a significant organizational change will likely require approximately 3 to 5 years for full implementation. VA intends to have a plan in place by mid-year 2012.

This work group is charged to deliver:

- Recommendations on deployment of a regional/central approach to the back office claims processing functions to support the Non-VA Care Program (Fee Care Program);
- A tentative deployment schedule, to include pilot assessment;
- An assessment of capital investment requirements; and
- Recommendations for additional teams for research/analysis, planning, and implementation of selected solutions.

**Question 13:** The NAPA white paper states that “[g]iven the significant organizational productivity challenges with the Fee Care Program, VA has a limited understanding of the services it is procuring through its program and their costs. The Fee Care Program does not appear to have been well managed at any level of VA. VA provides limited VISN-wide executive oversight of its purchased care program, and the program lacks clearly defined operational objectives or goals, and it is not guided by a coherent strategy for managing program expenditures.” Does VA believe the Fee Care Program has been well managed? Does VA believe that there is sufficient level of VISN-wide executive oversight? Does VA believe that the Fee Care Program has clearly defined operational objectives and goals and a coherent strategy for managing program expenditures?

**Response:** VA acknowledges the management and oversight of the Fee Care program could be improved and is actively pursuing program changes, IT solutions, and other initiatives to improve the oversight of the program. However VA believes the Fee Care Program does have clearly defined operational objectives and goals established at the enterprise level and several of these improvements are included below.  
Program Improvement Initiatives:

- Non-VA Care Coordination;
- Use of Contracts to Stabilize or Reduce Pricing;
- Internal Controls/Audit tools;
- Program Integrity/Fraud, Waste, Abuse training and technology; and
- External audits to assure positive results from programmatic changes.
- Technology Enhancements
- Implementing key technology changes to reduce payment errors and address key audit findings; expected delivery end of 2012.

**Question 14:** The NAPA white paper states that the “Chief Business Office estimates the error rates (that is, erroneous payments) at 12 percent per year, which equates to approximately \$500 million in FY 2011. By contrast, TRICARE has a reported error rate of 9.42 percent. Productivity varies across operating sites by nearly ten folds between the most and least efficient sites [footnotes omitted].” Please provide a detailed explanation to the Committee as to why the VA experiences such a high error rate compared to TRICARE and why there is a divergence across the VA system in the level of error rates. What policies or procedures are currently in place, or have been in place previously, that contribute to this high error rate and divergence, and what specific policy and procedural steps is the VA taking to address this high error rate and divergence?

**Response:** The high payment error rate in the Non-VA Care program can be attributed to the manual nature of the technology within a decentralized claims processing system that is the root cause for many errors. The payment program has more than 2,000 claims processors distributed across 153 medical centers. Given such a working environment, with multiple decentralized software products in place and technology that relies on manual payment processing, significant changes are being implemented to resolve these issues.

VA is currently pursuing technology changes that will address the top payment errors identified with our Improper Payments Elimination and Recovery Act IPERA and other audits conducted in FY 2011. These technology changes are expected to be released by the end of 2012.

**Question 15:** During the hearing, VA stated that it was going to roll-out Project HERO nationwide. What are the detailed policy rationales behind implementing this program nationwide? Please provide the Committee with a detailed plan on the proposed nationwide roll-out including detailed time frames, benchmarks, and costs associated with the roll-out. In addition, please provide the Committee with any detailed cost studies that have been prepared estimating any cost-savings, by VISN, that VA will achieve with Project HERO. If VA has not prepared detailed cost estimates, please provide the Committee with estimates regarding these proposed savings.

The Project HERO contracts with Delta Dental Federal Government Programs and Humana Veteran Health care Services are scheduled to end September 30, 2012. Once those contracts are closed, Project HERO will end.

Detailed cost studies/expenditures for health care services through Project HERO have been completed for fiscal years (FY) 2009–2011. Project HERO has realized a net cost-avoidance of \$24,380,746 in the three measured fiscal years. Cost savings, by FY, are noted below:

	FY09	FY10	FY11	Totals
Totals	\$1,864,834	\$16,197,039	\$6,318,873	\$24,380,746

VHA is leveraging the lessons learned from Project HERO and other pilot programs to develop requirements for new competitively awarded contracts. The effort to create these contracts, Patient-Centered Community Care, is focused on creating centrally supported, regional health care contracts available throughout the VHA. The goal is to provide Veterans coordinated, timely access to high quality care from a comprehensive network of high quality non-VA providers. Patient-Centered Community Care is still in the requirements development stage. An Independent Government Cost Estimate (IGCE) will be prepared as requirements are known. We are confident that within the cost of the program we will be able to assure high quality, access, and timely return of medical documentation not always seen in traditional Non-VA Care (Fee) programs.

The schedule for development of the contracting vehicles, solicitation, evaluation, award, and implementation are as follows:

Requirements development: August 2011—January 2012  
 RFP Development, review and finalization: December 2011—April 2012  
 RFP Release: May 2012  
 Evaluations: June 2012—July 2012  
 Award of new contracts: September 2012  
 Implementation/Start up: September 2012—February 2013

### Honorable Bob Filner, Question 8 Attachment 1

**OIG Recommendation 5:** “. . . that the Under Secretary for Health establish procedures to monitor performance measures to determine the impact of rural health care funding on improving access and quality of care for rural Veterans.”

**Actions Taken:** ORH has put in place a robust system of policies and procedures to monitor projects and their costs and measure performance for all funded projects and activities. To ensure appropriate monitoring, VA staff regularly visits Veterans Integrated Service Networks (VISN) to validate project activity and formally measure project status quarterly or as needed. ORH requires performance and impact data in the funding request application, and the Office assesses this required data in each application submission. As a result of this process, ORH evaluated the measurement and performance data and information when reviewing and approving rural health initiatives for FY 2012 project funding, to determine project performance and impact on rural Veterans. Based on these data, ORH was able to identify the greatest rural health needs and support projects with the greatest impact on Veterans.

In March 2011, ORH completed implementation of the Microsoft Access database and project monitoring system. The monitoring system uses a Microsoft Excel spreadsheet to collect and track project activity, progress, and performance. Because both tools have strengths and weaknesses, ORH continues to improve and develop them to ensure efficiency and effectiveness of use and response to customer needs. An electronic database system is needed to improve efficiency of measurement and performance collection, analysis, and reporting.

ORH has defined quality measures and applied them to all projects. The measures are dynamic and change over time to ensure accurate demonstration of performance and accountability. Some measurement data are difficult to access (e.g., the number of Native American unique patients seen for treatment) because they are self reported and often unreliable; other data are difficult to collect because specific tracking systems have not been developed yet in VA. Also, some clinical measures are not conducive to data collection and tracking currently at the CBOC or rural health clinic level. In response to these challenges, ORH is working with VA's Offices of

Quality Management and Business Intelligence to establish and implement this capability. In addition, at this time, VISN Rural Consultants (VRC) and local project leaders manually report project-specific data.

To ensure accountability for funded projects, equipment, and programs, ORH Program Analysts are making site visits to the VISNs to evaluate project and program performance.

In coordination with the VHA Support Service Center (VSSC), ORH completed and deployed a Rural Health Briefing Book in April 2011. The following month, ORH deployed a Rural Health Dashboard in May 2011. These new information resources provide timely and relevant information on socio-demographics, service use, diagnosis, clinical quality, outcomes, and cost data about over three million Veterans living in rural and highly rural areas.

Quality Measurement is an ongoing process. Further plans for action steps and follow-up include the following:

1. Ensure VISNs and VRHRCs report quarterly measures and accomplishment of any relevant milestones.
2. Develop the ORH Microsoft Access database output reports by December 31, 2011.
3. Evaluate data quality each quarter.
4. Establish a mechanism to over-sample patient satisfaction data in rural and highly rural areas by December 31, 2011.
5. Continue to develop standardized measures for all VISN projects and align them with national program measures when possible.

### **OIG RECOMMENDATION 3:**

**OIG Recommendation 3:** “. . . that the Under Secretary for Health implement an effective communication plan to effectively coordinate and collaborate with key rural health care stakeholders in the use of rural health care funds.”

**Actions Taken:** ORH has fully complied with the IG recommendation to implement an effective communication plan.

For internal stakeholders and partners, ORH leadership maintains: 1) bi-monthly teleconferences with leadership of the Veterans Rural Health Resource Centers (VRHRC); 2) monthly calls with VRCs; and 3) weekly meetings with ORH VA Central Office (VACO) staff. Minutes are taken and distributed. In addition, ORH hosts a face-to-face meeting with VRCs, VRHRC Leadership, and VACO staff twice a year, most recently in Iowa City, Iowa, on September 12–14, 2011.

For both external and internal stakeholders, ORH staff develops content for and manages both an Internet and Intranet Web site, publishes a quarterly newsletter featuring ORH-sponsored initiatives and demonstration projects, publishes a monthly fact sheet highlighting recently published research studies and policies relevant to rural Veterans' health issues, and utilizes Webinars to help educate VA health care providers. In addition, ORH staff create videos demonstrating the impact of ORH-sponsored programs on health care for rural Veterans and develop policy briefs based on evaluations of ORH-funded programs.

The latest addition to the ORH Web site is a new section devoted to the ORH Veterans Rural Health Resource Centers. These pages include information on each Center's focus, initiatives, leadership, and staff. The most recent newsletter was published in July 2011 and focuses on ORH-sponsored outreach programs for rural Veterans. It can be accessed online at: [http://www.ruralhealth.va.gov/news3/ORH\\_The\\_Rural\\_Connection\\_Newsletter.asp](http://www.ruralhealth.va.gov/news3/ORH_The_Rural_Connection_Newsletter.asp).

ORH distributes quarterly newsletters via an e-mail contact list, which resides in the ORH Contacts Database (see below). The most recent ORH Fact Sheet features up-to-date statistics on the number of rural Veterans enrolled in VA's health care system, the number of Veterans impacted by ORH projects, and the percentage of rural Veterans who served in Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn. An additional nine Fact Sheets are available on the ORH Web site for download. Archived ORH newsletters and fact sheets are available on the ORH Web site for download at: <http://www.ruralhealth.va.gov/publications.asp>.

Finally, ORH has created five videos about ORH and ORH-sponsored initiatives and how they impact rural Veterans. These are currently available on the ORH Web site for viewing at: <http://www.ruralhealth.va.gov/index.asp>. ORH distributed these videos at the National Rural Health Association (NRHA) annual meeting in Austin, Texas, as well as at the VHA Open House in New Orleans, Louisiana, this past August 2011.

ORH has used its Contacts Database to send several targeted messages to key stakeholders, who can in turn forward or print these messages for other interested

parties. For instance, ORH sends e-mails to staff at rural VA CBOCs and Outreach Clinics. We suggest they print out copies of the ORH newsletter for Veterans to read while in the waiting area. Stakeholder groups in the database include:

- the general public
- Veterans Service Organizations (e.g., Disabled American Veterans, Paralyzed Veterans of America, etc.)
- Veterans Service Offices (state and local)
- Rural Health Program Offices (Federal, state, and local)
- Rural Health Associations (National and state)
- Other Federal agencies (e.g., Health Resources and Services Administration, U.S. Department of Education, etc.)
- Academic institutions
- Representatives and Senators
- Native American Tribal organizations
- VA program offices and facilities, including:
  - VISN Offices
  - VA Medical Centers
  - VA CBOCs
  - Vet Centers
  - Office of Public and Intergovernmental Affairs
  - My HealtheVet staff
  - All ORH staff (VACO, VRHRCs, VRCs)
  - Veterans Rural Health Advisory Committee

ORH continually updates and supplements contact data, and there are currently 1,466 active stakeholder e-mails sent each quarter, an increase from the initial 1,017. In late March 2011, we added a subscription function to the ORH Newsletter Web page, which has resulted in an additional 140 contacts. We continue to work to identify key stakeholders who should be informed about ORH initiatives and improvements to access and quality of care for rural Veterans.

*Use of Social Media:* ORH staff are utilizing social media to provide even greater outreach and communication. For example, ORH has used the VA blog “VAntage Point” (<http://www.blogs.va.gov/VAntage/>) twice this year to discuss VA rural health initiatives and impacts. The first blog post was focused on increasing access to rural Veterans (April 5, 2011), and the second was an update on the work of ORH (June 28, 2011).

Rural health-related posts have appeared on the VHA *Facebook* page five times since February 2011 under the following titles:

- VA Reaching Out to Rural Veterans With Telehealth (August 19, 2011)
- VA’s Mobile Clinics—“Grillin’ on the River” Video (July 3, 2011)
- Rural Health: Exchanging Information—Health Care (April 23, 2011)
- Rural Health: A Health Frontier (March 28, 2011)
- “The Rural Connection” Newsletter (February 2, 2011)

Rural health-related posts have appeared on the VA *Facebook* page ([www.facebook.com/VeteransAffairs](http://www.facebook.com/VeteransAffairs)) six times since February 2010 under the following titles:

- Rural Veterans and the Tyranny of Distance (August 6, 2011)
- VA Reaches Out to Tribal Governments (July 5, 2010)
- Update: VA’s Office of Rural Health—Mary Beth Skupien (June 29, 2011) (also on the VA Blog, VAntage Point, <http://www.blogs.va.gov/VAntage/>)
- Salem VAMC Holds Ribbon Cutting Ceremony for Wytheville, VA. CBOC (June 20, 2011)
- VA Secretary Learns What “Rural” Means for Alaska Vets (May 31, 2011)
- Reaching Out to Tribal Governments (February 1, 2010)

VA has also begun using Twitter to inform others about ORH. The following rural health-related “tweets” have been distributed through VA’s Twitter account (@DeptVetAffairs) since October 1, 2010:

- Rural Veterans and the Tyranny of Distance: <http://t.co/akpBxM9> (August 8, 2011—Re-tweeted by 5 others).
- VA is taking measures to improve health care for Vets in rural areas. Learn more: <http://t.co/qPZjNu9> (July 1, 2011—Re-tweeted by 22 others).
- Guest post on VAntage Point: Increasing Access: Reaching Out to Rural Veterans <http://go.usa.gov/TIM> (April 6, 2011—Re-tweeted by 4 others).



- If you live in a rural area & it's a pain for you to reach the nearest VA facility, Project ARCH will be welcome news. <http://go.usa.gov/agz> (October 9, 2010—Re-tweeted by 18 others).

#### *ORH Communications—FY 2012*

For FY 2012, communications plans include regular “IN THE SPOTLIGHT: Rural Health Publications” e-mails, as well as special edition e-mails, such as “Bringing Ethics Consultation Services to Rural Veterans.” ORH will continue to use the social media tools outlined above.

ORH will develop and implement a Project Access Received Closer to Home (ARCH) Communication Plan by December 2011 and will have a booth at the National Rural Health Association (NRHA) 2012 Annual Rural Health Conference in Denver, Colorado, April 17–20, 2012.

#### **OIG RECOMMENDATION 6:**

**OIG Recommendation 6:** “. . . that the Under Secretary for Health reassess the rural health initiatives approved for funding by Office of Rural Health in their fiscal year 2012 budget to align planned use of resources to their greatest rural health needs.”

**Actions Taken:** ORH has reassessed the rural health initiatives requested in the FY 2012 budget to align planned use of resources to the greatest rural health needs.

(1) As discussed previously, ORH has instituted a robust system of measurement and performance monitoring for the budget and for all projects and activities it funds.

(2) ORH has completed needs assessments for health care and geographic areas and evaluated and trended them for all VA VISNs (see trend reports below). ORH has used this information to identify the greatest rural health needs and posted it on the ORH SharePoint site, and will continue to use it throughout the year for planning and program evaluation purposes. During the September 2011 ORH bi-annual meeting, ORH staff and leaders evaluated the needs assessment process to determine how it might be improved in the future.

(3) From the geographic needs assessment, ORH has developed a detailed national geographic map and used it to assist ORH and VISNs with aligning their use of resources with identified health care needs. The map demonstrates that 96.5 percent of all VA enrollees are within 60 minutes travel time to VHA primary care services. It also shows, by VISN, the percent of enrollee coverage meeting FY 2010 access standards (see attachment below).

(4) In FY 2011, ORH has funded projects and activities identified as priorities, including the Secretary’s initiatives to address women and homeless Veterans, and through priorities established by the ORH Advisory Committee and the ORH Strategic Plan. This Strategic Plan addresses efforts to improve outreach, mental health, telehealth, and recruitment and retention of providers into rural and highly rural areas. ORH has completed the “refresh” of its Strategic Plan and finalized it at the end of FY 2011.

(5) Finally, ORH completed several Veteran and community agency focus groups in FY 2011 to help determine the greatest needs for funding. The Western and Central Region VRHRCs are continuing outreach activities targeting rural and highly rural Veterans and have planned further focus groups to assess the needs of Veterans within the community-at-large for both enrolled and non-enrolled Veterans.

#### **OFFICE OF RURAL HEALTH STRATEGIC PLAN, FY 2012**

**Overview:** The Senate Appropriations Committee recommended that VA’s reassessment take into consideration both geographic and specific health needs and encourages the Department to compile Veterans’ records from multiple systems to create a single view of Veterans and the geographic area in which they live.

**Actions Taken:** ORH has compiled Veterans’ records from multiple systems to create a single view of Veterans and the geographic areas in which they live. This profile of rural Veterans helped VA target funding to programs for FY 2012. In FY 2011, ORH implemented a plan to meet with and collect data and information directly from Veterans in as many geographic locations, systems, and regions nationally as possible.

ORH leadership and staff have participated in a variety of events (including town hall meetings, listening sessions, outreach events, and round table discussions) with Veterans, to increase awareness and understanding of Veterans’ needs, issues, and perceptions. To obtain more information, ORH invited Veterans to participate in the health care needs assessment processes by contributing ideas at informational meet-

ings, providing data on comment cards, and answering satisfaction and perception questionnaires.

In 2011, the ORH Director and staff have participated in town hall events and listening sessions in Montana, Texas, South Dakota, Florida, and Maine. The VRHRCs in Eastern and Central regions have provided outreach events and have held numerous Veterans' focus groups in Utah, California, Nevada, Iowa, and Illinois, and more are planned. ORH has integrated and evaluated information from the geographic and health care needs assessments by identifying local, regional, and national trends and connecting these findings with the Secretary's initiatives, the ORH Advisory Committee recommendations, and the ORH strategic priorities. All of these sources of information help ORH determine as objectively as possible the areas of greatest need for funding. During the FY 2012 proposal review sessions, all reviewers were required to utilize findings from the sources to help guide them in making funding decisions in an informed and effective way.

ORH has refreshed its Strategic Plan with details for all rural health activities in FY 2012. The full plan is embedded. A summary of the Strategic Plan follows.

Prior studies indicate that Veterans who live in rural settings have greater health care needs than their urban counterparts. Specifically, compared to urban Veterans, rural Veterans have lower health-related quality-of-life scores and experience a higher prevalence of physical illness. While prevalence of most psychiatric disorders is lower for rural Veterans compared to urban Veterans, rural Veterans with psychiatric disorders are sicker as measured by lower health-related quality-of-life. These differences in health-related quality-of-life scores, which equate to lower self-rated health status among rural dwelling Veterans, are substantial, clinically meaningful, and associated with increased demand for health care services. Despite greater health care needs, rural Veterans are less likely to access health services for both physical and mental illness, either through VA or the private sector. In particular, rural Veterans have lower access to care for chronic conditions such as hypertension and post-traumatic stress disorder.

To ensure that ORH programs and initiatives are meeting the health care needs of rural Veterans, ORH used several different sources to develop a profile on rural Veterans. First, ORH conducted a geographical needs assessment to determine VA facility gaps in rural areas. It then conducted a clinical needs assessment to better understand unmet clinical needs. ORH leadership has participated in numerous town hall meetings and listening sessions to better understand the perspective of rural Veterans on accessing VA health care and has met with the Veterans Rural Health Advisory Committee (VRHAC) on 10 occasions to discuss its recommendations on how to improve the ORH program. This information, together with the Secretary's priorities on improving care for women, Native American, and homeless Veterans, provided the framework for the refresh of the ORH 2012 Strategic Plan.

In FY 2011, ORH formed a committee of internal and external stakeholders to refresh the ORH Strategic Plan for FY 2012 through FY 2014. Committee members represented the following groups: the VRHAC, VRCs, the VRHRCs, ORH Central Office, VA medical center directors, the Office of Telehealth Services, the Office of Mental Health Services, the Office of Geriatrics and Extended Care, the Utah State VA Office, VA's Office of Health Informatics, VA's Office of Academic Affiliations, VA's Employee Education System, and VA's Health care Retention and Recruitment Office. Six workgroups were created from the Committee to refresh the initiatives and action items associated with the strategic goals of ORH. ORH disseminated the draft compilation of all recommendations to a broad spectrum of VA field and program offices including all VISN directors and VISN planners.

Veterans Health Administration  
November 2011

**Honorable Bob Filner, Question 11 Attachment 2,  
Fee Data Disbursed Amounts**

FILNER QUESTION 11 ATTACHMENT 2 FEE DATA DISBURSED AMOUNTS

All Payment Locations	FY08	FY09	FY10	FY11
	\$3,028,962,367	\$3,818,112,936	\$4,416,267,157	\$4,561,833,762
V01	\$139,641,704	\$168,825,720	\$188,174,706	\$169,174,226
V02	\$51,489,344	\$69,644,612	\$81,036,946	\$65,054,534
V03	\$45,040,208	\$51,824,172	\$52,159,050	\$49,001,434

All Payment Locations	FY08	FY09	FY10	FY11
V04	\$150,207,208	\$194,650,669	\$209,107,662	\$213,771,370
V05	\$51,766,320	\$69,997,271	\$67,925,599	\$66,693,619
V06	\$171,051,337	\$227,459,348	\$262,310,696	\$244,605,261
V07	\$173,436,112	\$216,977,473	\$316,154,124	\$345,743,207
V08	\$271,965,844	\$299,863,068	\$372,462,614	\$413,079,860
V09	\$159,000,541	\$203,506,465	\$215,568,620	\$210,201,823
V10	\$122,347,224	\$167,294,344	\$237,650,491	\$172,680,508
V11	\$109,686,203	\$153,285,222	\$163,211,029	\$145,382,413
V12	\$84,189,137	\$108,029,431	\$128,735,652	\$131,510,900
V15	\$161,454,995	\$200,388,460	\$209,312,890	\$252,454,316
V16	\$229,161,049	\$289,354,762	\$361,412,448	\$328,289,259
V17	\$111,111,520	\$167,465,263	\$233,663,473	\$252,076,371
V18	\$162,456,908	\$205,022,885	\$222,857,447	\$242,174,849
V19	\$112,950,006	\$137,654,118	\$163,636,814	\$174,346,824
V20	\$196,148,762	\$219,976,592	\$231,026,120	\$297,091,637
V21	\$166,685,471	\$194,384,255	\$210,417,304	\$254,719,719
V22	\$183,267,837	\$214,861,462	\$250,646,232	\$239,626,188
V23	\$175,904,636	\$257,647,345	\$238,797,237	\$294,155,442

**Hon. Bob Filner, Question 11 Attachment 3, Wait Times**

FY 2011	VISN	Patient Category	Primary Care		Specialty Care		% of Pt Appts <=14 Days	
			# of Pt Appts <=14 Days	Total Patient Appts	# of Pt Appts <=14 Days	Total Patient Appts		
1		New Pts Desire Dt	23,234	25,015	92.90%	129,285	143,062	90.40%
1		Estab Pts	470,113	488,974	96.10%	890,986	928,656	95.90%
2		New Pts Desire Dt	12,946	14,810	87.40%	67,054	75,663	88.60%
2		Estab Pts	259,501	277,762	93.40%	490,215	507,014	96.70%
3		New Pts Desire Dt	18,431	22,497	81.90%	120,066	136,261	88.10%
3		Estab Pts	269,128	300,769	89.50%	889,940	943,243	94.30%
4		New Pts Desire Dt	27,999	33,763	82.90%	147,671	159,921	92.30%
4		Estab Pts	549,032	568,447	96.60%	967,192	999,592	96.80%
5		New Pts Desire Dt	15,767	16,715	94.30%	80,652	83,049	97.10%
5		Estab Pts	233,811	243,464	96.00%	483,563	495,184	97.70%
6		New Pts Desire Dt	39,198	42,954	91.30%	192,272	202,929	94.70%
6		Estab Pts	606,879	638,404	95.10%	998,535	1,030,376	96.90%
7		New Pts Desire Dt	47,163	53,223	88.60%	183,792	211,303	87.00%
7		Estab Pts	648,931	693,161	93.60%	1,060,181	1,122,361	94.50%
8		New Pts Desire Dt	58,287	68,146	85.50%	303,660	356,929	85.10%
8		Estab Pts	1,111,542	1,213,968	91.60%	1,923,540	2,055,938	93.60%
9		New Pts Desire Dt	27,390	32,684	83.80%	151,091	169,636	89.10%
9		Estab Pts	544,176	576,678	94.40%	931,626	976,146	95.40%
10		New Pts Desire Dt	27,536	29,691	92.70%	142,814	149,006	95.80%

FY 2011	VISN	Patient Category	Primary Care		# of Pt Appts <=14 Days	Specialty Care		% of Pt Appts <=14 Days
			# of Pt Appts <=14 Days	Total Pa- tient Appts		# of Pt Appts <=14 Days	Total Pa- tient Appts	
	10	Estab Pts	516,402	533,653	96.80%	848,878	870,001	97.60%
	11	New Pts Desire Dt	27,680	35,789	77.30%	137,279	155,688	88.20%
	11	Estab Pts	455,037	492,124	92.50%	774,831	812,512	95.40%
	12	New Pts Desire Dt	23,320	24,540	95.00%	135,313	143,905	94.00%
	12	Estab Pts	447,364	458,969	97.50%	927,229	951,779	97.40%
	15	New Pts Desire Dt	25,037	26,990	92.80%	118,168	137,322	86.10%
	15	Estab Pts	468,302	486,604	96.20%	714,178	745,270	95.80%
	16	New Pts Desire Dt	52,572	55,686	94.40%	240,270	260,906	92.10%
	16	Estab Pts	871,964	904,590	96.40%	1,403,157	1,463,219	95.90%
	17	New Pts Desire Dt	41,198	44,087	93.40%	150,631	160,046	94.10%
	17	Estab Pts	589,057	609,556	96.60%	829,917	852,195	97.40%
	18	New Pts Desire Dt	25,981	35,362	73.50%	114,587	135,127	84.80%
	18	Estab Pts	450,535	507,013	88.90%	709,936	759,101	93.50%
	19	New Pts Desire Dt	21,601	23,735	91.00%	83,828	88,808	94.40%
	19	Estab Pts	332,808	347,836	95.70%	525,300	540,463	97.20%
	20	New Pts Desire Dt	32,842	39,647	82.80%	116,602	136,966	85.10%
	20	Estab Pts	419,833	455,675	92.10%	675,126	723,520	93.30%
	21	New Pts Desire Dt	30,502	35,777	85.30%	135,335	154,310	87.70%
	21	Estab Pts	419,213	456,712	91.80%	796,658	849,194	93.80%
	22	New Pts Desire Dt	40,367	46,893	86.10%	176,835	196,906	89.80%
	22	Estab Pts	577,499	606,777	95.20%	1,056,806	1,101,986	95.90%
	23	New Pts Desire Dt	29,963	34,723	86.30%	131,454	157,427	83.50%
	23	Estab Pts	515,346	547,931	94.10%	852,946	908,992	93.80%