U.S. DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE FUNDING: APPROPRIATIONS TO PROGRAMS

HEARING

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COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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WEDNESDAY, DECEMBER 2, 2009

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. Bob Filner [Chairman of the Committee] presiding.

Present: Representatives Filner, Michaud, Herseth Sandlin, Mitchell, Perriello, Teague, Donnelly, Space, Walz, Adler, Kirkpatrick, Buyer, Brown of South Carolina, Miller, Boozman, Bilbray, Buchanan, and Roe.

OPENING STATEMENT OF HON. BOB FILNER

The CHAIRMAN. Good morning. The Committee on Veterans' Affairs will come to order.

I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks. Hearing no objection, so ordered.

Thank you all for being here this morning.

I think we all, during the time of our service on the Committee, hear about issues that suggest that Federal funds may not be flowing to the local U.S. Department of Veterans Affairs (VA) facilities in the way that we envision, either efficiently or effectively, to best serve our veterans.

We have worked very hard to provide a robust medical care budget. In fact, appropriations for VA medical care have increased over 40 percent in the last 2½ years.

The purpose of this hearing is to ensure that appropriated Federal dollars reach the local VA medical centers. This requires a good understanding of how the 21 Veterans Integrated Service Networks (VISNs) distribute the appropriated Federal dollars to the local medical centers and how the VA tracks the dollars spent at the local level.

It requires a good understanding of the budget planning process and how the VA Central Office involves the VISNs and the local medical centers to determine the resources needed to provide proper medical care to our veterans.

Some local VA medical centers claim that their allocation from the VISNs have either remained stagnant or have not been propor-

tional to the unprecedented increase in overall funding for VA medical care.

We have appropriated a lot of money and we hear that their local budgets have not increased accordingly.

Obviously we cannot examine every anecdotal concern without understanding the rationale that the VISNs use for allocating funds to the VA medical centers. I hope through today's hearing, we can learn more about the decision-making process that the VISNs use for distributing the appropriated dollars to the local medical centers.

In the VA medical centers that serve the veterans in my own district, I understand there is a hiring freeze which may be linked to the growing queues that our veterans face for mental health care appointments.

We have reports that the hiring freeze is not limited to mental health professionals and that it is VISN-wide. We have heard that this VISN-wide hiring freeze may have resulted from one particular medical center going over its budget in fiscal year 2009. This raises questions about how the VISNs track the funds that the local medical centers spend and whether VISNs are able to predict and prevent funding shortfalls at the local level before they occur.

Today, we hope to explore who decides how to prioritize, spend, and track the funding that the local medical centers receive. We would like to uncover how the VA Central Office (VACO), the VISNs, and local medical centers plan and execute budgets and manage potential funding shortfalls.

I constantly hear when I go around the country from local medical directors that they lack flexibility to move funds between the three accounts that are included in the VA medical care budget—Medical Services, Medical Support and Compliance, and Medical Facilities. Central Office tells me that they do have the flexibility to move money, but the medical director continues to tell me they do not. I want to know the facts.

Finally, in a September 2008 report, the U.S. Government Accountability Office (GAO) found that VA policies and procedures were not designed to provide adequate controls over the authorization and use of miscellaneous obligations, which totaled about $7 billion in fiscal year 2007.

The flaws in the design of the internal control system increase the VA's risk for fraud, waste, and abuse. Through today's hearings, we will examine whether the VA has an internal budget control system that is strong enough to track, safeguard and account for the flow of Federal dollars to the local VA medical centers.

I look forward to hearing from our witnesses as we work together to provide the best health care for our veterans by ensuring that appropriated Federal dollars reach VA medical centers in the most sensible and effective manner.

I yield to Mr. Buyer for any comments he would like to make.

[The prepared statement of Chairman Filner appears on p. 53.]

OPENING STATEMENT OF HON. STEVE BUYER

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

I note on panel two you have Michael Finegan. Michael worked on what we call the Collaborative Opportunities Steering Group (COSG), which as we were developing the Charleston model, the VA had put Mike Moreland in charge of that, and Mike Finegan worked very well on the, I think it was the finance piece, testing memories here, it was the finance piece.

And then you were also recruited to put together that very same model down in New Orleans. And I really appreciate your work on both of those models.

Any time whenever you want to think anew on how to come up with how we are building new facilities and trying to do things jointly, it is new and it is different. And so what you did, you made an investment and it was a great idea and a great concept, and we tried to bend it and the bureaucracy bent us back.

But one thing I do know about the quality of your work and what you and Mike Moreland did is that you cannot suppress good ideas forever. So I think what you have done is a great investment and in time, I think many people will begin to see what you have done and the quality of your work.

So welcome to the Committee.

Mr. Chairman, with regard to the questions you are asking here today, I think they are very pertinent. When you think about the last 12 years that VA has relied on the decentralized funding model for the VISNs to fund their respective medical centers, the VA provides the general guidance and then permits the flexibility and allocations with regard to these resources.

I believe in the clear delineation of responsibility, careful planning, and performance measures then to gauge the coordination and the accountability.

I think it is also prudent for us, and I was mindful of the questions that you had asked, for us to ask these key questions such as should allocations be formula driven or standards based with real-time analysis.

It has been 5 years since the GAO has placed their eyes upon the funding allocation issues and I endorse a meaningful, independent review.

Effective today, I will ask the GAO to conduct a review of the following: Number one, the criteria and process VA has for VISN allocation of resources to the medical centers; number two, how the VA ensures that VISNs conform to establish criteria and process in their allocation of resources; and, number three, how the VA centrally tracks and assesses the distribution and use of funds at the medical center levels.

I would invite cosponsors of the letter. I would be more than happy, Mr. Chairman, to sign one with you if you would like and invite any colleagues for any further recommendations of substance, analytical inquiry as necessary with regard to this letter to the GAO.

An issue that I would like to bring up, and I think with regard to Ms. Rita Reed, you can think about this as you come to testify, and that is with regard to the concerns on funding. If you do not have the funds over here, you take it from over there.

And what we have right now is the VA has depleted the stimulus dollars intended to help the VA process Post-9/11 GI Bill claims by hiring extra temporary staff. So it is now dipping into overtime pay funds intended to reduce the disability claims backlog.

Now, to put it another way, the VA is diverting resources from a disability payment program with a huge backlog to pay for a non-disability program.

So the latest VA data shows that the backlog of 26,000 Post-9/11 GI Bill claims for those who are currently enrolled, average processing time for those claims is now 47 days. And with second semester registration now underway, that time is likely to increase.

So I am requesting that the VA provide us with a projection of its GI Bill workload through the end of May so we can address the funding needs in this regard.

In the meantime, what I would ask of you, the gentlelady, is, ma'am, let us know what your needs are right now so we can continue to use compensation claims funding for its intended purposes.

With that, I yield back to the Chairman.

The CHAIRMAN. I thank the Ranking Member.

I will be glad to join with you on that letter.

Mr. BUYER. Good.

The CHAIRMAN. I would like to make sure we include the things that I mention.

Mr. BUYER. I will work with you.

The CHAIRMAN. I also would like to include the issue of flexibility of the local director in terms of the three different stove-piped accounts that they are given.

Mr. BUYER. Will the gentleman yield?

The CHAIRMAN. Yes.

Mr. BUYER. I think from our hearing today and from the other Members and their inquiries, I think we can put together a good letter. I will work together with the Chairman and we can do that.

The CHAIRMAN. Okay. I look forward to working with you. Thank you.

Our first panel is Mr. Clyde Parkis. Mr. Parkis is the Former Director of the VISN 10 Healthcare System for Ohio.

Mr. Parkis, thank you for joining us here today. We will include your written statement in the record and hope that your oral remarks can be made in about 5 minutes. You have the floor and we again, appreciate you being here today. Do not forget to press the button to start your microphone.

STATEMENT OF CLYDE L. PARKIS, SEBASTIAN, FL, AND FORMER DIRECTOR, VETERANS INTEGRATED SERVICE NETWORK 10, VETERANS AFFAIRS HEALTHCARE SYSTEM OF OHIO, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. PARKIS. It takes a while to retrain us retired guys.

I will let the statement for the record stand and would like to hit what I consider just the high points of my experience with the Veterans Equitable Resource Allocation (VERA) process.

First of all, I was a big fan of the VERA process because it did connect funding with workload, with veterans treated. I had trou-

ble frequently with people confusing medical center funding with veterans' care funding. And the VERA model funds veterans' care.

If a medical center wants more money, the incentive is to find ways to earn more money.

As I gained experience over 5 years distributing money at the network level, I began to emphasize the VERA model more and more. I would have directors talk about, you know, not getting their fair share of the VERA funding. And I would counter that with, you got your fair share of the earnings based on what you actually earned.

I called funding above what was earned as corporate welfare and wanted to get on a welfare-to-work program. I wanted the medical center leadership to understand where money comes from, why it comes, and what behaviors they need to exhibit to actually get the funding that they want.

Each year, it got a little better. You cannot distribute money to medical centers that does not come into the VISN or into the network.

As we got better at doing that, and times kept getting a little tighter each year, we were experiencing between 2001 and 2006 roughly 10 percent health care inflation in our costs. We were running five to 8 percent increased enrollment every year and our funding increase, as I recall, was limited to about 5 percent. That made it extremely difficult to continue our mission.

One of the things we were extremely proud of was Network 10 in Ohio kept our doors open to new enrollment. Ohio, as you may recall, was losing steel plants left and right, auto plants. A lot of people were losing their health insurance and turning to the VA. So our enrollment was always a little higher than the national average.

Because of the hard work of all the people in the network and our increased focus on funding follows veteran workload, not medical center history, we were able to perform actually quite well.

A couple of things I would kind of like to bring up today. While I used VERA for a starting point for budget distribution, it could not be the end point. You have different things that happen every year. We were fortunate to get two major projects, a replacement clinic for Columbus and a new addition, new wing to the hospital at Cleveland that will eventually allow for consolidating all of Brecksville at the Cleveland campus.

Along with the good luck comes activations funding, which at least back then and I think it is probably still the same way comes primarily from the network. You have to find a way to build that into your budget every year. So those are the things that you have to do in terms of cooperation.

As a Vietnam veteran, I sometimes have trust issues. And it took me a long time to kind of figure out who to trust in the process as we went through the budget cycles. I was aware that the Office of Management and Budget (OMB) liked to screen VA testimony before it came to the Committees and I thought sometimes that prevented us from asking for what we thought we really needed.

I was told to say we do not have our budget, you know, officially yet, so I cannot speculate on the impact of that. That made it dif-

ficult to answer my local Congressmen in terms of what was going on with the VA.

And I thought some of that actually was coming from this Committee, but maybe that was not the case. As I gained some trust over time, there are some things I wished I had spoken up about a little earlier.

With that said, I will answer any questions you have for me.

[The prepared statement of Mr. Parkis appears on p. 54.]

The CHAIRMAN. Thank you, Mr. Parkis.

Mr. Michaud, any questions?

Mr. MICHAUD. Thank you very much, Mr. Chairman, Mr. Ranking Member, for having this hearing. I think it is timely and a very important hearing. And I appreciate the Ranking Member for putting together that letter as well because I think that is also extremely important.

As a former VISN director looking at VISN 10, I notice that there are no new proposed Community-Based Outpatient Clinics (CBOCs) in your VISN. But how do you calculate the census for veterans? Is it by the U.S. Census Bureau, the veterans that actually are enrolled in the VA system, or some other mechanism to determine the appropriate allocations for the medical facilities that you have to deal with?

Mr. PARKIS. Our primary method was to follow enrollment or demand, the veterans that actually came to the VA.

Mr. MICHAUD. I mean, you hit the nail right on the head and I have seen it up in Maine where there are a lot of veterans who are not in the VA system because their current employment level or their employment, they offer health care and so, therefore, they do not need VA health care. But if their mill or factory shuts down, then they are in need of health care needs from the VA.

So how do you account for those who would be eligible for VA benefits but are not utilizing it in case of economic time? Is there a mechanism to increase funding for the clinics or hospitals within your VISN that you are director of?

Mr. PARKIS. In my experience, and I am having a little trouble hearing, I need hearing aids in both ears and I have been putting it off, in my experience, funding followed workload. If we thought we had a lot of veterans that were there, but we were not meeting their needs, we did enrollment fairs sometimes.

When the Ford plant shut down, we sent teams out there to actually enroll veterans at the plant before the shutdown happened. We coordinated that with their employers. We did the same at several steel mills.

Mr. MICHAUD. And when you account for veterans, and I am thinking of VISN 1, which is, you know, Maine, Massachusetts, where you will have a veteran in one region, for instance, I will use Maine, but because of whatever purposes that they are required to actually go to Boston in some cases, 8 or 9 hours travel time, how do you account—where does that veteran count? Is he part of the Maine system or would be part of the Boston system since he is using the medical facility in Boston because that is where they told him he had to go? How would you, not necessarily for the Maine situation, but how would account for that under VISN 10? Where is that veteran counted?

Mr. PARKIS. What we did in VISN 10, and, again, if I heard you correctly, we looked at, you know, where the veterans were, where the need was, and we put in total 25 or 28 community-based outpatient clinics. So we put care in their neighborhood.

Mr. MICHAUD. And my last question, and I notice looking at the VISN 10 map that came about through the Capital Asset Realignment for Enhanced Services (CARES) process, I notice that there are no CBOCs, new CBOCs according to this map, but during your tenure as VISN director, when you look at trying to establish new CBOCs that were recommended under the CARES process, that comes out of the VISN budget.

How were you as far as trying to care, or what the CARES process recommended, knowing that it might—you are going to have to use up some of your resources to establish a new CBOC, did you just ignore that and did what you had to do to make your budget balanced?

Mr. PARKIS. We definitely did not ignore it. What we did was we looked at how can we open CBOCs in the area where the veterans are and we tried to move a lot of our care there.

Cleveland probably set the best example in our network and grew the CBOCs the fastest. We did have some facilities that were a little reluctant to do that because he considered that as taking resources from the mother ship and moving it out to the CBOC.

But our policy and our emphasis was always on what the veteran needs. So we opened CBOCs. And in those medical centers that were slow to do it, we had one-on-one conversations to encourage them to do that.

Mr. MICHAUD. Thank you very much.

And thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Roe, any questions?

Mr. ROE. Just briefly, Mr. Chairman.

Mr. Parkis, thank you for your service in Vietnam and also thank you for your service as a VISN director.

And to sort of dovetail with what Congressman Michaud was saying is that in our area in Tennessee, we have a large VA system and I think some of the best resources.

My concern with this great increase in the VA budget is that the money gets down to the veterans. As it filters down—I mean, I see all these billions of dollars and I see all this need that our veterans have.

And in my district in Tennessee, we have more veterans than any other district in the States. So it is a real issue. And I think these outpatient clinics are the best money the VA has ever spent. I absolutely believe that. We have three. We need more.

How do you make a decision about, you know, what is the critical mass and how do you as the director make a decision about, okay, let us do another outpatient clinic because as our veterans age, it is harder for them to travel?

As you said, in the mother ship, you are not doing anything for most of them there that you cannot do in their local communities. And it makes absolute sense to do that. So I will let you answer that, if you would.

Mr. PARKIS. Our emphasis always started with, you know, where are the veterans, what are their needs. And we tasked the medical centers with developing plans and opening CBOCs that best met the veterans' need.

Mr. ROE. When you say that, how is that decision made? I mean, when you are sitting as VISN director and a hospital director there, I want to open an outpatient clinic. Here is this new money coming down through the system and there are veterans out there. How do you make a decision we are going to put one in X city or Y city?

Mr. PARKIS. Oh, I see. Okay. As we went through the strategic planning process every year, we come up with, you know, a new iteration of the plan. That was a major area we always looked at.

And in our VISN, we believe very heavily in CBOCs. And we called for the groups who do a planning process always based on veteran need and come in with the list of where those clinics should be.

Mr. ROE. Do you use the zip codes? I mean, if you have so many veterans coming to your major medical center, is that how you decide? I mean, it is not clear to me how a VISN director makes a decision about putting a clinic in, let us say, Rogersville, Tennessee, or something?

Mr. PARKIS. Okay. It was a combination of where the veterans are, you look at your demographics, you know, spread out by zip code or by county and in addition to that, where are you experiencing the demand. Sometimes we open CBOCs for different reasons.

In Cincinnati, we had a construction project that was just not coming to completion and we were down to one exam room per primary care provider. So we opened up a CBOC just to get local capacity. And that was so successful that it has continued until today even though at the medical center, the project was finally completed and they have enough, I believe, enough exam rooms to cover their workload.

Mr. ROE. See, I think taking the care out to the veterans is the way to do it. I mean, I think you are going to see more demand and I agree that as the economy worsens, the VA is going to see a higher click in demand. We certainly have at home.

And I would emphasize just for this Committee, I—have we ever closed an outpatient clinic; do you know? Have you ever closed one in yours? I bet you the demand always went up at those outpatient centers.

Mr. PARKIS. Our demand always went up. In my experience at one location, we switched from a contract model to a VA-run model because we just had too many logistical problems. We were contracting with our medical affiliate to run the clinic and the people in the clinic, it became too hard for them to differentiate between a veteran patient and a regular patient that would come there that they might refer over to the university for follow-up care.

And it was the veterans that got upset with it. We did not close it. We switched it to a VA-run clinic and the enrollment, as I recall, either doubled or tripled within the first 6 months after rededicating.

Mr. ROE. That has been our experience also.

I yield back, Mr. Chairman. Thank you.

The CHAIRMAN. Thank you.

Mr. Teague, any questions?

Mr. TEAGUE. Yes. Thank you, Mr. Chairman.

I also would like to associate myself with the letter that you all are going to prepare, if I could, please.

Sir, thank you for being here and thank you for your service.

In your experience as a director, did you have centers that fell short on their funding and if they did, what did you actually do to keep them going? Were services cut or how did you make that adjustment?

Mr. PARKIS. I was kind of tough in that area. I wanted to keep the programs going and keep the center going. What I would do when a medical center said, you know, I do not have enough money, the first thing I would do is ask for an assist team to come in and evaluate the programs and the operations and come up with a recommendation for are we doing everything we can there to address the budget issues.

One time that I recall, I would call it as much a matter of arrogance or just feeling that, you know, we are such a good medical center, you should fund us, you know, whatever we ask for. And there were several things within their power that they could do to manage better.

I did give them the extra money, but I also tried to hold their feet to the fire in terms of their performance. And I sat down with the leadership team and developed a corrective action plan to address the recommendations that came from the assist team. And the assist team, these were very well-intentioned people with expertise from all over the VA system and they were there to help, not to punish.

Mr. TEAGUE. Did you ever have any of the CBOCs, the outpatient clinics that continually lost money, ran out of money? How did you handle those, if you did?

Mr. PARKIS. It is almost impossible in my mind or my experience for a CBOC to actually be a money loser. They always generated way more funds than it cost to operate them. And that helped offset costs at the referral medical center or at the parent medical center because the patients that go to the CBOCs, they do have acute episodes. They do have issues that need to be addressed. And that does increase the cost at the parent facility.

Mr. TEAGUE. You know, and I am kind of reiterating things that other Congressmen have said before me, but, you know, as they did say, in New Mexico, which is a very huge State, the number of people that have to travel 5, 6, 8 hours to go to the VA hospital in Albuquerque is pretty large.

And also Congressman Roe asked, you know, about how you decided to open new CBOCs and things like that. And I was just wondering how do you do that and is there a number that they need to meet so that these people do not have to drive 6 and 8 hours?

Mr. PARKIS. Well, in addition to CBOCs, we look very hard at telemedicine. And it works. It works extremely well and the veterans love it. We worked hard on what are the things you can do to keep a patient, you know, out of a medical center. Telemedicine,

telehealth, telepsychiatry, all those things are very effective programs.

We even did telehome care where we could have a patient—one of them was on a respirator, so this is an extremely fragile, you know, high maintenance patient, but he wanted to be home up in the Plattsburgh area up in northern New York and his spouse wanted that. And they made it work for him. I was extremely proud of that.

Mr. TEAGUE. Okay. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Boozman.

Mr. BOOZMAN. Thank you, Mr. Chairman.

I appreciate your testimony. We do appreciate your service to veterans.

In your testimony, you talked about that you use the VERA model, you know, kind of as a basis.

Mr. PARKIS. Uh-huh.

Mr. BOOZMAN. And then you challenged the folks to produce the income that they needed. Can you talk a little bit more about that? The best practice management tools that were used at the medical centers that were doing a good job, how did you distribute those among the other centers? Does that make sense?

Mr. PARKIS. I am not sure I understood the last part of the question.

Mr. BOOZMAN. Well, again, the medical centers that were doing a good job as far as producing income and, you know, thinking outside the box——

Mr. PARKIS. Uh-huh.

Mr. BOOZMAN [continuing]. And supporting themselves, how did you distribute or did you distribute those best practice models from those successful centers versus the ones that were not pulling their weight?

Mr. PARKIS. I used to run into the National Institutes of Health (NIH) syndrome or not invented here. It is always difficult to spread a best practice model, but we did do it. We did emphasize doing that.

I am going to try a different track to answer your question. I had five medical centers. Two of them were two division medical centers in my network. Two of them were consistent, positive in the VERA model. One was some years it was, some years it was not. And the other two always cost way more money to operate than VERA produced.

Well, what we challenged the leadership at those centers with doing is learn the VERA model, learn what it is that is being done at these centers that are so successful that you can adapt where you are.

One center had always been a, you know, long-term care neuropsychiatric center. But over time, it developed into a tremendous community support center that did a lot of basic care and then started building on that higher-level care.

We got them a, I think it was a CT scanner so they could expand the level of medical patients that they were taking care of. And as

I was retiring, they were becoming more and more positive in the VERA model.

Also, the CBOCs that we added there tended to produce a lot more revenue for them. So they were transitioning from a neuropsychiatric mission to a medical care mission for all of southeast Ohio.

Another one was running some very expensive programs and we did not honestly have the numbers to support the program at that center, although they had the expertise. And we started transferring that workload to another center. That was the Open Heart Surgery Program.

Mr. BOOZMAN. Very good. I think, you know, that is really a good story to tell in the sense of—and it seems like perhaps that we need to do a better job of moving in that direction.

So thank you very much. We do appreciate your hard work.

Mr. PARKIS. Thank you.

The CHAIRMAN. Thank you, Mr. Boozman.

Mr. Mitchell.

[No response.]

The CHAIRMAN. Mrs. Kirkpatrick.

Mrs. KIRKPATRICK. Thank you, Mr. Chairman.

And thank you very much for your testimony.

I appreciate your telling us that one of the factors you look at in distributing the money is demand. However, that causes me some concern and let me put this in context for you.

I represent a huge district in Arizona that is rural. I have 11 Native American tribes who have their own tribal land. We have a very high percentage of veterans but an underutilization of services.

So I am concerned that if you are looking at demand, that may be skewed against the rural areas where they either do not know what services are available to them or it is so difficult to get those services, they are not asking for them.

So is there some adjustment so that we make sure that the rural areas get their fair share?

Mr. PARKIS. Yes. Is that the Prescott area, by any chance?

Mrs. KIRKPATRICK. Yes. Prescott is in my district, yes.

Mr. PARKIS. Okay. I was in Phoenix for a while and I knew Pat McLenman——

Mrs. KIRKPATRICK. Yes.

Mr. PARKIS [continuing]. In that area.

Mrs. KIRKPATRICK. It is a great facility. They do a great job.

Mr. PARKIS. Yes, they do.

Mrs. KIRKPATRICK. They just have a huge area to cover.

Mr. PARKIS. Yes. Veterans' outreach activities, they are extremely important not just for the funding stream of the medical centers but to tie the missions of the medical centers to the needs of the veterans served by that center.

The way I would recommend going about outreach in that area is talking to the tribal leaders, going out—we used to do health fairs all the time—and start gathering that information. People live a long ways away, but I bet you that through the tribal buildings or tribal councils or whatever, it would be very effective to set up telemedicine programs.

Most health care these days is actually chronic health care, not acute. And chronic care does very well being evaluated through telemedicine programs. You only bring the veteran in when they need an inpatient or specialty diagnostic episode. Other than that, they can be treated locally.

Mrs. KIRKPATRICK. And there are some good programs. You are right. Telemedicine is working there. There is also a mobile van that goes up to the remote areas.

But my concern is in the formula of distributing the funds, at that level, is there some kind of factoring? I am looking at your indexes in the written report you gave us. For instance, I do not see anything, an adjustment for, say, transportation or motel stays or length of travel to a center in terms of making a distribution of a fund.

So just keep in mind my goal is to make sure the rural areas get their fair share in comparison to the metropolitan areas. And I just do not see that in the indexes in your statement.

Mr. PARKIS. Okay. Most of my experience was in more populated areas, although I did have experience in working with people doing rural outreach.

I think where we would address the concerns that you brought up would be in the annual strategic planning process, identify the patients, identify their needs, and then come up with alternative strategies about how to meet those needs.

Mrs. KIRKPATRICK. Thank you very much.

The CHAIRMAN. Mrs. Kirkpatrick, the issues you brought up are very important. In January, we are going to be concentrating on rural access for veterans because everything you pointed out is correct.

My experience has been that if you build it, they will come. That is, the model says one thing, but if you put it up, they do come. That is what happened in my district.

You mention certain factors that were not taken into consideration, but I would include poverty, for example. If they say you have to be within 100 miles but nobody owns a car, what does it matter how close you are if you are 2 hours away?

Many Members of Congress have the exact same issues and we are going to focus on them in the first part of next year because, the problem is nationwide and you brought up some real important factors, thank you.

Mrs. KIRKPATRICK. Thank you.

The CHAIRMAN. Mr. Brown.

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman.

And thank you, Mr. Parkis, for giving your testimony this morning.

I represent the area around Charleston, South Carolina, which is a long, narrow Congressional district, and we have one major hospital in Charleston, but it serves, I guess, probably a 200-mile, you know, radius on either side.

But my question to you, and I know that you already expressed that you had a pretty dense populated district that you were involved in, my question is along the lines of providing service to those veterans that cannot get to the major, you know, facilities.

We do have an outpatient clinic in Myrtle Beach which is probably 100 miles away. And I know that we talked about the telemedicine and some other creative ideas about trying to meet the needs of the veterans.

But we also have in my district, and I am sure probably yours, too, these community health centers. And I was just wondering if you had any experience of maybe trying to share some of the medical facilities that the State already provides the general population or whether that could be, you know, some kind of a, you know, compromise to be able to help meet the needs rather than establishing two CBOCs and a community health center which basically boils down to saying resources, you know, administered to a different population base.

I know in Charleston, we have been working with the Medical University and the VA hospital. Mr. Finegan here I think will be testifying that we have been a big part of that process of trying to see where we could reach across those lines to provide better health care delivery for our veterans by drawing from the expertise from both the VA and the Medical University to be able to provide better health care.

I wonder if you had any direction you might give us as trying to do the same idea out in some of the rural communities where you have, you know, already have established a community health center and maybe somehow or another through a voucher program or some other means you could share those facilities rather than create whole new, you know, CBOCs.

Mr. PARKIS. Okay. I found the VA always extremely open to that kind of process, those kind of arrangements. When I was in Alabama in the early 1980s, we had a lot of community-based clinics that would share, say, like an American Legion hall. We would go there however many times a month and hold a clinic there.

In Vermont, I know of a State veterans nursing home where the VA has been operating a clinic in there for years.

As you get into the more rural areas, people actually have probably more use to sharing and working with each other to develop solutions. And there are a lot of examples across the VA.

In Cincinnati, they came up with some—I cannot remember the specifics, but I remember just by having somebody tasked with developing those kinds of partnerships, a lot of success stories generated from that. And then the next set of ideas generate.

It is a path that you have to start on and just assume that good things are going to come out of it. You do not come up with a whole solution the first time. As people begin to trust each other, you get more and more people volunteering to help you out.

Mr. BROWN OF SOUTH CAROLINA. I think because as the veteran grows older, you know, even if he has a mode to travel, you know, his ability to operate that vehicle might not be possible and so he is dependent upon somebody else. And so I would think as close to his home that we could provide some kind of health care, not maybe the major portions, but by using telemedicine, some other, you know, techniques that we could meet most of his needs without having him to travel into the main facility.

Mr. PARKIS. We had a program called hospital-based home care and a lot of it was focused on veterans, that if they were not in

that program, they would be in a VA nursing home. And we provided nursing home-like services in their home. They loved it. It worked really, really great.

Mr. BROWN OF SOUTH CAROLINA. Well, I think that is exactly the direction we ought to be going to try to allow them to stay in their facilities where they have familiar surroundings rather than transport them into a nursing home or either to a hospital.

But thank you for your service. I noticed my time has expired, but I appreciate you being here today.

Mr. PARKIS. If I remember the numbers correctly, you can serve three veterans in their home for every one that you have in a nursing home. It is just so much better and they like it better.

The CHAIRMAN. Thank you.

Mr. Perriello, you have any questions?

Mr. PERRIELLO. No.

The CHAIRMAN. Mr. Bilbray.

[No response.]

The CHAIRMAN. We thank you, Mr. Parkis, for your testimony. We appreciate your being here.

Mr. PARKIS. Thank you very much.

The CHAIRMAN. And enjoy further retirement.

Mr. PARKIS. Okay. Go back and take my shoes off again.

The CHAIRMAN. Thank you.

Our second panel is Ms. Rita Reed who is with the Office of the Assistant Secretary for Management and Michael Finegan who is the Director of the Veterans Integrated Service Network Number 11 in Ann Arbor, Michigan.

Accompanying the two witnesses are William Schoenhard who is the Deputy Under Secretary for Health Operations and Management, Veterans Health Administration (VHA) and Paul Kearns who is the Chief Financial Officer (CFO).

We thank you all for being here. Your written testimony will be made a part of the record and hopefully your oral remarks can be done in about 5 minutes.

Ms. Reed, you have the floor.

STATEMENTS OF RITA A. REED, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR MANAGEMENT, OFFICE OF THE ASSISTANT SECRETARY FOR MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS; MICHAEL S. FINEGAN, DIRECTOR, VETERANS INTEGRATED SERVICE NETWORK 11, ANN ARBOR, MI, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY WILLIAM C. SCHOENHARD, DEPUTY UNDER SECRETARY FOR HEALTH OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND W. PAUL KEARNS III, FACHE, FHFMA, CPA, CHIEF FINANCIAL OFFICER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF RITA A. REED

Ms. REED. Thank you, Mr. Chairman. Thank you for introducing the panel with me. I will not need to repeat that. As you know, they are all senior long-time operational and financial managers in

the VHAs and private sector in the case of Mr. Schoenhard who recently joined VA.

Mr. Chairman, Ranking Member Buyer, distinguished Members, thank you for the opportunity to discuss appropriations to Veterans Integrated Service Networks, also known as VISNs.

The process of making appropriated funds available to the VISNs and then to the medical centers begins immediately after the Congressional bill becomes law. Our central Budget Office reviews financial and performance metrics in concert with VHA's Financial Office to construct the usual apportionment documents that all departments must do.

Once these documents are approved by OMB, the central Budget Office allocates these funds to VHA in total through the Financial Management System. VHA can then distribute to its program offices and field facilities for obligation.

At the beginning of the fiscal year, VHA prepares operating budget plans for monthly obligations. These plans, once approved, provide the basis for monitoring macro expenditures. Oversight from a national perspective is accomplished with monthly performance reviews chaired by the Deputy Secretary of VA and senior management officials.

For this meeting, the Budget Office compiles extensive comparisons of plans, obligations, and metrics versus the actual data. These monthly reviews concentrate on these metrics and financial performance, workload, and access; this is the primary vehicle that top management uses in Central Office to help ensure the Department achieves its financial and program performance goals.

They also provide data for risk analysis and serve as a warning system to highlight potential operational or funding issues. However, as you have heard, the first line of accountability for resources in VA's decentralized health care system is the hospital and VISN director. These directors and their financial staff maintain frequent communication with VHA's Chief Financial Officer.

The first category of funding for the medical care program is by the three direct appropriations—medical services, medical support and compliance, and medical facilities.

The second category for funding is through collections and reimbursements. Collections are received from——

The CHAIRMAN. Ms. Reed, I am sorry to interrupt you, but you mentioned those three categories.

Ms. REED. Yes, sir.

The CHAIRMAN. While I have those on my mind, every medical director I meet seems to say that they are inhibited because there is a wall between those three accounts and how they are able to be spent.

Is that factually correct that they have no flexibility? Does the VISN director have flexibility? For instance, if a director had money for a program, but did not have the space for it, could they use these funds to build it?

Ms. REED. Yes, sir. There are mechanisms, as I know you know, in terms of transferring and we are required, as the appropriation law provides for each and every year, to come before the Committees to request permission to transfer money between and among the appropriations. And that has been done in the past.

The CHAIRMAN. But the medical director does not have any flexibility?

Ms. REED. I would have to defer in terms of how VHA provides flexibility once the funds are allotted.

The CHAIRMAN. And who does? Do you have to come to a Committee for that? If somebody needs space for a program that has been allocated, it would seem that they ought to be able to build the space.

Do you need more flexibility than you have is what I am asking? Does the law work for you or do you need some changes?

Ms. REED. I can relate exactly what I have heard from the financial managers in VHA over the years. I believe speaking for them when they sit here, but I am sure that they will have an opportunity if I misspeak, that they would enjoy a bit more flexibility in terms of being able to move funding as they see the need come up.

Thank you.

The CHAIRMAN. Sorry to interrupt you, but we will take the timer off so you can have as much time as you need.

Ms. REED. We are happy to answer as we go along.

The second category of funding that is provided, of course, is through the collections and reimbursement mechanisms. These collections are received from some veterans and their health care insurance policies. These collections are added to the medical services account at each medical facility that generates the collections. This also applies to reimbursements earned for activities such as sharing agreements with U.S. Department of Defense (DoD) and other facilities.

The allocation process by VHA's Financial Office involves only the first category because, as I stated, the second category goes directly to the medical facilities.

To be specific in some of the examples of how this has worked, in the 2009 allocation for the three medical accounts, which totaled almost $41.5 billion including $1 billion provided by the American Recovery and Reinvestment Act, of the total funding, $31.8 billion or about 77 percent was allocated to the 21 VISNs using the Veterans Equitable Resource Allocation model, what you have referred to as VERA.

VERA is primarily based on the estimated number of patients treated in each VISN, the severity or complexity of each patient's treatment, and the cost of the services provided. The balance of about $9.7 billion was allocated outside the VERA model. Slightly more than $1.5 billion was for specific initiatives, which were allocated separately, for example, Priority 8 veteran expansion, prosthetics and sensory aids, housing and homeless programs, and rural health initiatives.

Funding in the amount of about $6.8 billion was allocated as specific purpose funds. This includes operation of VHA's program offices and centrally managed programs such as salaries of clinical trainees and State nursing home per diem payments.

Funding provided by the American Recovery and Reinvestment Act was distributed to the VISNs based on a pro rata share of each medical center's facility improvement needs. The VISN director is then responsible for making the allocations to each of their medical

facilities. They use the method best suited for their specific needs which are in turn reported to the VHA Office of Finance.

The directors consider many factors in making their allocations such as patient care needs, adjustments to the prior year base, and workload increases.

Finally, Mr. Chairman, the basic principle of this allocation process is that health care occurs locally. The VISN director has the most complete knowledge of the changing requirements at each medical facility and the needs of the veterans they serve.

We appreciate the opportunity to participate in this hearing and my colleagues and I will be pleased to answer any questions after Mr. Finegan presents his testimony.

The CHAIRMAN. Thank you.

Ms. REED. Now or after Mr. Finegan——

The CHAIRMAN. Mr. Finegan.

Ms. REED [continuing]. Offers his testimony. Thank you.

The CHAIRMAN. Thank you.

[The prepared statement of Ms. Reed appears on p. 56.]

STATEMENT OF MICHAEL S. FINEGAN

Mr. FINEGAN. Thank you, Mr. Chairman, Ranking Member Buyer. It is good to see you. Thank you very much, distinguished Members of the Committee, for the opportunity to be here this morning to review the process we use to allocate funds from the VISN to the local medical centers.

I will share this morning our steps in the process, the rationale supporting it, our monitoring systems, and how we ensure these resources are most effectively used in caring for our veterans.

Mr. Chairman, most of my 20 years in the VA have involved resource allocation at various levels and positions in the agency. In each of these assignments, several principles have guided my approach to allocating funds. Specifically funding should follow the workload. It should support access and quality care, have a component of efficiency, recognize case mix or patient complexity, be easy to understand, and, most importantly, should be fair and use thresholds to manage large magnitude changes. We use the principles today in our VISN 11 model.

Our model of funding the medical centers uses workload and patient complexity data to ensure that funding follows workload growth. In any given year, depending on our VERA allocation, an adjustment may be made to the facility's funding level to either encourage efficiency or to mitigate what might otherwise be a significant budget change.

We also established a VISN-level capital pool to help us invest strategically in new growth, expensive high-tech equipment, and also address our top facility maintenance priorities. In 2009, this pool comprised 3.7 percent of our overall VERA distribution.

We asked a VISN-level panel of clinical experts to develop a detailed investment plan for equipment. This plan provides a structured schedule for investing in new technologies, replacing outdated equipment, reducing duplication, and leveraging volume discounts.

In one example, we were able to save over $12 million off of retail and $6 million off of the Federal supply schedule pricing by purchasing physiological monitors in bulk.

The funds for these strategic purchases are held in reserve at the beginning of the year by the VISN until later in the year as budget execution is monitored to ensure that we meet our overall funding targets. Reserving these funds is necessary to address unforeseen conditions at medical centers such as inordinately complex clinical cases, dramatic workload changes, or facility emergencies. These costs are often above and beyond what medical centers budget.

For example, in 2009, one facility in our Network experienced an electrical fire in the acute psychiatry floor causing us to evacuate the patients and resulting in over $1 million worth of repairs. We had to supplement that facility for $1.4 million from our VISN funds.

In a prior assignment as a Facility director, I encountered a young woman veteran with a very complex and rare condition that was beyond our ability to treat. We arranged for care for her at a specialized facility with expertise in her condition, but at a cost of over $64,000 a month.

So unforeseen expenses like this occur throughout the year and require a funding process that is flexible enough to cover the costs while enabling normal business to continue.

In VISN 11, all funds that we hold in reserve that are not expended for such unforeseen events are either spent on our strategic items or distributed to the facilities.

After receiving the budget, each medical center is required to submit an operating plan that describes how the budget will be spent appropriately to meet the mission requirements and the performance expectations.

We track monthly through variance reports financial performance at the facility, the VISN, and the national level. And the facilities that are over or under budget, we can discuss why this occurred and determine if corrective action is needed.

We also monitor on a monthly basis clinical and administrative performance measures including access, quality, satisfaction, and business metrics. These performance reports are discussed in my network each month at our quality meeting, our Executive Leadership Council, and during my site visits at the medical centers. I also have a quarterly performance review with my boss to make sure VISN 11 is meeting its targets.

Mr. Chairman, the allocation process used in VISN 11 is similar to those I have experienced throughout my career in VA. The process assures that medical centers are moving in the direction set by senior VA leadership and Congressional mandate. It does allow for local action to meet the changing circumstances and manage the risk of unforeseen events that occur every day in health care. And at the same time, our performance measures and business metrics ensure that quality access and satisfaction remain high and the mission requirements are met.

Thank you again for the opportunity to be here and I am available for any questions you may have.

[The prepared statement of Mr. Finegan appears on p. 57.]

The CHAIRMAN. Thank you.

Mr. Michaud.

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

Ms. Reed, is the distribution formula the same for all VISNs? Are they all treated the same?

Ms. REED. Sir, I will attempt to answer any VISN and hospital questions as best I can, but I would like to be clear that I do not participate in that process.

Mr. MICHAUD. As far as Central Office distributing to the different VISNs.

Ms. REED. We do not distribute to the——

Mr. MICHAUD. You do not?

Ms. REED [continuing]. VISNs, sir, from my office. We make those funds available to VHA who then follows the VERA allocation as well as special purpose or initiative funds that need to be put out specific to programs.

Mr. MICHAUD. Can anyone on the panel answer that question?

Mr. KEARNS. Yes, sir. Basically we use the same model for all 21 VISNs, which basically is the VERA model, which assesses patient volume, patient complexity, and various factors like that.

So to answer your question, we use the same model across the 21 VISNs. The results are different because the patient mix and patient volume are different.

Mr. MICHAUD. Okay. And when you distribute that money, do you take into consideration the CARES process that recommends that—for instance, the map I have here for VISN 11 at this time was three new CBOCs. Do you take that into consideration, the new CBOCs as recommended under CARES?

Mr. KEARNS. The new CBOCs would be incorporated in the VISN's financial plans. We would pick those in the VERA model once the patient population is actually served.

Mr. MICHAUD. Okay. Here is my concern in talking about the mother ship that was mentioned during the first panel, is under the CBOC process, those are operating money that comes out of the VISN budget.

So if you have a VISN, for instance, VISN 11, where there is required for three new CBOCs, I am not comfortable that the mother ship is going to be very aggressive in getting those CBOCs up and running because it comes out of their operating budget.

And I can tell you from the State of Maine for VISN 1, the only State actually in VISN 1 that was recommended under the CARES process for multiple CBOCs was actually the State of Maine. So when you look at the mother ship in Boston, they are not going to be very amendable to sending their operating dollars to a rural State like Maine.

And as you heard from the first panel, and I have heard the 7 years I have been on this Committee, is access to health care regardless of whether you live in an urban area or rural area. The rural areas unfortunately have not had that access. And it is because the mother ship tends to be hoarding the money because of the way the CBOC dollars are allocated. And if you do not take that into consideration, then they are not going to get their share and then the clinics and the CBOCs will not be up and running.

And that is where a lot of frustration among Members of Congress and veterans service organizations (VSOs) that they have is

that access issue. And until we change in the way we are distributing the money, particularly into the CBOCs to allow the mother ship to let those funds go, I guess I still will have a big concern with the access issue in rural areas.

The other issue I want to talk about, when you distribute the funding, how do you account for the census? Is it the veterans that are actually utilizing the facility or is it the population of veterans? Do you use the VA—how do you account for the veterans? Is it actual veterans using the system and it is a VA count versus what the census say there are for veterans in that particular region?

Mr. KEARNS. Yes, sir. We look back for the last 3 years for veterans that seek acute care and the last 5 years for veterans that are seeking our specialty care like spinal cord injury, long-term care, that we count a veteran one time in all of those periods and we use that as the projection for the current budget year.

Mr. MICHAUD. So it is veterans who actually seek the care, not the veterans who might qualify——

Mr. KEARNS. That is right, sir.

Mr. MICHAUD [continuing]. That you distribute the money?

Mr. KEARNS. That is right, sir.

Mr. MICHAUD. Okay. And in your process when you figure this out and it gets right back to the mother ship, and I will use VISN 1 as an example where people would have to travel 7 or 8 hours to go to Boston for their health care needs, is that veteran counted for the Boston versus where the veteran actually lives which is Maine and, if so, does that not tend to skew good policy manners as far as the mother ship wanting to keep the money that she is receiving so, therefore, she is counting that veteran as utilized in the Boston facility versus where they actually might be able to utilize or contract out a place that is closer to home?

So where is that veteran counted for? I would assume it would be where it is receiving the services which might not be fair or——

Mr. KEARNS. The individual veteran is counted and the cost of their care at the location where they receive the care. If it is at a local CBOC, it would be counted proportionately there. If it is at the mother ship, in your words, it would be there. And if it is in another VISN, we pro rate it across the VISNs.

Mr. MICHAUD. So, in other words, it would be to the benefit of Boston to keep that veteran coming there and the VISN director can dictate to the other States that you have to send your veterans there versus trying to find access to health care locally because they are getting money from it.

In closing, actually, Mr. Chairman, I would like a very detailed funding distribution, and I do not want for the system-wide because I will not be able to digest all of it, but for VISN 1, I want to know how the money is allocated to VISN 1 in a very detailed manner, as well as where they are counted from, where the resident or that veteran might be located, physically actually living so I can really follow this through as far as how the distribution of funds are allocated.

And it gets back to a lot of the questions you heard earlier from the first panel, and I am sure you will hear again, with veterans in rural areas being able to get the health care that they need. And part of it is the distribution method.

And the problem with medical facilities in rural areas is trying to get the money they need to establish the clinics or CBOCs that they are not going to be able to get because for whatever reason, you know, the VISN office, actually, it comes out of their operating budget and it might be more of a problem how we appropriate the funding.

Mr. KEARNS. Yes, sir. We will provide it.

I might add that this last year and for next year, we have a special funds reserve for rural initiatives where the VISNs and the facilities come in and compete for those funds. And we allocate them out separately to target new outreach initiatives for rural veterans to actually be like seed money to begin to start that. And then once the care is provided out there, it would be accommodated in our VERA model.

So we had last year $250 million set aside for that and we will have a comparable amount in this year.

[The VA subsequently provided the following information:]

FY08 VISN 1 Patients and Costs Includes Place of Enrollment and Place of Care

VISN Where Care was Provided	Enrolled VISN	Unique Patients	Expenditures	Unique Patients Not Seen in VISN 1	Cost of Unique Patients Not Seen in VISN 1
1	Enrolled VISN 1	205,834	$1,456,761,872	0	0
2	Enrolled VISN 1	847	$5,861,533	488	$3,962,922
3	Enrolled VISN 1	847	$10,105,630	590	$7,972,489
4	Enrolled VISN 1	1,000	$7,231,950	780	$5,083,467
5	Enrolled VISN 1	1,138	$4,312,528	425	$3,312,298
6	Enrolled VISN 1	1,436	$9,848,442	1,126	$7,887,085
7	Enrolled VISN 1	1,275	$7,984,126	1,003	$6,710,077
8	Enrolled VISN 1	7,964	$39,141,062	4,947	$28,533,095
9	Enrolled VISN 1	505	$4,492,586	383	$2,286,617
10	Enrolled VISN 1	327	$2,118,372	262	$1,732,050
11	Enrolled VISN 1	284	$2,020,192	236	$1,620,452
12	Enrolled VISN 1	215	$1,588,234	170	$1,345,464
15	Enrolled VISN 1	195	$1,416,692	155	$1,146,889
16	Enrolled VISN 1	733	$4,444,323	559	$3,692,351
17	Enrolled VISN 1	492	$3,074,128	360	$2,181,111
18	Enrolled VISN 1	740	$4,187,801	513	$3,394,957
19	Enrolled VISN 1	356	$2,663,228	260	$2,337,975
20	Enrolled VISN 1	467	$3,395,480	388	$2,929,403
21	Enrolled VISN 1	1,033	$3,429,094	660	$2,882,090
22	Enrolled VISN 1	873	$6,507,490	668	$5,613,522
23	Enrolled VISN 1	269	$2,301,526	207	$1,863,418
		20,996	$126,124,417	14,180.0	$96,487,732
1	Enrolled in Another VISN	22,664	$157,400,053	0	0

Expenditures are the Allocation Resource Center Cost used in the VERA allocation.

Mr. MICHAUD. Thank you very much. I appreciate it.

The CHAIRMAN. Mr. Michaud, you are asking some really good questions. Is there an internal dynamic to the bureaucracy that forces resources?

I have found it very difficult in my experience to get answers from that same bureaucracy about whether that is good or bad. You were not getting good answers. I think that is where we may need the GAO to give us those answers.

I think in the same dynamic maybe you could comment on the fee basis, I do not see the directors using their fee-basis authority very liberally or conservatively.

That decreases their budget and leaves either less for the—I love that term—the mother ship or it may be a factor in their promotions. The bigger surplus they return may be a factor in promotions and, therefore, they do not want to spend that money on veterans' access.

Those are the kinds of questions that I think really go to the heart of accountability and are very difficult to get the answers from panels from that bureaucracy.

Does anybody want to comment on that? Should I trust what you are saying?

There seems to be some internal dynamics here, as I think Mr. Michaud pointed out very, very well, that they would rather have the money coming to them, so they are not going to build the CBOCs or they want to save money for their budget, so they will look better to the Central Headquarters. Is that going on or how do you deal with that?

Mr. SCHOENHARD. Mr. Chairman, I am new to the VA, but I would just respond, and perhaps would ask Mr. Finegan to expand, that I think a lot of what in terms of accountability for medical center directors and VISN directors and all line officers charged with serving veterans is incorporated in the performance review plan.

In my early weeks, I am very impressed. Really gets at access and other issues. And what I have learned so far, that is much more on the minds of medical center directors than the financial incentives or disincentives that might——

The CHAIRMAN. Yes, but what if the performance review includes that? Are you looking at the amount of money they return to Central Office? I am sure you are, and does that mean the director is doing a good job or does that mean that they are not using their money to serve all the veterans they should be?

Mr. FINEGAN. Mr. Chairman, I have something in my network I call the refrigerator list. These are the performance measures that go on the refrigerator for each director and those are the ones that are of top priority. And they are access, quality, and satisfaction first and foremost.

We build our strategic plan around the access standards and so the three new CBOCs that Mr. Michaud——

The CHAIRMAN. Tell me what that means in practice. What if I tell you that 100 veterans in a rural part of my area are complaining? I bet you do not measure performance based on that kind of anecdotal evidence. Otherwise, you would be listening to us a lot more.

I do not know what that measurement means. We heard in Maine that the guy may not be looking at Maine. He is looking at Boston. So what does access mean? How do you measure that?

Mr. FINEGAN. Well, it is measured several ways. One is the days to appointment and——

The CHAIRMAN. Which?

Mr. FINEGAN. The number of days until the appointment, so getting veterans in within 30 days in all of our clinics. The other is the mileage and those are the mileage standards that are established.

The CHAIRMAN. What about a guy who cannot come because it is too far away? He is not even in the measurement? You are missing some very important things here.

Mr. Brown brought up the aging of veterans. When they are less able, and drop out of the system. Access is not even measured for those people.

That is the problem that we, in Congress, have. We have these anecdotal but very accurate stories about access and I bet you can provide us the exact things that go into access and that these other areas are not even measured.

Again, I will refer to the fee-basis issue. How do you measure that? If 100 people have asked for fee basis and 98 were rejected, is that part of your performance measure? I suspect not. Yet, you have denied access to those people.

I am not saying that one is wrong and one is right. I will bet that somebody has in mind how much money access is costing and that is what is measured, not that 98 people were denied fee basis.

Has anybody looked at what percentage of fee basis is granted? There is a performance measure that I think you ought to look at.

I am just making the point that you think you are measuring stuff that you are not. I am not telling you something you do not know, but some things are easily measured and some things are not. I believe you leave out the things that are hard to measure and you put such things as the number of waiting times.

By the way, that was manipulated, if you remember. People were entering the time they entered the clinic versus the time they applied for an appointment or they were told to call back in 2 weeks. Those 2 weeks were not counted in the measurement. So anything you measure can be manipulated, I suspect.

Our anecdotes, or the things we hear from our constituents, probably are more accurate than some of your measurements. You get locked into this measurement and there are other things, as Mr. Michaud pointed out, where you need three CBOCs, but people will have to take it out of their operations, so it is not in there.

Do you want to respond to my intellectual critique of measurement and bureaucracy?

Mr. FINEGAN. I wonder if I could respond to the three CBOCs. I mean, I know, of course, VISN 11 best. We have actually set aside money for the activation of each of those CBOCs in the lower peninsula of Michigan because the mother ship, the Saginaw VA, does not have the money in their operating budget to support the activation of those clinics.

So the debate that we have among our Executive Leadership Council is how much money do we set aside up front for our imag-

ing equipment budget versus how much money we set aside for the activation of those clinics.

Our strategic plan drives how we allocate the money. So I draw a 30-mile circle around population centers. I also look at the demand. Pardon me? Thirty miles for primary care. So I draw a circle around every reasonable population size and it does not get at some of those rural communities that——

The CHAIRMAN. What if there is a mountain between the two areas? I mean, that is what they did in San Diego and I have a mountain between two counties. They just did not put that in the measurement. It takes a little bit of time to go from one county to another.

What does a radius mean when you have a mountain? What does a radius mean if you do not own a car? What does a radius mean if you have to rely on a Disabled American Veterans bus that is only running once a week? What does that mean? It does not bring in the real circumstances that people have.

Mr. FINEGAN. So that is, I think, why we use the fee-basis authority and the telehealth technologies that Mr. Parkis mentioned.

The CHAIRMAN. Can you find out the percentages of approval of fee-basis requests to show what I am talking about or maybe we have something here that ought to be looked at?

Mr. KEARNS. Mr. Chairman, I can comment on that. The fee basis has been going up each year and we have it tied to the performance measures of access. So if a facility or VISN director cannot meet the access standards within their facility, they are required to fee out the care.

The CHAIRMAN. Yes, but that is putting the cart before the horse. I have rural and urban areas in my district. Now, it is a lot easier and more cost effective in the long run if people get their eye examinations 150 miles away from the mother ship, but all your formulas show you have the ophthalmological capacity to handle those guys at the mother ship. So denying the fee basis goes according to your model. They have the ability and they have you come in any time.

If they have to go 150 miles and they cannot see and do not have a car and they have an examination building in the block next to them. That is just stupid. Yet, by your model, it is accounted for. It comes out rational. It is not rational to the person who cannot go for the exam.

All right. I owe Mr. Brown, I think, questions.

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman.

And thank you all for coming and giving testimony today.

I know, Mr. Finegan, you were involved in trying to create the Charleston model and I know we have been very patient trying to see it work.

Do you know whether it has been implemented in any of the facilities around the country?

Mr. FINEGAN. Sir, I cannot speak to that specifically. I know that we have examples around the country. I know of a facility that I was the director of several years ago. We installed a computerized axial tomography (CAT) scanner purchased with VA money in the local facility and got free scans in return. The local facility managed the scanner, paid the electric bill, and that sort of thing. But

I think there are pockets of those initiatives throughout the system.

Mr. BROWN OF SOUTH CAROLINA. I know that we have some illustration in Charleston where they put some kind of a scanning type device in the Medical University which is run by the Medical University, but it was paid for by VA.

I know back in 2006, we actually put, I think, $37 million in the VA Reauthorization Bill to start construction of a hospital in Charleston. The Medical University is undergoing a massive uplifting, refitting, building new facilities. And we were hoping somehow or another we could implement that Charleston model in that overall plan. But so far, we have not been able to make any real major direction in that part.

And I do not know whether you had any insight. I know we talked about in Denver and maybe down in Orlando and maybe New Orleans and whether any of that has actually taken legs.

Mr. FINEGAN. No. I was on the project for the duration of the report and then was relieved and went back to my day job after that, so I do not know. I cannot speak to any more progress since then.

Mr. BROWN OF SOUTH CAROLINA. But you were pretty bought into the process, though, were you not?

Mr. FINEGAN. Pardon me?

Mr. BROWN OF SOUTH CAROLINA. You were pretty convinced that that model should have some implications in the better health care delivery for veterans?

Mr. FINEGAN. Well, I think the issue is how to spread the dollars as far as possible and provide as much continuity as possible for the veterans. And so I think whenever you can make a model that reduces the travel time and creates a seamless handoff between providers, you are on to something. And that sort of governed my approach.

Mr. BROWN OF SOUTH CAROLINA. I know during the last panel, we talked about, you know, using some kind of a sharing with the community health centers, particularly rural community health centers, that we have available, I know in my district, and I am sure they must be around the rest of the country.

Do you have any insight of maybe how that could practically work?

Mr. FINEGAN. Yeah. I mean, as I said, I think, you know, you work with the assets that are available in the community that you are serving and you supplement those somehow. So if the local provider does not have something that the veterans need, you can supplement that with some kind of VA asset of some sort.

We had a clinic that was not particularly rural when I was the director in Buffalo that was a hybrid clinic that treated both non-veterans and veterans and we sort of leased the doctor time and the exam rooms from this big practice, but it also enabled veterans whose wife, for example, wanted to be followed by the non-VA doctor, they could show up at the same clinic. One would go one way and one would go the other way.

So I think those kinds of models do make sense.

Mr. BROWN OF SOUTH CAROLINA. That is pretty interesting. Do you know whether there are any other VISNs that are using that same——

Mr. FINEGAN. I do not know.

Mr. BROWN OF SOUTH CAROLINA. That seems like to me that would work for us.

And I believe, Mr. Michaud, that would probably work well in Maine, too, where there is, you know, I know, a lot of travel distance between the CBOCs there.

So that model, that certainly looks, you know, very workable to me and I would be interested to get a little bit more information on that.

The CHAIRMAN. Thank you, Mr. Brown.

Mrs. Kirkpatrick.

Mrs. KIRKPATRICK. Thank you, Mr. Chairman.

I thank the panel for being here today and testifying. This is interesting information.

And I share the concerns expressed by Chairman Filner and also Mr. Michaud. What we are hearing as Members of Congress is that a one-size-fits-all model or formula is not adequately serving our veterans, especially in rural areas.

So my question is back to process. Who decides what the VERA model looks like and is there a regular update of that model and really who makes that decision?

Mr. KEARNS. Basically we have a Finance Committee that is made up of a number of VISN directors, a number of facility directors, and then a few people from the Central Office. We look at it each year, propose, recommend changes to it, and then it goes up through our national Leadership Board and to the Under Secretary for final approval.

Each year of the last 5 that I can remember, we have had enhancements or improvements to the model. It has also been reviewed three times by GAO and three times by RAND. In all of those instances, they have recommended slight enhancements or improvements to it which we have addressed. None of them have ever recommended a replacement for it, that there would be a better way, and we have asked them.

Mrs. KIRKPATRICK. Is geography and diversity taken into consideration in choosing the Members of that Committee?

Mr. KEARNS. Yes, ma'am. And the Committee Membership is updated periodically, but we have a fairly diverse membership.

Mrs. KIRKPATRICK. I have a little bit of concern if most of the members are VISN directors.

Mr. KEARNS. No, ma'am.

Mrs. KIRKPATRICK. Okay.

Mr. KEARNS. I think we have three VISN directors, a number of facility directors, and then some other individuals on it too.

Mrs. KIRKPATRICK. Okay. Would it be possible to get a breakdown of that Committee in terms of where they live, what they represent?

Mr. KEARNS. Sure.

Mrs. KIRKPATRICK. You know, just back to that concern to make sure that the rural areas are being heard from adequately and in the model-making process.

Mr. KEARNS. Yes, ma'am.

[The VA subsequently provided the following information:]

Veterans Health Administration National Leadership Board
Finance Committee Members as of December 4, 2009

Peter Almenoff, Assistant Deputy Under Secretary for Health for Quality & Safety

Gary Baker, VHA Chief Business Officer

Larry Biro, Director, VISN 7

Donna Chirwa, Business Operations Liaison, Office of the Deputy Under Secretary for Health for Operations and Management

Stanlie Daniels, VHA Deputy Chief Patient Care Services Officer

Hugh Deery, Chief Financial Officer, VISN 11

Mike Finegan, Director, VISN 11 (Co-chair)

Michael Fisher, Deputy Director, VISN 20

Danny Foster, Chief Financial Officer, VISN 9

Lisa Freeman, Director, Palo Alto VA Medical Center

Sandy Garfunkel, Director, VISN 5

Florence Hutchison, Chief of Staff, Charleston VA Medical Center

Paul Kearns, VHA Chief Financial Officer (Co-chair)

Jim McGaha, VHA Deputy Chief Financial Officer

Mary Ellen Piche, Director, Albany VA Medical Center

Lynn Ryan, Chief Financial Officer, VISN 16

Jim Tuchschmidt, VHA Director, Patient Access and Care Management

Dan Tucker, VA Deputy Assistant Secretary for Budget

Mark Yow, VHA Associate Chief Financial Officer for Resource Management

Mrs. KIRKPATRICK. Thank you.

The CHAIRMAN. Thank you, Mrs. Kirkpatrick.

Mr. Roe.

Mr. ROE. Thank you, Mr. Chairman.

And, Congressman Michaud, what people will do is look after their own best interest and you are absolutely right. What will happen, let me give you an example about how this works.

If you go to Boston, and I do not know that area very well, I know Tennessee pretty well, but let us say a patient is going from Maine to Boston and it is in their best interest to keep their resources there because who are they around every day? They are around people that tell them we do not have enough resources right there in the center where they are. I hear it all the time at Mountain Home.

And what you can do, Chairman Filner, to make the statistics work is this. Let us say you are seeing a post-traumatic stress disorder (PTSD) patient and to meet this 30-day criteria, you are seeing a clinical psychologist every month. Well, then you say, well, no, you can see a clinical social worker every 6 months. And you just change the criteria on whatever process you are seeing. You meet the criteria to get in the 30 days, but are you getting the quality care that you need. And I have seen those things manipulated and happen.

And what I heard Mr. Parkis say originally, and I would want to know on the CBOCs, every time you open one up, they are full. And so if you do that in Maine, I can assure you that what is going to happen is those patients are going to be seen there and there is no incentive for that person in Boston to be shipping their money off to Maine.

And the rural health that you mentioned, Mr. Kearns, is going to be meeting in my hometown in March of this coming year, 2010, and I would like to invite, if he has the time, to come with us and we will check into this down there. That rural health, $250 million, I am very familiar with.

And we need to look at that because the area where I live, as Chairman Filner has said, there is a mountain between everywhere where I live. So you can look on MapQuest and it will take you 30 minutes to go somewhere. Well, it may take you 2 hours to get there. So I think we have to look at this.

And the incentive is wrong for the local, and I am not blaming them. They have limited resources too. They do not have unlimited resources at the Mountain Home VA, so they have to look after their own well-being along with then trying to provide this outpatient therapy out of their own budget. So I am not really pointing a finger at them. We may have the incentive lined up wrong is what I am saying.

Another question I have, and it should work better, how is this 2 year—you all have not had a chance to do it yet, but how do you like the 2-year budgeting? I just wondered about your comments about that, where you can make your plans 2 years ahead now.

Ms. REED. Well, sir, certainly we are very much looking forward to actually getting those funds. We were hoping it would be this month, but now it looks like we are hearing it will be February.

But in concept, I think we are all excited about the opportunity to be able to know at least what core funds for medical care will be long before we have been able to in the past and be able to plan on that.

If any of my VHA colleagues would like to comment.

Mr. FINEGAN. I mean, my planning horizon has normally been 12 months and, you know, it gets murkier out beyond there. So I consider it a privilege to be able to now look out 24 months before the murkiness starts. So I am looking forward to it.

Mr. ROE. I think what we need to do and as our veterans age, as they are more infirmed, as people live longer, we have to look at whether it is telemedicine or regional health clinics, as Congressman Brown said, or whatever, but to get the care out to the veterans, not have them come long distance. It is much less efficient.

I have done it that way and I practiced medicine for 30-plus years before I came here. And you are much better off taking the care out. It is much more efficient. It is cheaper. The veterans certainly like it where I am. They absolutely like it.

They do not like 8-hour drives as you are talking about. And last year when gas, quite frankly, was $4.50 a gallon, many of them could not afford to come to the doctor because it just cost too much money. Two tanks of gas was more money than they had.

So I think we have, as a VA and as a resource, to look at how we expand that. Certainly in rural areas where obviously many of us live, we need to do that and it will be cheaper. It will actually save money.

But we cannot go to the hospital directors and say we are going to take this money away from you, so you will provide this care out there. I think that is something we have to look at.

Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Mr. Roe.

Ms. Herseth Sandlin.

Ms. HERSETH SANDLIN. Thank you, Mr. Chairman. I thank you and the Ranking Member for holding this hearing on this important topic.

I thank the witnesses for their testimony. I apologize for not being here sooner. Three other Committee hearings going on simultaneously.

But I understand that Mr. Michaud explored with you the issue, and perhaps Mr. Roe was following up on that, the issue of the CBOCs. There are 11 in South Dakota. There is a 12th being constructed.

And I do think in light of what I have heard the response was to Mr. Michaud's line of questioning, we do need to do some work here. I, for one, think there is an obvious disincentive for a medical center to look at constructing a new CBOC if it comes out of their operating budget. Fortunately in South Dakota, given the various needs and given how this is not just a rural State, some parts of South Dakota are really frontier more than they are rural when you look at other regions of the country, I think that is true for some other Members of the Committee, we need to work very closely with you as it relates to the allocation of the funds and any disincentive that any medical center may have to look at the long-term planning for additional community-based outreach clinics to serve veterans of all generations in some of these outlying areas to avoid the long distances they have to seek their primary care and other specialized needs.

Ms. Reed, could you talk with me about the oversight that the VA Central Office exercises as it relates to the different VISNs and the flexibility they have being left to determine how they allocate funds among their facilities to make sure that they are distributing the funds in the most efficient and effective manner and then how the various VISNs share data or best practices as it relates to developing the methods for distributing these funds?

Ms. REED. Ma'am, I think you were not here when I mentioned what we do at the Central Office, what we consider or what I consider macro oversight. And so we participate with the Deputy Secretary, with top leadership that is called the Senior Management Council in terms of monthly reviews, looking at national aggregates.

However, in terms of data specific to VISNs, resources given by VISNs to hospitals or how that may be shared, that manifests itself ultimately in terms of performance measures that we have talked about. But formulating or executing up front is very much decentralized and begins with VHA's Financial Office and flows down through their VISNs.

So I would defer to Mr. Kearns if he would like to add specifics.

Mr. KEARNS. I think specifically we look at the performance each month of the VISNs. And Mr. Schoenhard has weekly meetings with the VISN directors. I have biweekly conference calls with the VISN CFOs.

And so as we identify practices in one VISN versus another, we will communicate that so that the best practices can be proliferated

throughout the system. As problems surface, we also address those. And then we have a VHA Finance Committee, which looks at the overall execution of the financial program throughout the year.

Ms. HERSETH SANDLIN. So could either of you speak specifically then to how allocation decisions have been affected either by the influx or Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans or a significantly higher proportion of women veterans seeking access to medical centers within a particular VISN? Have any of those issues come up in the discussions you have had either with the Senior Management Council or at the VISN level?

Mr. KEARNS. Yes. Relative to the OEF/OIF, at least nationally, we are fairly on track with our estimates. In fact, we had overestimated what the actual experience has come in.

And with women veterans, we are creating a new initiative to target any increases or target facilities where there are not the proper facilities to accommodate the growing number of women veterans and also in those instances where we do not have the proper provider mix to address that. In other words, any places that do not have the proper provider mix for gender-specific care. And we have a program office that is doing that under Dr. Hayes, monitoring that across the networks.

Ms. HERSETH SANDLIN. And, Mr. Finegan, would you like to add anything?

Mr. FINEGAN. Thank you. Yeah.

Women veterans' issues and OEF/OIF inform our strategic planning process, so we have, for example, built our facility maintenance plan around issues like women's privacy, look at the services that we provide in mental health such as PTSD services, residential care and see if we have adequate resources for women. And that drives then the submission of construction projects to change that footprint.

And the same thing with OEF/OIF, case management, field-based services as opposed to hospital-based services, connections with the Vet Centers. Those are all deliberate parts of the strategic planning process, again both in the mental health uniformed services plan, the women's comprehensive health plan, and just normal facility planning.

Ms. HERSETH SANDLIN. Thank you all.

I yield back.

The CHAIRMAN. Thank you.

Mr. Bilbray.

Mr. BILBRAY. Thank you, Mr. Chairman.

Let me get back to the data you have basically based on the clientele mix. You were saying you have those who are served at a location.

Do you have their residents in your data system? So if they go from Maine and they are going in, you can detect that?

So let me just say bluntly rural is never going to be served to the level of urban. It may sound terrible and insensitive, but that is a fact of life that we have just got to understand.

And there are advantages to being out there. I am looking at my father-in-law. He drives into Stennis or New Orleans, but there is

no way in the world he wants to move into the city and get that closer service.

But that stated, how can we improve it and have our system more reality based? Do you have the addresses?

Mr. KEARNS. Yes, sir, we do. We track where the care is provided and the cost of that care in our allocation file.

Mr. BILBRAY. But do you residence location of the person receiving the care?

Mr. KEARNS. Yes, sir.

Mr. BILBRAY. Okay. So now, with that, you can create a model that basically will detect these long-distance commuters down the line.

The question is, when you talk about a 30-mile circle, have you looked into the Council of Governments and the transportation agencies that can give you drive times, because the Chairman's point was if there is a mountain, that may look good on a map, but this is a three-dimensional—no offense, but getting somebody to drive out of El Centro and come to San Diego in August is a service to them, not a problem. But those who have been in Imperial Valley in August will understand what I mean.

But the question is——

The CHAIRMAN. I ask that the gentleman's remarks be taken down.

Mr. BILBRAY. Mr. Chairman, you forget. I grew up and was Mayor of the city named after the Imperial Valley because all the farmers used to come to the beach during the summer.

The CHAIRMAN. And they wanted you out of town, so they sent you to Congress, right?

Mr. BILBRAY. Yeah. Yeah. One way to fight crime.

Let me just say, has anybody looked at drive times and looked at getting that data from transportation agencies and Council of Governments because they develop these models where you can literally see the way it works out?

A good example would be, let us just say the Chairman's district, it may only be an hour out to El Centro, but then it could be, you know, another hour out to the northern parts of Imperial Valley.

Has anybody even looked at creating that level of sophistication?

Mr. FINEGAN. I can answer. The second part is, no, I have not looked at external third-party transportation data sets. That is a very good idea.

The first part, though, yes, we do build in feedback from veterans who live there and remind us of the mountains, for example. And so the level of service that we put into our CBOCs is commensurate with the drive time to the parent facility.

So, for example, the further away you are either in mileage or drive time, the more likely we are to try to build in more robust specialty services, for example. Whereas, where I came from in Buffalo, if the CBOC was closer to the facility and there was an interstate and you could get there in 45 minutes, we might just make it a primary care and primary mental health.

So that factors into our strategic planning. And, I mean, I do not think I need to tell you that the veterans' community is very vocal about keeping us honest as far as drive times and things like that.

Mr. BILBRAY. Well, one of the things that we found very essential in serving the active-duty military was the ability to identify where the residents were and that allowed us to do modeling to specifically engineer it based on the maximum coverage with a minimum amount of effort.

And I do not know if you have the ability, if you have looked at literally mapping out where your veterans live, where they live, where are locations, and that is a lot more effective in the long run and much more cost effective in the long run than drawing a circle.

And I understand why you drew the circle, but I am just saying those are things we used to do back in the 1970s. We are not doing that anymore. If you ran a transportation agency or run any kind of marketing group, you know, they would throw you overboard if you were drawing circles.

And I think that what we have to do is identify your market, identify the clients you have to serve, and know where they are. And then you add in what kind of triage, how you are going to do it, and it becomes multidimensional. But you have people doing this across the board, very, very sophisticated.

And I think a lot of the complaints we hear from the Chair and from veterans can be addressed to a large degree by looking at new modern modeling concepts so that you now know what is out there. You are not flying blind and waiting for them to come to you. You already know where they are and get out to.

Thank you. We call it scouting in bow hunting, but you guys would not know what I mean.

The CHAIRMAN. Thank you, I think.

Mr. Buyer.

Mr. BUYER. Thank you.

I would like to first address to Ms. Herseth Sandlin, we are going to put together a letter to the GAO for an independent review. This funding and allocation, this flexibility that we have given unto the VISN directors, great discretion, we have our questions on allocation on those resources.

But even the Chief Financial Officer here has testified that what we have here has been in place since 1997. And so when that was put in place, Ms. Herseth Sandlin, in 1997, a lot has changed. And so what we have are VERA. We have out of VERA. We have specialized.

We also have this question about the more we sophisticate our collections through our Consolidated Patient Accounting Centers (CPACs) and we are working on this and the VA is also working on how to increase our collections on fee-basis care, more money has come in, how do those get allocated. It is all part of this. I mean, this is a little more complex than what it was when we put it together in 1997.

And so I think the questions that you asked are very similar to what Mr. Michaud has asked and the Chairman, everybody has given a pretty good contribution here today and I think please work with us. And I would ask you to join with us in this review for the GAO. I think it is timely. The last time it was done was 5 years ago. And I think it would be good, so I welcome the gentlelady for her to join us with that.

I yield to her.

Ms. HERSETH SANDLIN. Would the gentleman yield?

I would be more than happy to join you in that. You know, the situation in South Dakota, we are part of VISN 23, they do not use the VERA model. We have a lot of urban and rural parts in this VISN.

And while I think some of the directors of the medical centers feel that the funds have been allocated fairly, they are not using that model. And I think that there are some questions being raised again about the CBOCs that Mr. Michaud had pursued and we want to get more information in terms of how VISN 23 operates.

Mr. BUYER. Your VISN director would have to follow the VERA model, that they have great discretion with regard to how those dollars are then distributed. And that is the core of the question that you are asking and Mr. Michaud. And I think that is really pertinent for us.

Ms. HERSETH SANDLIN. But it also reflects, if the gentleman would——

Mr. BUYER. Yes.

Ms. HERSETH SANDLIN [continuing]. Some misunderstanding because as we explored this with some of the people that we work with in South Dakota, their description of it was essentially, and I do not know how much flexibility they are using out there, but VISN 23 according to some of the folks we talked to does not follow the VERA model very closely, if at all.

And so while there may be a requirement, they are using historical data and trends. They are using expected inflation numbers to adjust from the previous year's allocation in the new fiscal year.

So, again, as we all get more information from our medical centers and what VISN is doing what, it does seem to me just as you described the measure of discretion that they have been given and how that has modified sort of the expectations or the understandings of some of the directors out there of the medical centers and how they have adapted to these changes.

But I think it is very timely not only in the fact that you mentioned it has not been done in 5 years, but the dramatic increase in funding that we have seen over the last few years to get answers to some of the questions we are hearing on the ground about what the new hires have been for some of the PTSD funding and how that is meeting the needs of the veterans at the different centers or CBOCs.

Mr. BUYER. Let me reclaim my time.

Ms. HERSETH SANDLIN. Thank you for yielding.

Mr. BUYER. I thank the gentlelady's contribution.

Let me go right to Mr. Finegan. I not only respect your intellect, but I also respect your candor. So you have come right out of VISN 4, now with VISN 11.

Can you describe for me the differences between the allocation methods in VISN 11 and VISN 4 in the distribution of funds to the medical centers?

Mr. FINEGAN. Sure. Thank you.

They are not all that different at the end of the day. Every network uses some form of workload, whether it is the VERA workload passed down to the facility or more current workload or some

kind of case mix adjusted something. VISN 4 uses one. VISN 11 uses one.

Most every network uses some comparison to last year's budget, so any one facility does not get either too much of an increase at the expense of another or too little of an increase so as not to be able to cover inflation. VISN 4 uses that kind of governor and so does VISN 11.

The actual, I cannot remember, frankly, the actual data element for workload that was used in VISN 4, but it was an element of workload, either some case mix adjusted workload from our data systems or the VERA data, and then the outcome of that model is then compared to how much we got in VERA as a network and then what is the percent change from last year.

And so you are either kind of a low capper or a higher capper or low floor or high capper depending on how much you grew last year. And that same philosophy is what we use in VISN 11 and in the VISN 2 where I came from and those VISNs that I have worked in.

Mr. BUYER. So, Mr. Michaud, this was the answer to the question you were asking earlier, but there are some differences.

And let me go to the Chairman's point of inquiry a little bit earlier with regard to performance measures. Are the performance measures different from VISN 4 and VISN 11? If so, how are they different?

Mr. FINEGAN. No. Our executive contract, performance contract is the same for all directors across the system. The wait times that I mentioned, access in terms of the number of days to wait and the mileage and then the quality measures and the satisfaction measures.

Mr. BUYER. So even though you have flexibility and discretion, the Central Office gives you these types of guidance, i.e., performance measures?

Mr. FINEGAN. Right. I call it that there is the tight, loose, tight. We have a very tight budget that is given to us from Congress. We have some discretion as to how we allocate to the facilities, but we are all held very tightly to the performance measures. And that is, frankly, what we manage to——

Mr. BUYER. And so let us go to the Chairman's concern. The Chairman's concern is that if within a particular region or medical center you have some issue, if it comes down from Central Office to you, how does it go back up to either alter or change a particular measure?

Mr. FINEGAN. Well, within the authority that I have in the VISN, I can move the money from what VERA would have allocated. If VERA was passed down directly to a facility, which is how it is built from the ground up, it could allocate right back down to a facility.

The problem with that is our workload is not equally distributed among all of our facilities. So a complex psychiatric hospital, for example, has a disproportionate share of real complex, real expensive patients. A more basic hospital, a small general medical hospital has more of what we would call the less expensive kinds of patients.

So VERA, it loses its effectiveness the further down into the organization you go. So I have the ability to move the money according to where our strategic priorities are and where I see potential performance issues. And then if I am running short as a network, I have the ability to go into Washington and ask for what Mr. Parkis described, either a site review team or ask for a supplement if I was inclined to do that.

Mr. BUYER. Mr. Chairman, with your indulgence, I have two questions.

The last question I would like for you to answer was the one that I opened in my opening statement to you, Ms. Reed. But I also would like the Chief Financial Officer to comment with regard to the funding that is being done here to cover the shortfall that you have paying for overtime on the GI Bill claims being utilized out of another pot of money.

Let us go to the question. I want to make sure this is in our request for the GAO review and this deals with the collections. So as we have also been noticing the increase in fee basis and we know that we are in our 4th year on this pilot from this company down in Jupiter, Florida, you know, it is kind of the challenge we have had all along with information technology. I mean, my gosh. We get pilots that just kind of continue on and at some point, they have to go to request for proposal or you have to change something here.

But I am getting off on a tangent. We are increasing our collections not only on fee-basis care, but also with regard to our third-party collections. As we sophisticate and say we are done with our CPAC, we have now brought so much more moneys into the system, okay, over and above what we even had expected.

So my question is, given the increasing focus on our specialized programs, should we be taking a portion of the increase in allocations and placing those collections into the specialized programs?

Now, I know VSO partners out there would always say, oh, you have to keep it within health care. I understand that. We are going to do that. But, you know, when we started this process, we said unto the medical directors out there, you know, you work hard on your collections and you get to keep the money. Well, the world is changing here a little bit. Do we need to change our paradigm?

Mr. KEARNS. Well, sir, I would say right now the collections and reimbursements, whether reimbursements come from sharing that we normally do at DoD, that type of thing, those automatically go back to the local facility where it was generated.

So we think that that is the proper incentive. Even under the CPAC model where we are going to centralize a lot of the collection functions and activity for economy and efficiency, where the collection was generated at that facility, the collections still go back there. And we do that each month as the collections come in.

Mr. BUYER. I know that.

Mr. KEARNS. Now, I——

Mr. BUYER. Do we change the paradigm is my question?

Mr. KEARNS [continuing]. I do not know. I guess I would suggest if that is to be considered, consider some of the potential unintended consequences and incentives.

The Chairman brought up at the very beginning about the three accounts that we have and the comments he received from facility directors that they have no flexibility. Within the three-account structure, we have a flexibility at the appropriation level, so we can make the movements to accommodate the facility or the VISN director as long as we do not break the overall limits. If we need movement beyond that, we do have to come back to the two Appropriations Committees, the House and the Senate, to ask permission.

It would be nice if we had more flexibility in that. The last year in the Appropriations Act, we had up to a 1 percent threshold between medical services and medical support and compliance which was very helpful and we just had to submit notification, not ask for permission.

Anything in or out of the medical facilities account, though, we have to ask permission. So that is a restriction that does limit our flexibility and our ability to respond to the changing needs in the field to support the veterans.

Mr. BUYER. Do you need a legislative fix with regard to your request for increased flexibility or is this something that the Secretary can do?

Mr. KEARNS. The Secretary does not have that authority, sir, to approve transfers into or out of the medical facility account.

Mr. BUYER. You need a legislative fix? Will you shop that? If that is your testimony, would you shop that to the Secretary? I mean, either that or we take our own unilateral actions at the Committee.

Mr. KEARNS. I think I was just describing a situation, sir, that we have. We are operating within it.

Mr. BUYER. I understand. But, you know, you just provided testimony to us with regard to how we can best——

Mr. KEARNS. Yes, sir. Well, I——

Mr. BUYER [continuing]. Improve the system.

Mr. KEARNS [continuing]. I guess for the record, I would suggest or I would offer that I think 2 years ago, we did come over with a proposal to combine the two accounts and Congress chose not to accept that.

Mr. BUYER. Well, you know, send it back. Send it back to us. Seriously we will take a look at it. Okay?

Mr. Schoenhard, we are not picking on you. We know you are new on the job. But, you know, put your eyes on it for us, give us your consideration. You have a lot of intellect and experience out there. And the Committee will take a look at that.

The last thing, can you tell us what we are going to do here about the accounts, the paying, robbing from Peter to pay Paul here with regard to the disability?

Ms. REED. Sir, I am sorry. But, quite frankly, I am not aware of that situation in detail. It is not something that we have discussed at the central level.

Mr. BUYER. Do you know about it?

Mr. KEARNS. Sir, I am the CFO for the Veterans Health Administration. I think you are referring to the Veterans Benefit Administration.

Mr. BUYER. Okay. I will send it over and ask the right question to the right person.

Ms. REED. And we will get the right people to answer it.
Mr. BUYER. Okay. All right. Thank you.
I yield back.
[The VA subsequently provided the following information:]

The FY 2009 budget submission requested combining the Medical Services and Medical Administration appropriations into one appropriation. Please see the following cover page of FY 2009 President's Budget Submission Vol. 2 of 4, and page 1A–1 showing only 2 appropriations (Medical Services with Medical Administration combined with it and Medical Facilities), and page 1C–2 explaining that the Medical Services and Medical Administration were combined.

The Congress did not accept this proposed combination, but instead continued the three appropriation structure and renamed Medical Administration to Medical Support & Compliance.

Since that time there have not been any other formal proposals to combine the accounts.

Cover Page

FY 2009 BUDGET SUBMISSION

U.S. DEPARTMENT OF VETERANS AFFAIRS

"To care for him who shall have borne the battle, and for his widow, and his orphan. . . ."

Medical Programs and Information Technology Programs

Volume 2 of 4
February 2008

2009 Budget Submission, Page 1A–1

Executive Summary of Medical Care

Department of Veterans Affairs (VA) is committed to providing veterans and other eligible beneficiaries timely access to high-quality health services. VA's health care mission covers the continuum of care providing inpatient and outpatient care; a wide range of services, such as: pharmacy, prosthetics, and mental health; long-term care in both institutional and non-institutional settings; and other health care programs such as CHAMPVA and Readjustment Counseling. VA will meet all of its commitments to treat Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans and servicemembers in 2008 and 2009. In meeting our commitment, VA faces many of the same financial challenges as the health care industry in general and some that reflect our unique population of veterans.

To meet our commitment VA is requesting $41.2 billion in direct appropriation for 2009 for the two medical care appropriations, an increase of nearly $2.3 billion over the 2008 level. The direct appropriation includes $2.5 billion in collections, a 5.4-percent increase in the Medical Care Collections Fund. This request supports an increase of 3,076 full-time equivalents (FTE) or 1.4 percent over the 2008 current estimate of 215,515 FTE. The funding for each of the medical appropriations is displayed in the following table. In the 2009 request, VA is proposing that the Medical Administration appropriation be consolidated into the Medical Services appropriation.

Medical Care Budget Authority
(Dollars in Thousands)

		2008			
	2007 Actual	**Budget Estimate**	**Current Estimate**	**2009 Estimate**	**Increase/ Decrease**
Appropriation:					
Medical Services	$28,298,231	$30,609,671	$32,500,837	$34,075,503	$1,574,666
Medical Facilities	$3,911,165	$3,592,000	$4,073,182	$4,661,000	$587,818
Total Appropriation	$32,209,396	$34,201,671	$36,574,019	$38,736,503	$2,162,484
MCCF Collections	$2,219,169	$2,352,469	$2,340,787	$2,466,860	$126,073
2007 Emergency Supplemental (PL 110–28)	$1,311,778		✔		
Total Budget Authority	**$35,740,343**	**$36,554,140**	**$38,914,806**	**$41,203,363**	**$2,288,557**
FTE	204,574	197,117	215,515	218,591	3,076

[1]*FY 2008 Current Estimate does not reflect rescission of $66 million for Polytrauma Center in Medical Services.*

Medical Services, Excerpt from Page 1C–2

Explanation of Change in Appropriation Language

In the 2009 request, VA is proposing that the Medical Administration appropriation be consolidated into the Medical Services appropriation. Merging these two accounts will improve the execution of our budget and will allow VA to respond rapidly to unanticipated changes in the health care environment throughout the year. This portion of the Medical Services appropriation finances the expenses of management, security, and administration of the VA health care system through the operation of VA medical centers, other facilities, Veterans Integrated Service Network offices and facility Director offices, Chief of Staff operations, quality of care oversight, legal services, billing and coding activities, procurement, financial and human resource management.

The CHAIRMAN. Thank you.

Let me just make a couple of quick points. Whenever we say accountability, you say performance measures. I do not know all of your performance measures, but what I heard you describe does not sound like they are necessarily appropriate. Somebody has to look at that and maybe that is what the GAO should do.

For example, the first thing you said was access. You are talking about the data you have of people enrolled in the system who come to the VA. What about the ones who cannot get there because they do not have access? You are measuring access and you are not including people who have no access. Do you see what I mean?

I do not know if that is right or wrong. I am just taking what you said in your testimony. It sounds to me like that is not a good performance measure of access.

Do you have a comment on that? Are you only measuring those enrolled and who come——

Mr. FINEGAN. No. We actually——

The CHAIRMAN [continuing]. And ask for an appointment so you can measure the days?

Mr. FINEGAN. We actually have data on veteran population by zip code and by county. And so I measure market penetration which is total enrollment as a percentage of total veterans who live in a county.

And, frankly, VISN 11 is the lowest in the country. And so I have set targets at several percentage points higher than where we are now and that informs where I draw my circles and where I start to put my clinic applications in an attempt to get at those pockets of veterans who do not right now, are not——

The CHAIRMAN. It does not sound like the measure gets down to the bottom of the issue. Every time VA did a study for a CBOC in one of my counties, they would say, well, you do not have enough enrolled veterans. Well, I kept saying build it and they will come. I forget what the measure was you needed, say 11,000 and there were only 7,000. Well, as soon as they built it, 15,000 came.

Everybody kept saying you only have 7,000, you only have 7,000. But I knew there were more veterans there and I assume you did too. Why was that not used in a CBOC determination?

Mr. FINEGAN. I cannot speak to the policy, but I think the value in looking at the market penetration gets at exactly what Mr. Michaud was mentioning with——

The CHAIRMAN. Yes, but I would like to see some——

Mr. FINEGAN [continuing]. Those that do not have access.

The CHAIRMAN [continuing]. We would all like to see some of that data relative to where facilities are located. It seems to me to be primary.

Every one of us has heard people testify here and almost everyone who asked a question said our local people think they are not getting the resources that you all appropriated. We had a 40-percent increase, right? They do not see that they are not hiring 40 percent more psychiatrists. They do not have 40 percent more of everything.

What is going on between what we did and what they feel or see? Are they just not seeing the whole picture? What is going on there, assuming we are accurate or they are? Maybe we are getting wrong information.

Everywhere we go, we do not see the increase in our hospitals, whether it is staffing or space or access. We keep talking about how we added $20 billion more. Where is it going? That is what the medical directors are asking us.

Mr. SCHOENHARD. Sir, Mr. Kearns may want to comment on this more, but we are committed in VHA to getting the money to service the veterans. And Mr. Kearns may want to speak a little bit about some of what——

The CHAIRMAN. Can you tell me right now, whether there are 158 medical centers?

Mr. SCHOENHARD. One hundred fifty-three, sir.

The CHAIRMAN. One hundred fifty-three. Can you tell me immediately from a computer, what the budget is for each of those 153 medical centers and compare it with last year's budget? Certainly you should be able to do that. I will bet they do not reach some of the levels that we have been talking about here. I just have a sense of that, but can you do that?

Mr. SCHOENHARD. I think that will be—yes.

Mr. KEARNS. Yes, sir, we can provide that to you. And you will find that probably almost half of them had a larger increase and the others had a smaller increase. And much of the time, it was due to changes in workload. Sometimes you will see facility projects that are at one facility, one-time purchases that were not the next year, but we can provide that information.

And I think to say also, I think maybe what you might be hearing sometimes is we have a multi-step process of how the funds are allocated. The majority go out in VERA. But then separately after we get the appropriation, funds go out that are specifically targeted for such things as prosthetics, about $1.8 billion, and then the salaries of the clinical trainees from the local medical schools that work in our facilities, they go out separately.

Then last year, Congress tagged certain additional items that had to go out separately. So I think sometimes what you hear is a comparison of the initial allocation rather than the ultimate allocation. And also some facility directors——

The CHAIRMAN. Most of them are more sophisticated than that to tell us.

Mr. KEARNS [continuing]. And sometimes the facility directors will not include the collections money that is theirs in their analysis and those are increasing.

[The VA subsequently provided the following information:]

Fifty-six percent of requests for Mill Bill Claims were granted for FY 2008. The percentage is based on FY 2008 Mill Bill Data, the most recent data available. The percentage reflects the percentage of approved fee claims versus total claims received.

Data for every VAMC (153) on their change in budget from FY 2008 to FY 2009 follows:

Obligations as of September 30 (Millions)					Change		
VISN	**Station**	**Name**	**FY 2008**	**FY 2009**	**Amount**	**%**	**Comment**
1	402	TOGUS	$222.7	$240.0	$17.2	7.7%	
1	405	WHITE RIVER JCT	$141.3	$152.7	$11.3	8.0%	
1	518	BEDFORD	$153.8	$177.3	$23.5	15.3%	
1	523	VA BOSTON HCS	$552.8	$609.5	$56.7	10.3%	
1	608	MANCHESTER	$113.0	$129.0	$15.9	14.1%	
1	631	NORTHAMPTON	$108.5	$107.6	−$0.9	−0.8%	$7.9 million of one-time non-recurring maintenance requirements funded in FY 2008 did not require funding in FY 2009
1	650	PROVIDENCE	$178.7	$199.4	$20.7	11.6%	
1	689	VA CONN HCS	$396.9	$430.9	$34.0	8.6%	
TOTAL VISN 1			$1,867.9	$2,046.3	$178.4	9.6%	
2	528	UPSTATE NY HCS	$937.5	$1,013.0	$75.5	8.1%	
TOTAL VISN 2			$937.5	$1,013.0	$75.5	8.1%	

Obligations as of September 30 (Millions)					Change		
VISN	Station	Name	FY 2008	FY 2009	Amount	%	Comment
3	526	BRONX	$250.2	$255.5	$5.3	2.1%	$2.0 million of one-time non-recurring maintenance requirements funded in FY 2008 did not require funding in FY 2009, $4.1 million of one-time equipment replacement/refresh in FY 2008 reduced the FY 2009 need, and change to market-based acquisition of natural gas reduced requirement by $2.0 million in FY 2009 as compared to FY 2008
3	561	VA NEW JERSEY HCS	$426.3	$453.7	$27.4	6.4%	
3	620	VA HUDSON VALLEY HCS	$213.1	$215.7	$2.6	1.2%	$13.3 million of one-time non-recurring maintenance requirements funded in FY 2008 did not require funding in FY 2009
3	630	VA NY HARBOR HCS	$621.2	$659.4	$38.2	6.1%	
3	632	NORTHPORT	$253.9	$268.9	$15.0	5.9%	
TOTAL VISN 3			$1,764.8	$1,853.2	$88.4	5.0%	
4	460	WILMINGTON	$142.8	$154.7	$11.9	8.3%	
4	503	ALTOONA	$96.1	$109.0	$12.8	13.4%	
4	529	BUTLER	$79.4	$94.3	$15.0	18.8%	
4	540	CLARKSBURG	$120.3	$142.7	$22.4	18.6%	
4	542	COATESVILLE	$162.0	$170.7	$8.7	5.3%	

4	562	ERIE	$99.7	$108.7	$8.9	8.9%	
4	595	LEBANON	$201.2	$227.1	$25.9	12.9%	
4	642	PHILADELPHIA	$362.0	$401.0	$39.0	10.8%	
4	646	VA PITTSBURGH HCS	$465.0	$514.9	$49.9	10.7%	
4	693	WILKES BARRE	$185.2	$189.9	$4.7	2.5%	$4.7 million of equipment replaced/refreshed in FY 2008, coupled with a similar amount in FY 2007, reduced the FY 2009 need
TOTAL VISN 4			$1,913.6	$2,112.8	$199.2	10.4%	
5	512	VA MARYLAND HCS	$453.5	$496.0	$42.5	9.4%	
5	613	MARTINSBURG	$236.3	$254.6	$18.3	7.7%	
5	688	WASHINGTON	$374.0	$413.2	$39.2	10.5%	
TOTAL VISN 5			$1,063.9	$1,163.8	$100.0	9.4%	
6	517	BECKLEY	$90.2	$104.1	$14.0	15.5%	
6	558	DURHAM	$359.5	$403.1	$43.7	12.1%	
6	565	FAYETTEVILLE, NC	$172.6	$186.9	$14.3	8.3%	
6	590	HAMPTON	$228.4	$233.9	$5.5	2.4%	Centralized acquisition site for one-time $20.3 million investment in furnishings and fixtures for VISN-wide refresh of patient waiting areas, CBOCs, education and employment areas for applicants
6	637	ASHEVILLE	$206.5	$228.7	$22.2	10.8%	
6	652	RICHMOND	$325.9	$365.0	$39.2	12.0%	

Obligations as of September 30 (Millions)					Change		
VISN	**Station**	**Name**	**FY 2008**	**FY 2009**	**Amount**	**%**	**Comment**
6	658	SALEM	$243.3	$266.0	$22.7	9.3%	
6	659	SALISBURY	$342.8	$375.2	$32.3	9.4%	
TOTAL VISN 6			$1,969.2	$2,163.0	$193.8	9.8%	
7	508	ATLANTA	$444.5	$484.3	$39.8	9.0%	
7	509	AUGUSTA	$324.6	$346.6	$22.0	6.8%	
7	521	BIRMINGHAM	$317.8	$331.0	$13.2	4.2%	
7	534	CHARLESTON	$255.5	$268.2	$12.7	5.0%	
7	544	COLUMBIA, SC	$307.8	$334.8	$27.0	8.8%	
7	557	DUBLIN	$160.1	$170.8	$10.7	6.7%	
7	619	VA CENT AL VET HCS	$222.3	$224.2	$1.9	0.9%	$8.4 million of one-time equipment replacement/refresh in FY 2008 reduced the FY 2009 need
7	679	TUSCALOOSA	$129.3	$136.5	$7.3	5.6%	
TOTAL VISN 7			$2,161.8	$2,296.4	$134.6	6.2%	
8	516	BAY PINES	$526.7	$564.8	$38.2	7.2%	
8	546	MIAMI	$407.6	$424.4	$16.8	4.1%	
8	548	PALM BCH GRDNS	$327.6	$340.7	$13.1	4.0%	
8	573	N FL/S GA HCS	$708.9	$785.4	$76.4	10.8%	

8	672	SAN JUAN	$440.6	$482.0	$41.4	9.4%
8	673	TAMPA	$720.1	$802.5	$82.3	11.4%
8	675	ORLANDO	$172.9	$215.3	$42.4	24.5%
TOTAL VISN 8			$3,304.5	$3,615.1	$310.6	9.4%
9	581	HUNTINGTON	$175.9	$189.5	$13.6	7.8%
9	596	LEXINGTON	$256.3	$277.4	$21.1	8.2%
9	603	LOUISVILLE	$243.1	$262.0	$18.9	7.8%
9	614	MEMPHIS	$310.1	$347.5	$37.4	12.1%
9	621	MOUNTAIN HOME	$266.0	$301.1	$35.2	13.2%
9	626	MID TENN HCS	$531.0	$580.3	$49.2	9.3%
TOTAL VISN 9			$1,782.3	$1,957.8	$175.4	9.8%
10	538	CHILLICOTHE	$163.0	$190.2	$27.2	16.7%
10	539	CINCINNATI	$287.3	$328.3	$41.0	14.3%
10	541	CLEVELAND	$599.2	$683.2	$84.0	14.0%
10	552	DAYTON	$259.8	$286.6	$26.8	10.3%
10	757	COLUMBUS VAOPC	$135.5	$153.6	$18.1	13.4%
TOTAL VISN 10			$1,444.8	$1,641.9	$197.1	13.6%
11	506	VA ANN ARBOR HCS	$262.0	$305.1	$43.1	16.4%
11	515	BATTLE CREEK	$206.7	$219.8	$13.1	6.3%
11	550	DANVILLE	$164.1	$200.0	$35.8	21.8%

Obligations as of September 30 (Millions)					Change		
VISN	Station	Name	FY 2008	FY 2009	Amount	%	Comment
11	553	DETROIT	$255.8	$283.6	$27.9	10.9%	
11	583	INDIANAPOLIS	$335.8	$380.1	$44.4	13.2%	
11	610	VA N INDIANA HCS	$181.8	$209.5	$27.7	15.3%	
11	655	SAGINAW	$123.7	$140.3	$16.6	13.5%	
TOTAL VISN 11			$1,529.8	$1,738.4	$208.6	13.6%	
12	537	CHICAGO HCS	$319.5	$341.6	$22.1	6.9%	
12	556	NORTH CHICAGO	$206.4	$221.7	$15.2	7.4%	
12	578	HINES	$475.9	$495.5	$19.6	4.1%	
12	585	IRON MOUNTAIN	$88.6	$102.1	$13.5	15.2%	
12	607	MADISON	$236.7	$251.4	$14.7	6.2%	
12	676	TOMAH	$106.8	$116.5	$9.7	9.1%	
12	695	MILWAUKEE	$411.3	$442.8	$31.5	7.7%	
TOTAL VISN 12			$1,845.2	$1,971.5	$126.3	6.8%	
15	589	VA HEARTLAND WEST	$887.4	$929.0	$41.6	4.7%	
15	657	VA HEARTLAND EAST	$674.9	$750.4	$75.5	11.2%	
TOTAL VISN 15			$1,562.3	$1,679.4	$117.1	7.5%	
16	502	ALEXANDRIA	$166.0	$185.3	$19.3	11.6%	

16	520	VA GULF COAST VHCS	$286.9	$303.0	$16.1	5.6%
16	564	FAYETTEVILLE, AR	$178.3	$213.0	$34.6	19.4%
16	580	HOUSTON	$580.1	$623.7	$43.7	7.5%
16	586	JACKSON	$298.8	$333.0	$34.2	11.4%
16	598	LITTLE ROCK	$446.8	$507.2	$60.4	13.5%
16	623	MUSKOGEE	$165.3	$206.5	$41.2	24.9%
16	629	SE LOUISIANA VHCS	$216.9	$268.9	$52.0	24.0%
16	635	OKLAHOMA CITY	$327.3	$390.4	$63.2	19.3%
16	667	SHREVEPORT	$219.7	$229.4	$9.7	4.4%
TOTAL VISN 16			$2,886.0	$3,260.4	$374.4	13.0%
17	549	VA N TEXAS HCS	$671.3	$729.8	$58.5	8.7%
17	671	VA S TEXAS HCS	$553.4	$657.8	$104.4	18.9%
17	674	VA CENT TEXAS HCS	$439.9	$509.3	$69.4	15.8%
TOTAL VISN 17			$1,664.6	$1,896.8	$232.3	14.0%
18	501	NEW MEXICO VAHCS	$324.6	$342.2	$17.6	5.4%
18	504	AMARILLO VAHCS	$145.2	$156.9	$11.7	8.1%
18	519	BIG SPRING	$89.0	$95.3	$6.3	7.1%
18	644	PHOENIX	$379.1	$408.5	$29.4	7.8%
18	649	PRESCOTT	$127.5	$138.9	$11.4	8.9%
18	678	TUCSON	$302.3	$354.8	$52.5	17.4%

Obligations as of September 30 (Millions)					Change		
VISN	**Station**	**Name**	**FY 2008**	**FY 2009**	**Amount**	**%**	**Comment**
18	756	EL PASO VAHCS	$100.9	$129.9	$29.0	28.7%	
TOTAL VISN 18			$1,468.5	$1,626.4	$157.9	10.8%	
19	436	VA MONTANA HCS	$144.2	$162.0	$17.8	12.4%	
19	442	CHEYENNE	$85.0	$96.2	$11.2	13.2%	
19	554	E COLORADO HCS	$394.8	$425.3	$30.5	7.7%	
19	575	GRAND JUNCTION	$78.0	$80.7	$2.7	3.4%	
19	660	SALT LAKE CITY	$295.5	$321.8	$26.3	8.9%	
19	666	SHERIDAN	$78.4	$81.5	$3.1	4.0%	
TOTAL VISN 19			$1,075.9	$1,167.5	$91.6	8.5%	
20	463	ANCHORAGE	$116.9	$131.4	$14.5	12.4%	
20	531	BOISE	$130.4	$151.3	$20.9	16.0%	
20	648	PORTLAND	$446.0	$503.4	$57.4	12.9%	
20	653	ROSEBURG	$125.4	$134.0	$8.7	6.9%	
20	663	PUGET SOUND HCS	$535.2	$557.4	$22.2	4.1%	
20	668	SPOKANE	$124.7	$133.1	$8.5	6.8%	
20	687	WALLA WALLA	$71.4	$77.5	$6.1	8.5%	
20	692	WHITE CITY	$72.1	$77.1	$4.9	6.8%	

TOTAL VISN 20			$1,622.0	$1,765.2	$143.2	8.8%	
21	358	MANILA	$9.1	$9.9	$0.8	8.3%	
21	459	HONOLULU	$148.7	$168.5	$19.8	13.3%	
21	570	FRESNO	$159.2	$164.7	$5.4	3.4%	
21	612	N CAL HLTH CARE	$424.4	$461.8	$37.4	8.8%	
21	640	VA PALO ALTO HCS	$628.6	$694.8	$66.2	10.5%	
21	654	SIERRA NEVADA HCS	$198.4	$192.7	−$5.7	−2.9%	$24.6 million of one-time non-recurring maintenance requirements funded in FY 2008 did not require funding in FY 2009
21	662	SAN FRANCISCO	$431.5	$435.3	$3.9	0.9%	$25.4 million of one-time non-recurring maintenance requirements funded in FY 2008 did not require funding in FY 2009; $2.1 million one-time build-out cost for Santa Rosa CBOC in FY 2008
TOTAL VISN 21			$2,000.0	$2,127.7	$127.8	6.4%	
22	593	LAS VEGAS				11.7%	
22	600	LONG BEACH	$384.4	$400.2	$15.8	4.1%	
22	605	LOMA LINDA	$397.0	$432.8	$35.8	9.0%	
22	664	SAN DIEGO	$437.8	$465.5	$27.7	6.3%	
22	691	LA HCS	$705.8	$779.3	$73.4	10.4%	
TOTAL VISN 22			$2,183.4	$2,366.4	$183.0	8.4%	
23	437	FARGO	$139.7	$162.5	$22.8	16.3%	

Obligations as of September 30 (Millions)					Change		
VISN	**Station**	**Name**	**FY 2008**	**FY 2009**	**Amount**	**%**	**Comment**
23	438	SIOUX FALLS	$136.3	$141.4	$5.1	3.7%	
23	568	VA BLACK HILLS HCS	$156.3	$168.7	$12.4	7.9%	
23	618	MINNEAPOLIS	$587.8	$610.8	$23.1	3.9%	
23	636	NEB–W IOWA HCS	$709.4	$785.4	$76.1	10.7%	
23	656	ST CLOUD	$158.6	$180.1	$21.5	13.6%	
TOTAL VISN 23			$1,887.9	$2,048.9	$161.0	8.5%	
VA HQS, CHAMPVA AND OTHER			$1,452.0	$1,712.6	$260.6	17.9%	Increase driven by centralized Fee Care payments and activation of CPACs
VHA TOTAL			$39,388.0	$43,224.7	$3,836.8	9.7%	

The CHAIRMAN. All right. I yield to Mr. Buyer for a question.

Mr. BUYER. Mr. Chairman, you asked a really good question.

Let me go right to Mr. Finegan. The difference between your budget from last year to this year and what did you do with any increase? Tell me the difference. Do you know?

Mr. FINEGAN. From 2008 to 2009 was 8.7 percent all in. Part of what I think Mr. Kearns was describing was the closest apples to apples comparison we make is last year's VERA to this year's VERA. But what happens after that is money comes in for prosthetics and some of the——

Mr. BUYER. That is all non-VERA?

Mr. FINEGAN. That is all non-VERA. Some of the centrally driven initiatives and that takes that VERA allocation and steps it up several percentage points.

Mr. BUYER. So your VERA allocation—no. All in is 8 percent or all in is approximately what?

Mr. FINEGAN. Pardon me?

Mr. BUYER. That is approximately what kind of dollar figure?

Mr. FINEGAN. In terms of dollar? Well, let us see.

Mr. BUYER. Just a ballpark.

Mr. FINEGAN. A couple hundred million.

The CHAIRMAN. A couple hundred million?

Mr. FINEGAN. We are at $1.3 billion in my network all inclusive. And so I cannot do that math in my head.

Mr. BUYER. No. That is okay.

The CHAIRMAN. All VISN directors should be able to do that in their head.

Mr. FINEGAN. My kids might be watching on the Internet, sir.

The CHAIRMAN. I am watching.

Mr. BUYER. With regard to the allocation of the increase that came, let me ask the Chief Financial Officer here, do you know approximately how much of this went into non-VERA?

Mr. KEARNS. From last year, yes, sir.

Mr. BUYER. Yes.

Mr. KEARNS. There were specific items that Congress targeted that would not be in VERA. I think it was $300 million of nonrecurring maintenance, $200 million of fee-basis care, and then the additional money that we got for the Priority 8 increased enrollment. And all that, it went out separately, but it was not——

The CHAIRMAN. But that is not a lot compared to the increase you got.

Mr. KEARNS. It is not a lot, no, sir. Well, it was the bulk of the—last year, as I recall, the increase over the President's budget was approximately, I think it was $1.5 billion, if I recall. And most of it was all targeted by Congress to go out a special way. And we did comply with that.

Mr. FINEGAN. It was a $100 million, sir. I had it right in front of me.

Mr. BUYER. One hundred million dollars?

Mr. FINEGAN. One hundred million dollars was the increase from 2008 to 2009, all inclusive. That was construction, equipment, and operating funds.

Mr. BUYER. That is not a lot.

The CHAIRMAN. It just does not sound like a lot compared to what we thought we appropriated.

Mr. BUYER. Well, this included construction?

Mr. FINEGAN. Not major and minor. Just NRM construction.

Mr. BUYER. It does not include nonrecurring maintenance?

Mr. FINEGAN. It does include nonrecurring maintenance. It does not include major or minor construction.

Mr. BUYER. Well, that would account for some of the increase.

Can I ask——

The CHAIRMAN. Sure.

Mr. BUYER. Mr. Finegan, I need to ask you this specific question. If we are going to be increasing non-VERA more specialized, go back to this collections question, should we be dedicating? I mean, we can do specifically from the Committee in our authorization that a specific percentage of allocation of our increases here in collections from the Central Office go to a specific cause. Should we be doing that?

Mr. FINEGAN. I feel very strongly in the incentives right now. I have seen growth in collections by targeting it to the facility. The whole facility gets around the concept of better documentation, quicker billing, better collections. They see the little thermometer in the facilities showing the increases in collections and how that can be plowed into local initiatives at the facility.

So I think any change to that would have unintended consequences that I would not recommend.

The CHAIRMAN. I will end the hearing by thanking Mr. Buyer for his initiative on the GAO letter. We will work together with you. Accountability is difficult to evaluate on your own. We would evaluate ourselves different by than our voters, for example. I appreciate the initiative, and we appreciate you being here today and look forward to working with you in the future.

This hearing is adjourned.

[Whereupon, at 12:08 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Bob Filner, Chairman, Committee on Veterans' Affairs

I would like to thank everyone for attending the hearing today. Recently, I have become aware of potential issues which suggest that Federal funds may not be flowing to the local VA facilities in the most efficient and effective manner to best serve our veterans. This is a concern for me, since I have worked alongside my colleagues to provide for a robust VA medical care budget. In fact, appropriations for VA medical care have increased over 40 percent since I assumed leadership as the Chairman of this Committee.

The purpose of this hearing is to ensure that appropriated Federal dollars reach the local VA medical centers. This requires a good understanding of how the 21 VISNs distribute the appropriated Federal dollars to the local medical centers and how the VA tracks the dollars spent at the local level.

It also requires a good understanding of the budget planning process and how the VA central office involves the VISNs and the local medical centers to determine the resources needed to provide proper medical care to our veterans.

Some local VA medical centers claim that their allocations from the VISNs have either remained stagnant or have not been proportional to the unprecedented increase in overall funding for VA medical care. At this time, we are not able to examine these anecdotal concerns without a full understanding of the rationale that the VISNs use for allocating funds to the VA medical centers. Through today's hearing, my goal is to learn more about the decision-making process that the VISNs use for distributing the appropriated dollars to the local medical centers.

In the VA medical centers that serve the veterans in my district, I understand that there is a hiring freeze which may be linked to the growing queues that our veterans face for mental health care appointments. We have reports that the hiring freeze is not limited to mental health professionals and is VISN-wide.

Also, we have heard that this VISN-wide hiring freeze may have resulted from one particular medical center going over its budget in fiscal year 2009. This raises questions about how the VISNs track the funds that the local medical centers spend and whether VISNs are able to predict and prevent funding shortfalls at the local level before they occur.

Through this hearing, I plan to explore who decides how to prioritize, spend, and track the funding that the local medical centers receive from the VISNs. I would also like to uncover how the VA central office, VISNs, and local medical centers plan and execute budgets, and manage potential funding shortfalls.

Finally, in a September 2008 report, the Government Accountability Office found that VA policies and procedures were not designed to provide adequate controls over the authorization and use of miscellaneous obligations, which totaled about $7 billion in FY 2007. The flaws in the design of the internal control system increased the VA's risk for fraud, waste, and abuse. Through today's hearing, we will examine whether the VA has an internal budget control system that is strong enough to track, account for, and safeguard the flow of Federal dollars to the local VA medical centers.

I look forward to hearing from our witnesses as we work together to provide the best health care to our veterans by ensuring that appropriated Federal dollars reach VA medical centers in the most sensible and effective manner.

Prepared Statement of Hon. Harry E. Mitchell

Thank you Mr. Chairman.

I would also like to thank our distinguished panels for joining us today to discuss our priorities for the VA going forward.

This year's veteran's budget has increased the investment in veterans' health care and services by 60 percent since January 2007, including the largest single increase in the 78-year history of the VA.

This funding has strengthened health care for more than 5 million veterans, resulting in the addition of 17,000 new doctors and nurses, and more Community-Based Outpatient Clinics and new Vet Centers.

It has been critical to meeting the needs of the 363,000 veterans returning from Iraq and Afghanistan in need of care over the last 3 years. This funding also is expanding mental health screening and treatment—vital to the many veterans suffering from PTSD and Traumatic Brain Injury.

I am very proud of that legislation, and I know it will make a difference in the lives of millions of veterans and their families.

And while it represents an important step forward, I think we can all agree that we need to do more.

Unfortunately, we already know that our veterans are facing a host of challenges. They're encountering unacceptable wait times for care, questions about the safety of their personal information, and difficulties accessing their medical records from the Department of Defense, just to name a few. We have an obligation to work together to address these issues.

We also have an obligation to provide the resources necessary to help veterans cope with the new and different kinds of injuries they are suffering in Iraq and Afghanistan.

We need to ensure that they have access to treatments for traumatic brain injury and post-traumatic stress disorder, as well as the latest in prosthetic technology.

We clearly have a lot of work to do, and that's why I am looking forward to today's hearing. I yield back.

Prepared Statement of Clyde L. Parkis Sebastian, FL, and Former Director, Veterans Integrated Service Network 10, Veterans Affairs Health Care System of Ohio, Veterans Health Administration, U.S. Department of Veterans Affairs

The VERA (Veterans Equitable Resource Allocation) workload methodology is broken into two categories: BASIC and COMPLEX.

- BASIC is further broken down into six groups composed of 30 classes, mostly outpatient care and short-stay inpatient care (surgeries).
- COMPLEX is further broken down into five groups in FY 2010, composed of 24 classes, mostly inpatient mental health and long-term nursing home care (now called Community Living Centers).

The Allocation Resource Center (ARC) has identified reimbursement/funding rates for the 11 Basic and Complex groups. These rates are the same for all VISNs. The rates are based on average costs of the classes that are assigned to each group, and cost relationships to the other groups.

VERA distributes funding to the 21 VISNs by a workload-based methodology. The overriding premise is that all VISNs are large enough to provide a similar continuum of care to the veteran patient population, i.e., each VISN provides the same care as every other VISN. Therefore, a workload-based methodology would be a fair and consistent approach for funding distribution to all VISNs.

However, there are a few identified factors that are necessary for consideration to level the playing field. These are salary and other cost factors that differ across the country, and the difference in commitment to other missions of the VA such as Research and Education.

Patients (workload) are counted based on 1) where they receive their care, and 2) the attributed costs incurred. If all care is provided at one site, then that site receives credit for 1.0 patient. If care is provided at more than one site, whether inside the VISN or not, that one unit of credit is split, based upon the costs incurred at each site. So, if the first site sees the patient for 10 outpatient visits and then the patient goes for surgery to a second site, and the second site incurs 85 percent of the cost to care for that patient during the fiscal year, then the second site would receive 0.85 of a patient count and the former site would receive 0.15 of a patient count.

Because reimbursement rates for the eleven groups are the same for all 21 VISNs, Indexes were developed to level the playing field in certain areas:

- The Geographic Index moves money from the Midwest to the coasts to account for higher cost-of-living–salaries, utilities, contracted care, research involvement, and education commitment.
- The Research Support Index recognizes that some medical centers incur greater unit costs for care because their Research Mission takes medical-care-funded providers with grants away from patient care.
- The Education Index provides funding to those sites with residents, to cover greater costs incurred for tests, etc.
- The HiCost Patients Index covers costs above a certain threshold incurred by caring for catastrophic patients whose costs do not match well with reimbursement under the 11 groups. In FY 2010 that threshold is $95K, which means that once the patient's costs reach that threshold, the model will reimburse the medical center dollar-for-dollar for actual expenses. However, VISNs will have to absorb any costs between reimbursement for the group the patient falls into and the assigned threshold. This approach creates a shared financial responsibility between the VISN and the model.

Other factors/Indexes have been looked at by the ARC over the years, but have been determined to have not enough significance to be distinguished in the model.

The ARC continually reviews components of the model to ensure that the composition of the groups is consistent and material, and works well with other components of the model. That is why in FY 2010 a determination was made to form an 11th group, Long Term Stay Users, patients who are essentially institutionalized and incur major expenses well beyond the reimbursement figure of $65K, greatly distorting the composition of the group they formerly fell under. By breaking these patients out into a new category, funding is increased by $160K.

Distribution of funding to the medical centers has been the responsibility of each VISN. Most VISNs utilize some form of the VERA model for that task. VISNs usually modify the model to account for those medical center missions that may not blend as well under VERA as under other models. This provides an opportunity for VISN leadership to make budget allocation adjustments to account for those requirements.

The VERA model promotes seeing more patients in the most cost effective setting, ensuring that the mix of long-term care, mental health and primary care is such that the system meets the VA missions to serve the needs of the veteran patient population, and makes sense to the field leadership.

During five budget cycles as VISN 10 director, I began to focus increasingly on using the VERA model at the medical center level as a starting point for budgeting individual VAMCs, and then challenging VAMC leadership to develop strategies to earn any additional funding they needed to support their programs. I preferred this to reallocating money earned by another medical centers. As I recall, only two or three of the five VAMCs in VISN 10 were resource positive under VERA. I labeled funding allocated above money earned as "corporate welfare," and challenged each VAMC to replace welfare with earnings. This strategy helped people understand where funding comes from and to connect the VERA process with program management.

VISN 10 was able to avoid or minimize the use of waiting lists while responding to increased enrollment during my tenure. 2001–2006 Health Care cost index rose approximately 10 percent per year, while our enrollments increased by 5–8 percent per year. During this time our budget increase averaged about 5 percent per year. This provided an enormous challenge to our Health Care providers and I am very proud of the way they met the challenge. Team members in VISN 10 met the challenge by continuously finding ways to improve performance and provide quality compassionate care to an ever-increasing number of veterans.

SUMMARY

1. The VERA model's workload-based system is the best way so far created to distribute core funds to 21 VISNs that support over 150 medical centers. The model accounts for historical workload as well as future projections of workload.
2. VERA supports seeing more patients, as funding is based on the number of individual patients seen and not the number of times the same patient is seen.
3. It is important to recognize that not all sites have the same mission, and thus there are differences in financial needs to support differing missions. Identifying workload based on costs to provide that varying workload through the

Basic/Complex categories to 11 groups and 54 classes provides funding based on complexity of care.
4. Understanding that providing the same care does not necessarily incur the same costs in different regions of the country, through no fault of the VISNs or medical centers in those regions, it is appropriate to level the playing field in areas that are material, such as salaries, utilities, research involvement and education commitment.
5. There is flexibility in the methodology as the ARC constantly reviews the classes and groups, to ensure that they are viable and current. Just for FY 2010 alone, substantive changes were made to more appropriately account for institutional long-term stays and movement toward more defined telehealth, and to support costs associated with patients who are seen as both outpatients and inpatients during the same period.
6. There has been no better system developed to date to effectively replace VERA and ensure as much equity and keep politics at arms length.

I would like to take this opportunity to thank the Committee for inviting us here to discuss this issue. Our veterans depend on you and the VISNs depend on you to see that they receive the necessary funding and support to enable them to meet the increased call to provide veterans with the care they deserve.

Prepared Statement of Rita A. Reed, Principal Deputy Assistant Secretary for Management, Office of the Assistant Secretary for Management, U.S. Department of Veterans Affairs

Chairman Filner, Ranking Member Buyer, Distinguished Members of the Committee, thank you for providing this opportunity to discuss the Department of Veterans Affairs' (VA) Health Care Funding: Appropriations to Programs and the decision-making process used by Veterans Integrated Service Networks (VISN) to distribute appropriated dollars to VA medical centers (VAMC). I am accompanied today by Mr. William Schoenhard, Deputy Under Secretary for Health Operations and Management, Veterans Health Administration (VHA); Mr. Michael Finegan, Network Director, VHA VISN 11, Ann Arbor, Michigan; and Mr. Paul Kearns, VHA Chief Financial Officer (CFO).

The process of making appropriated funds available to the VISNs and then to the VAMCs begins immediately after Congress passes and the President signs VA's appropriations bill. The Department's central Budget Office in concert with the VHA CFO's office, reviews financial and performance metrics associated with VA health care to construct the apportionment documents that request funding availability approval from the Office of Management and Budget (OMB). These apportionments, once approved by OMB, stipulate how much funding is available throughout the fiscal year (FY) for each appropriation account. If necessary, reapportionments may be resubmitted throughout the year to adjust the availability of funds.

Once the apportionments have been approved by OMB, the central Budget Office allocates these funds to VHA in total through VA's Financial Management System. At this point the resources are available to VHA to distribute to its program offices and field facilities for obligation.

At the beginning of the fiscal year, VHA prepares operating budget plans that outline planned obligations, by month, for each appropriation account. The Department's central Budget Office prepares extensive comparisons of planned vs. actual data, generally on a national basis, for Monthly Performance Reviews (MPRs) chaired by the Deputy Secretary and attended by senior management officials. These monthly reviews include metrics that measure financial performance, workload, and access and are one of the primary vehicles used at the central office level to help ensure that the Department achieves its financial and program performance goals. These reviews provide data for risk analysis and serve as a warning system to highlight potential operational or funding problems that could be significant. Nevertheless, the first line of accountability in assuring adequate resources for VA's decentralized health care system on a facility-by-facility basis is the hospital and VISN directors. These Directors and their financial staff maintain frequent communication with VHA's CFO and provide timely information to ensure necessary resources are available.

The medical care program is largely funded by three direct appropriation accounts (medical services, medical support and compliance, and medical facilities) and collections received from some Veterans and their health care insurance policies. These collections are added to the medical services account at each medical facility that generates the collections; as well as, reimbursements earned for activities such as

sharing agreements with the Department of Defense are also added to each medical facility where the reimbursements have been earned. The allocation process by VHA's CFO office involves only the first category described above because the second category (i.e., collections and reimbursements) go directly to the medical facilities that generated the collections or reimbursements.

What follows is an overview of the FY 2009 allocation process for medical funding. The appropriations in the three medical accounts totaled almost $41.5 billion, including $1 billion provided by the American Recovery and Reinvestment Act. Of the total funding, $31.8 billion (77 percent) was allocated to the 21 VISNs using the Veterans Equitable Resource Allocation (VERA) model that is primarily based on the estimated number of patients treated in each VISN, the severity or complexity of each patient's treatment, and the cost of the services provided. The balance of about $9.7 billion (23 percent) was allocated outside the VERA model. Of the $9.7 billion, slightly more than $1.5 billion (3.6 percent) was identified in the appropriations process for specific initiatives and was allocated separately for each initiative such as: Priority 8 Veterans, Vet Centers, new generation prosthetics and sensory aids, HUD–VA supportive housing program, Homeless grant and per diem program, Homeless grant and per diem liaisons, rural health initiative, expanded outpatient services for the blind, Eye Injury Center of Excellence, FEE-based services outside VERA, non-recurring maintenance projects outside VERA and a major lease. Funding in the amount of about $6.8 billion (16.9 percent) was allocated as specific purpose funds of which $1 billion (2.5 percent) was for the operation of VHA's program offices and $5.8 (14.4 percent) was for the centrally managed programs such as prosthetics prescriptions in each medical facility, salaries of clinical trainees at specific medical facilities, State Nursing Home per diem payments paid by the supporting medical facility, and the CHAMPVA benefit claims paid to both VA medical facilities and civilian medical facilities and providers. Funding provided by the American Recovery and Reinvestment Act were distributed to the VISNs based on a pro-rata share of each medical centers facility improvement needs.

After each VISN receives its VERA allocation, the VISN Director is responsible for making the allocations to each of their medical facilities using the method that best suits the specific needs of each VISN and consistent with long established guiding principles that focus on such things as ensuring support for high quality health care delivery in the most appropriate setting; improving access to care; and, consistency with the network's strategic plans and initiatives.

The specific allocation methods used by each VISN are reported to the VHA Office of Finance. In FY 2009, the allocation methods used by the 21 VISNs were grouped into four broad categories: two VISNs used a patient workload basis and modified VERA capitation; two VISNs used an adjustment to the prior year's base; eight VISNs used a combination of patient workload, modified VERA capitation, and adjustment to the prior year's base; and nine VISNs used other methods, for example: one used a combination of the Stochastic Frontier model, utilization, and care lines; four used a combination of VERA and facility workload; three used a combination of adjusted VERA, historical funding, workload increases, and marginal costs; and one used the service delivery model budget process incorporating care lines.

Mr. Chairman, the basic principle of this allocation process is that health care occurs locally. Allocation decisions and adjustments during the budget execution year are best vested in the VISN director who has the most complete knowledge of the changing requirements at each of his/her individual medical facilities and the needs of the Veterans that each medical facility serves. Should situations arise that dictate additional funding is needed for a particular facility during the year, the VISN director would provide additional funds to ensure veterans health care needs are met or would request these funds from VHA Central Office from funds reserved to meet unanticipated needs.

Mr. Chairman, we appreciate the opportunity to participate in this hearing. My colleagues and I are available to respond to questions from you and the other members of the Committee.

Prepared Statement of Michael S. Finegan, Director, Veterans Integrated Service Network 11, Ann Arbor, MI, U.S. Department of Veterans Affairs

Chairman Filner, Ranking Member Buyer, distinguished members of the Committee: thank you for the opportunity to appear before you today to review the process used to allocate appropriated funds from the Veterans Integrated Service Network (VISN) to our local medical centers. I will share the steps in our process, the rationale supporting it, our monitoring and communications systems used through-

out the year, and how we ensure these resources are most effectively used in caring for our Veterans.

Mr. Chairman, most of my 20 years in the Department of Veterans Affairs (VA) have involved resource allocation, whether at a facility and network level as a financial manager, as a medical center director or interim director at three facilities, or as a VISN director conducting financial reviews at several VA medical centers. I have also dealt with this issue during my many years as a member and now co-chair of the Veterans Health Administration's (VHA) Finance Committee. In each of these assignments, several principles have guided VHA policy and governed my approach to resource allocation: funding should follow workload, support access and quality care, have a component of efficiency, recognize case mix or patient complexity, be easy to understand, and most importantly, should be fair and use thresholds to manage changes. Each year, at all levels of the organization, improvements to the allocation models addressing these principles are debated and enhanced. These principles are reflected today in our VISN 11 model.

Our process begins with the release of the Veterans Equitable Resource Allocation (VERA) allocation from VA Central Office (VACO). Our model of funding to medical centers involves using workload and complexity data to ensure that funding follows the workload and that more complex workload receives greater resources. In any given year, depending on the overall VERA allocation, an adjustment to a facility's requested funding level might be applied to encourage efficiency or mitigate what might otherwise be a significant change in workload. Research and education support funding is disbursed directly to medical centers to ensure appropriate support of these missions. Specific purpose allocations, such as prosthetics, are allocated from VA CO directly to facilities.

Capital funds (such as high dollar value equipment and facility maintenance or construction projects) are allocated at both the facility and VISN levels. We established a VISN level capital pool to help us invest strategically in expensive high tech equipment and address our top operational priorities. In fiscal year (FY) 2009, this pool represented 3.7 percent of our overall VERA distribution. Over several years, a VISN level clinical expert panel has developed prioritization criteria and a detailed investment plan for imaging equipment. This plan provides a structured schedule for replacing outdated equipment, investing in new technologies, reducing duplication, and leveraging economies of scale and volume discounts. For example, in 2009, VISN 11 was able to save $12 million off retail and $6 million off Federal supply schedule pricing by purchasing physiological monitors in bulk.

The funds for these strategic purchases are held until later in the year, as budget execution is monitored, to ensure that overall funding needs are met. Reserving such funds is necessary to address unforeseen conditions at medical centers, such as increased needs for inordinately complex clinical care, larger than expected workload changes, or facility emergencies. These costs are often above and beyond what medical centers budget, but they do not necessitate supplemental appropriations. For example, in 2009 one facility in VISN 11 experienced an electrical fire in the acute psychiatry wing, resulting in evacuation of patients to other facilities in the VISN and increasing non-VA hospitalization costs for subsequent admissions and substantial repairs. This required an increase to the facility's budget of just over $1.4 million from the resources held at the VISN level. Another medical center today has two chronic ventilator patients in a specialized facility outside VA; their care costs approximately $1 million each annually and represents an extraordinary expense for the medical center. In a prior assignment as a facility director, I encountered a young woman Veteran with a complex and rare service-connected condition that was beyond our ability to treat. We arranged care for her at a specialized facility with expertise in her condition at a cost of over $64,000 per month. While the VERA allocation to the VISN will be adjusted in future years to account for these extraordinary expenses, we must be able to address such unforeseen expenses when they occur throughout the year. In VISN 11, all funds budgeted, but not expended for such unforeseen events are used to fund our strategic items or are distributed to the medical centers by the end of the fiscal year. If necessary, the VISN can request funds from VA Central Office, from funds held in reserves for such purpose.

Each year our Business Operations Board analyzes this process and the allocation model outcomes. This Board is comprised of associate directors from each medical center and VISN leaders in finance, logistics and capital assets. This Board's recommendations are submitted to the VISN Executive Leadership Council, which consists of all medical center directors in the VISN, select clinical leaders from throughout the VISN, and the VISN Chief Medical and Quality Officers. The Council's deliberations are often spirited, and we have made changes to our allocation based on recommendations from various stakeholders.

Our budget process is communicated to stakeholders in numerous ways throughout VISN 11. Medical centers discuss their budgets periodically with congressional members or staff. We also hold facility townhalls, community Veterans Service Organization meetings, county service officer meetings, and state level functions. Each of these briefs contains a budget update. At the VISN level, I have established Management Assistance Councils in each state to engage Federal, state and local elected officials, state and county Veteran agencies, Veteran advocates, and community health partners. Invariably these meetings include budget updates and discussion. Finally, our VISN annual report contains information on our budget for our stakeholders.

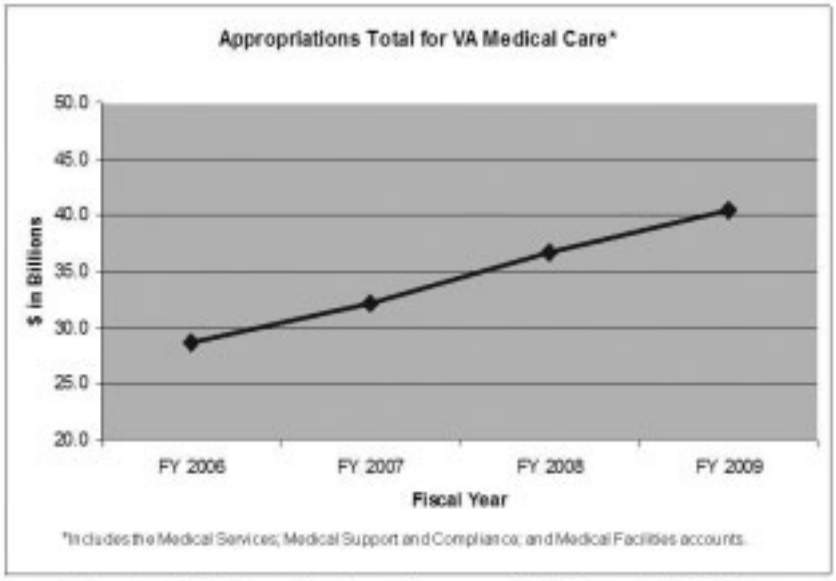
Upon final approval of the budget, each medical center is required to submit an operating plan describing how the funds will be spent. VA has established several mechanisms to ensure its resources are spent appropriately to meet mission requirements and performance expectations. First, throughout the year, monthly variance reports track overall financial performance to plan. This occurs at the facility, VISN and national levels. If facilities are over or under budget, we can discuss why this has occurred and determine if corrective action is needed. Second, we monitor on a monthly basis clinical and administrative performance measures, including access, quality, patient satisfaction and business metrics. In VISN 11, monthly performance reports are discussed at our Executive Leadership Committee and during my regular site visits to medical centers. I also have a quarterly performance review with the Deputy Under Secretary for Health for Operations and Management to ensure VISN 11 is meeting its targets. Nationally, the VHA Finance Committee tracks monthly financial variance reports and financial indicators to ensure budget execution is appropriate. Finally, each VISN has both required and locally developed performance improvement projects that are tracked and reported nationally and spread through our systems redesign infrastructure to keep the focus on efficiency and effectiveness. VISN 11 is currently involved in national projects concerning the effective use of non-VA care, cancer care, reduced length of stay, non-institutional care alternatives, clinic productivity improvement, and infection control and prevention. These projects will allow us to accomplish our mission more efficiently and effectively.

Mr. Chairman, the allocation process used in VISN 11 is similar to those I have experienced throughout my career in VA. It is a process that assures each medical center is moving in the direction set by VA senior leadership and congressional mandate. It also allows for local action to meet changing patient circumstances and to manage the risk and unforeseen events that occur everyday in health care. At the same time, our performance measures and business metrics ensure quality and access remain consistently high. This allocation process also funds both routine operations and strategic investments that support our mission. I am now available to answer any questions you or other members of the Committee may have.

MATERIAL SUBMITTED FOR THE RECORD

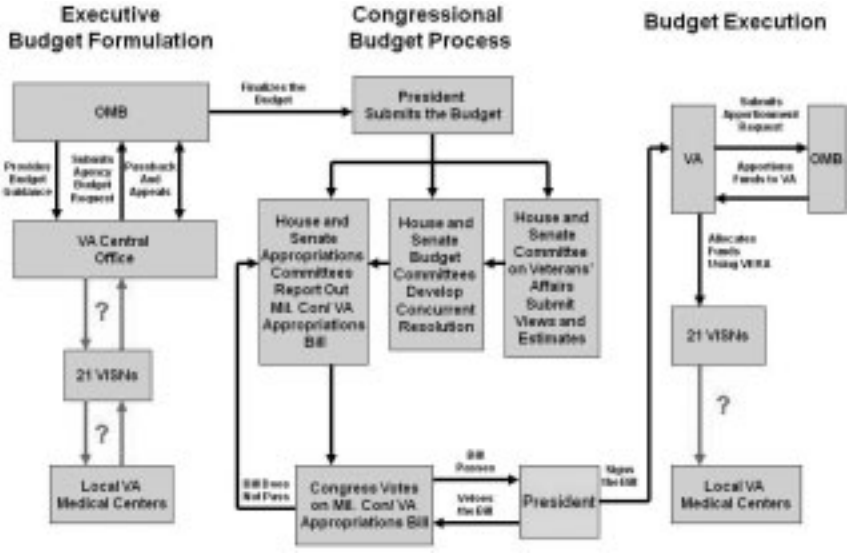
Background Charts:

Appropriations Total for VA Medical Care Line Graph



- Funding for VA medical care increased 41% from FY 2006 to FY 2009.

Budget Process Flow Chart



Post-Hearing Questions and Responses for the Record:

Committee on Veterans' Affairs
Washington, DC.
December 4, 2009

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 "VA Health Care Funding: Appropriations to Programs" on December 2, 2009, I would appreciate it if you could answer the enclosed hearing questions by the close of business on January 15, 2010.

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 Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

CW:ds

Questions for the Record

Hon. Bob Filner, Chairman
House Committee on Veterans' Affairs
"VA Health Care Funding: Appropriations to Programs"
December 2, 2009

Question 1(a): How does each VISN allocate funds to local VA medical centers?

Response: The Veterans Heath Administration (VHA) uses a decentralize funding model with inherent flexibility to adapt to real-time, changing patient needs at the local level. VHA has found this to be the most effective method of ensuring Veterans are best served. Each Veterans Integrated Services Network (VISN) has discretion to use its own allocation methodology to allocate funds to their medical centers. In FY09:

- Eight VISNs used a combination of workload and the prior year's funding baseline.
- Four VISNs used a combination of Veterans Equitable Resource Allocation (VERA) and workload.
- Three VISNs used a combination of VERA, historical funding, workload and marginal costs.
- Two VISNs used workload and a modified VERA capitation methodology.
- Two VISNs used the prior year's funding base.
- One VISN used a Service Delivery Model incorporating Care Lines.
- One VISN used a combination of a Stochastic Frontier Model, Utilization and Care Lines.

Question 1(b): Are there 21 separate funding allocation formulas?

Response: Each VISN Network Director has the final decision on how funds are allocated to each of the medical centers within that VISN; therefore, there are variances between VISNs. However, the VISN allocation methodologies can be categorized into seven general models described in the response to question 1a. above.

Question 1(c): Please provide an explanation of the formulas used by each of the VISNs.

Response: Examples of Allocation alternatives used by VISNs include:

a. Allocation A: Pro-Rated Persons (PRP) multiplied by the VERA prices in each of the patient classes.
b. Allocation B; PRP multiplied by a Weighted Work Unit (WWU) Facility Workload (FACWORK) / Adjust). The Weighted Workload Unit (WWU) = National Cost per PRP (for a patient class) / National Cost per PRP (all classes).
c. Allocation C: Adjusted Workload.

Allocation A: PRPs are created by the Allocation Resource Center (ARC), to account for care across networks or facilities based on a pro-ration of the cost of care provided at each facility. A PRP is a measure of patient workload based on the proportionate distribution of cost. PRPs are used in the VERA System to allocate funds to networks. PRPs are computed from patient workload data obtained from the National Patient Care Database (NPCD), Patient Treatment Files (PTF), Census files and Fee files for non-VA care. Costs associated with patient care are obtained from the Decision Support System (DSS) National Data Extract (NDE).

Allocation A example: The facility has a share of its unique patients in the VERA Price Group of $20,000. In this specific VERA Price Group 90 percent of the PRP patients are in Facility A and 10 percent are in Facility B. In Facility A, 90 percent of $20,000 provides $18,000 which is allocated to Facility A. In Facility B, 10 percent of $20,000 equals $2,000 which is allocated to Facility B.

Allocation B: FACWORK is a workload measure created by VERA patient care class using patient workload and costs. Facility Workload is computed using a fiscal year of clinical and cost data (unit's pro-rated patients and weighted work units) and takes into account the age of the patient. This workload measure is used to describe the intensity of resource requirements for a grouping of patients. For example, the greater the Facility Workload value, the more resource intensive the patient workload. Facility Workload is frequently used to compare the relative efficiencies of VHA units (i.e., networks or facilities). Allocation B is the allocation using FACWORK. When applying FACWORK each unique patient is placed in one of the 54 Patient Classes annually. FACWORK provides a Weighted Workload Unit (WWU). One WWU is the average cost of treating a Veteran for 1 year.

Allocation B example: The national average cost per patient is $100. One Patient class with national average cost is $50 which is equivalent to 0.5 WWU. Another Patient class with national average cost of $200 is equivalent 2.0 WWU.

Allocation C: Adjusted Workload is a workload measure computed using Facility Workload as a base that is further adjusted by factors intended to normalize the differences between VHA units. The specific factors include indices representing the labor cost differences, and workload associated with a unit's education and research missions. In addition, workload is further modified for specific high cost procedures and for patients with an eligibility status of sharing. Sharing patients are not VERA-funded so their workload is removed in Adjusted Workload.

Allocation C example: The VISN uses the most current workload versus the historical workload, and allocates funding by VERA Patient Classes rather than VERA Price Groups. The VISN then distributes funding to each facility according to where the services were provided rather than where the patient resides.

Question 2(a): Does VA Central Office provide guidance to the individual VISNs on the common factors that they should consider when allocating funds to the local VA medical centers?

Response: In 1997, ten principles were established to guide the allocation of resources at all levels within the VHA to move the entire organization toward accomplishing its systemwide goals and objectives. These principles are to be followed when networks allocate funds to their facilities. These principles are published each year in the annual VERA handbook. While the VERA model is an effective system for allocating resources at the network level, the VERA methodology is not designed to allocate funds to the facility level. This is because there are significant differences at the facility level that, in the aggregate, are not a factor when allocating at the network level. Among the factors that significantly affect facility-level health care environments are: the size of the facility, the mission, and the locality of local facilities; levels of affiliations with academic institutions; efficiency of operations; proportions of shared patients; and patient complexity and case-mix. As a result, the following guiding principles are to be used by networks in providing allocations below the network level. Network allocations must:

- Be readily understandable and result in predictable allocations.
- Support high quality health care delivery in the most appropriate setting.
- Support integrated patient-centered operations.
- Provide incentives to ensure continued delivery of appropriate Complex Care.

- Support the goal of improving equitable access to care and ensure appropriate allocation of resources to facilities to meet that goal.
- Provide adequate support for the VA's research and education missions.
- Be consistent with eligibility requirements and priorities.
- Be consistent with the network's strategic plans and initiatives.
- Promote managerial flexibility, (e.g., minimize "earmarking" funds) and innovation.
- Encourage increases in alternative revenue collections.

Question 2(b): Are there financial accounting steps in place? Please explain.

Response: Yes. Financial accounting for allocation of funds is accomplished through the Automated Allotment Control System (AACS). VISN Chief Financial Officers and VA Central Office Budget Officials prepare Transfer of Disbursing Authority (TDA) documents that are entered into AACS. The VHA Chief Financial Officer (CFO) ensures that the submitted TDAs balance to the total allocations approved for each VISN and Program Office. Once all TDA submissions are in balance, AACS transfers the funding authority from the VHA Office of Finance to the facility level for execution. TDAs are issued by fiscal quarter and on an as needed basis when VISN CFOs or VA Central Office Budget Officials want to make additional allocations or adjust previous allocations.

Financial accounting for the obligation and disbursement of funds is accomplished through the Financial Management System (FMS). Obligation and disbursement status is available within FMS daily at facility level and in many additional levels of detail (appropriation, budget object code, accounting classification code, program code, etc.).

Question 3: Does VA Central Office have reporting requirements and/or an oversight process in place to ensure that funds are allocated to the individual VA medical centers in a fair and equitable manner? If so, please provide a detailed explanation of the requirements and the process.

Response: Yes. The CFO requires the VISN Network Directors to complete an annual network-to-facility allocation survey describing how the Networks allocate funding to each of their facilities. The Network Directors identify and briefly describe the approach used to allocate their funds to facilities, how their allocation process adheres to the allocation principles described in the response to question 2, above. If their methodology has changed from the prior year, they must also describe the changes in detail and the rationale for the changes.

Question 4(a): Since fiscal year 2006, how many local VA medical centers experienced growth in funding proportional to the overall increase in appropriated funds for VA medical care?

Response: (NOTE: FY 2006 funding included Information Technology costs, and in subsequent fiscal years, these funds were removed from VHA budgets and placed in a separate appropriation. This serves to make FY 2006 a very dissimilar base year for comparison; therefore, responses to question 4 address changes from an FY 2007 base year. Also, although the VA operates 153 VA Medical Centers, some of these centers have been merged within the Financial Management System as a single station for accounting purposes; therefore, the total number of reporting stations is 129).

From FY 2007–2008, total obligations for all stations increased by an average of 12.7 percent. Obligations for 63 stations increased at or above this average, 65 stations increased below this average, and one station decreased (see explanations in 4c).

From FY 2008–2009, total obligations for all stations increased by an average of 9.4 percent. Obligations for 57 stations increased at or above this average, 70 stations increased below this average, and two stations decreased (see explanations in 4c).

Question 4(b): How many experienced a decrease in funding?

Response: See Response to question 4.a. above.

Question 4(c): What is the rational for this pattern?Response: The primary driver of changes in funding from 1 year to the next is workload, as reflected in the General Purpose fund allocation using the VERA model. In addition, there are changes from year to year in the VERA Specific Purpose allocations and there are

other factors that can cause significant variation from 1 year to the next. Examples of these other factors include:

- One time non-recurring maintenance projects that are a significant expense in a single year.
- One time equipment replacement or refreshment costs that are not required in the next subsequent year or years.
- "Green" energy investments that yield utility savings in subsequent years.
- Negotiated savings in contract costs that reduce funding requirements in subsequent years.
- Centralized acquisition at a single station in a single year can cause a 1 year increase in obligations that is not repeated in subsequent years.
- Lease build-out costs in the first year of a lease period that are not required in subsequent years.

Question 5: Who determines the allocations for program dollars and is there a mechanism in place to track program dollars at the local level and VISN levels? In other words, who are the decision-makers?

Response: Allocation recommendations are prepared by VHA's CFO based upon guidance from VA and VHA senior leadership. These recommendations are submitted to the VA National Leadership Board (NLB) Finance Committee, the NLB, and the Under Secretary for Health. Final allocation decisions are approved by the Secretary of Veterans Affairs.

Question 6: Are resource allocations linked to strategic planning so that the allocations are clearly associated with VA long-range goals, performance standards, and workload priorities?

Response: Yes. For FY 2010, several new strategic initiatives are being separately funded to supportVA's Strategic Goals, Integrated Objectives, and Integrated Strategies as articulated in the VA Strategic Plan. The vast majority of these funds will be allocated to the facility level and all of these funds will provide benefit to Veterans at the facility level.

Question 7: Please explain the existing internal control system that provides oversight of Federal funds, including funds provided through the annual Appropriations Act and the American Recovery Reinvestment Act (ARRA)?

Response: Funds are managed through the VA's FMS. The allocation of funds to facilities is based on the direction of VHA Central Office and VISNs. At the facility level, funds are distributed through FMS and monitored by management through FMS financial reports. Expenditures are initiated by the facility using the VA's Integrated Funds Distribution, Control Point Activity, Accounting, and Procurement System (IFCAP) through which procurement requests are entered, executed by the Acquisition Office, and forwarded to Finance for obligation of funds. Receipt of goods and services is accepted by the receiving office. Payment invoices are sent by vendors to the VA's Financial Service Center (FSC) in Austin, TX for processing through the On-Line Certification System where they are entered into that system for certification by the receiving office and processing for payment by the FSC. Separation of duties is managed through assignment and control of access through the various phases of the execution process and periodic review of those accesses for appropriateness.

Question 8(a): How do VA Central Office, VISNs, and local medical centers plan, execute, and manage potential shortfalls in funding?

Response: Potential shortfalls in funding are first identified at either the VISN or facility level. The VISN leadership and financial staff review the issues in detail and make a determination as to whether or not the issues can be resolved within the VISN's total funding allocation. If the VISN cannot accommodate the requirement, the VISN leadership presents the issue to the VHA leadership for resolution. The VHA Office of Finance, the NLB Finance Committee, and Deputy Under Secretary for Health for Operations and Management review the issues in detail and make a recommendation to the Under Secretary for Health on how to address the issue within the VHA's total resources.

Question 8(b): Also, are funding shortfalls a common occurrence and at what point does VA central office get involved to restore the issue instead of entrusting

VISNs to take care of the problem? If so, has VA revisited the budget planning process to refine the budget projections?

Response: Shortfalls above VISN level are generally infrequent and typically involve a relatively small portion of VHA's total funds. Issues like this are resolved using a portion of the unallocated funds that are reserved for contingencies and unanticipated requirements. When issues like this arise, they are considered in updating future budget planning processes.

Question 9: Mr. Parkis testified that the VHA Finance Committee tracks monthly financial variance reports and financial indicators to ensure budget executions are appropriate. Could you explain to the Committee what actions are taken when a VISN is found to be out of compliance with what is considered appropriate? In other words, what accountability mechanisms are in place to ensure compliance?

Response: The VHA NLB Finance Committee and the VHA NLB review monthly financial execution reports at the VISN level. When a VISN appears to be significantly above or below their annual operating plan, the VHA Chief Financial Officer, who co-chairs the VHA NLB Finance Committee, contacts the VISN Director and the VISN CFO to determine if the variance is a temporary anomaly or an indication of a significant issue. If there is a significant issue, the VHA CFO conducts a review with the VISN staff to determine the best course of action to resolve the requirement and makes recommendations to the NLB Finance Committee and the VHA senior leadership.

Question 10(a): Please explain the existing transfer authorities between the three medical accounts at VACO, VISN and VAMC levels respectively.

Response: The only current transfer authority for the three VHA Medical Appropriations is included in Public Law 111–117, section 202, which states:

Amounts made available for the Department of Veterans Affairs for fiscal year 2010, in this Act or any other Act, under the "Medical services", "Medical support and compliance", and "Medical facilities" accounts may be transferred among the accounts: Provided, That any transfers between the "Medical services" and "Medical support and compliance" accounts of 1 percent or less of the total amount appropriated to the account in this or any other Act may take place subject to notification from the Secretary of Veterans Affairs to the Committees on Appropriations of both Houses of Congress of the amount and purpose of the transfer: Provided further, That any transfers between the "Medical services" and "Medical support and compliance" accounts in excess of 1 percent, or exceeding the cumulative 1 percent for the fiscal year, may take place only after the Secretary requests from the Committees on Appropriations of both Houses of Congress the authority to make the transfer and an approval is issued: Provided further, That any transfers to or from the "Medical facilities" account may take place only after the Secretary requests from the Committees on Appropriations of both Houses of Congress the authority to make the transfer and an approval is issued.

The decision to exercise this transfer authority is retained by the Secretary and not further delegated. However, realignments among the three appropriation accounts that do not exceed the total amount appropriated in each of the three accounts, are approved and executed by the VHA Office of Finance at the VACO, VISN and VAMC levels to ensure effective execution of the appropriated amounts in the three accounts.

Question 10(b): Please provide examples that illustrate when a transfer is needed. If the transfer is not done, how is the shortfall resolved?

Response: An example, in the 4th Quarter of FY 2009, under the provisions of section 202 of Public Law 110–329, the Secretary approved the transfer of $44.5 million from the Medical Support and Compliance appropriation to the Medical Services appropriation to address emerging Fee Basis care requirements, with appropriate Congressional notification as required by the statute.

If an emerging requirement for current year funds in one appropriation exceeds the funds available in that appropriation, and funds are available in a different appropriation, those funds are identified and the requirement is presented by the VHA CFO through the VHA and VA leadership to the Secretary for decision in accordance with section 202 of Public Law 111–117.

Question 11: Please provide the Committee what decision-making process is in place on determining if a Veteran is going to be granted Fee Basis care or not. Does VA keep track of how many Veterans are denied access to Fee Basis care and for

what reason? If so, please provide to the Committee a report, broken down to the lowest level, on number denied and for what reason.

Response: VA Medical Centers receive requests for non-VA (Fee) care in multiple ways, via paper, electronic, phone contacts, etc. For care referred from a VA facility to the community, the approval is based on clinical need, availability of VA resources and geographic accessibility to services. Emergency services are self-referred by Veterans, requiring review and approval by the local facilities. These emergency services require assessment of specific eligibility factors and a clinical decision on the emergent nature of the service provided.

VA does track denials for Mill Bill (emergency) claims. In FY09, a total of 662,813 claims were received, with 384,431 approved and paid, 278,352 denied.

Below is a listing of denied claims and reasons for those denials. The most significant of these are:

- Veteran with other health insurance coverage
- Services were non-emergent, and
- Timely filing

Major reasons for denial are identified in Attachment A. It should be noted that a Veteran may submit more than one claim each year and the columns do not represent mutually exclusive numbers as a claim may have multiple denial reasons.

* These represent the top 9 reasons for denials. Not all denials are included in Attachment A. In addition, as claims may have multiple denial reasons, these denial reason totals will not match total claims denied.

Question 12: In a September 2008 report, the Government Accountability Office found that VHA policies and procedures were not designed to provide adequate controls over the authorization and use of miscellaneous obligations, which totaled about $7 billion in FY2007. The flaws in the design of the internal control system increased the VA's risk for fraud, waste and abuse. Also, a December 2, 2009, VAOIG report entitled Audit of Veterans Health Administration's Undelivered Orders found that internal controls to identify invalid undelivered orders needed improvement. VAOIG estimated that hundreds of millions of dollars could be put to better use if invalid orders are identified in a timely manner and funds de-obligated. VAOIG further found that current policies were not being followed or enforced; such as VHA's practice to conduct follow-up after the end date instead of every 90 days of inactivity. This is not the first time audits have found material oversight weaknesses in VHA. There seems to have been no improvement over the last 3 years. Please provide to the Committee a detailed plan on how VHA plans to provide oversight, follow-up, accountability, and enforcement of policy, down to the medical center levels, on Financial Management System reports.

Response: A systems patch was installed September 2009 in IFCAP that will enable local management at facilities to have improved oversight over the use of miscellaneous obligations. Reports are now available that identify those obligations that do not have the required procurement information and those that were created in violation of separation of duties policies. To improve follow-up and accountability, a monthly analysis of open obligations was initiated in December 2009. This analysis identifies open obligations that are inactive for 90 days and those that do not contain end dates. Additionally, this information is being provided to the VISN and VAMC CFOs for review and necessary follow-up action.

Attachment A—Question #11

FY 2009—Total of 662,813 Mill Bill Claims Were Received—Approximately 58% Were Approved and Paid; 42% Were Denied										
FY 2009	**Total # Veterans Submitting Claims**	**(1725) Claim Not Timely Filed**	**(1725) Non-Emergent Care**	**Has Other Insurance**	**Request Additional Documentation**	**VA Approved to Stabilization/Past Stabilization Dates**	**No VA Treatment Past 24 Months**	**Not Enrolled with the VA**	**VA Facilities Available (Could have used VA)**	**Refused Transfer to VA**
Q1	30,982	6,377	9,225	24,566	375	312	3,589	270	6,259	6
Q2	29,939	6,288	8,876	22,454	460	280	3,288	253	5,870	5
Q3	28,633	6,800	7,400	25,366	580	345	3,756	299	6,189	33
Q4	31,866	6,488	7,956	23,899	622	360	3,589	296	6,433	13
* **Grand Total**	121,420	25,953	33,457	96,285	2,037	1,297	14,222	1,118	24,751	57

* These represent the top 9 reasons for denials. Not all denials are included in the table above. In addition, as claims may have multiple denial reasons, these denial reasons totals will not match total claims denied.

○