104TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPORT
104–443

AUTHORIZING MAJOR MEDICAL FACILITY PROJECTS AND MAJOR MEDICAL FACILITY LEASES FOR THE DEPARTMENT OF VETERANS AFFAIRS FOR FISCAL YEAR 1996, AND FOR OTHER PURPOSES

DECEMBER 22, 1995.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. STUMP, from the Committee on Veterans' Affairs, submitted the following

R E P O R T

[To accompany H.R. 2814]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 2814) to authorize major medical facility projects and major medical facility leases for the Department of Veterans Affairs for fiscal year 1996, and for other purposes, having considered the same, report favorably thereon without amendment, by unanimous voice vote, and recommend the bill do pass.

INTRODUCTION

On February 24, 1995, the Committee received testimony on the fiscal year 1996 Department of Veterans Affairs (VA) budget, including major construction plans. Those testifying included the Honorable Jesse Brown, Secretary of Veterans Affairs, who was accompanied by Deputy Secretary Hershel Gober; Under Secretary for Health Kenneth W. Kizer, M.D.; Under Secretary for Benefits R.J. Vogel; National Cemetery System Director Jerry W. Bowen; Assistant Secretary for Management D. Mark Catlett; and General Counsel Mary Lou Keener. Also testifying were Mr. James Magill, Legislative Director of the Veterans of Foreign Wars; Mr. Russell Mank, Legislative Director of the Paralyzed Veterans of America; Mr. Richard Schultz, Legislative Director of the Disabled American Veterans; Mr. Noel Woosley, National Service Director of AMVETS; Mr. Larry Rhea, Deputy Director of Legislative Affairs of the Non Commissioned Officers Association; and Mr. Carroll Williams, Director, Veterans Affairs and Rehabilitation of The American Legion.

On April 6, 1995, the Subcommittee on Hospitals and Health Care heard testimony on the Veterans Health Administration Reorganization proposal. Testifying were Assistant Secretary for Health Kenneth Kizer, M.D.; Mr. William Schuler, President and CEO of the Portsmouth Regional Hospital, representing Columbia/HCA; Dr. Daniel H. Winship, Dean of the Stritch School of Medicine at Loyola University of Chicago and representing the Association of American Medical Colleges, Dr. Samuel Spagnolo, President of the National Association of VA Physicians and Dentists; Ms. Lynna Smith, President of the Nurses Organization of the VA; Mr. Louis Jasmine, National President of the National Federation of Federal Employees; Mr. David Gorman, Deputy National Legislative Director of the Disabled American Veterans; and Mr. Terry Grandison, Associate Legislative Director of the Paralyzed Veterans of America.

The full Committee met on December 21, 1995 and ordered H.R. 2814 reported favorably to the House by unanimous voice vote.

SUMMARY OF THE REPORTED BILL

H.R. 2814 would:

TITLE I—CONSTRUCTION AUTHORIZATION

1. Authorize the following projects:
   - (a) construction of an outpatient clinic in Brevard County, Florida;
   - (b) construction of an outpatient clinic at Travis Air Force Base in Fairfield, California;
   - (c) renovation of nursing home facilities at the Department of Veterans Affairs medical center in Lebanon, Pennsylvania;
   - (d) environmental improvements at the Department of Veterans Affairs medical center in Marion, Illinois;
   - (e) replacement of psychiatric beds at the Department of Veterans Affairs medical center in Marion, Indiana;
   - (f) renovation of psychiatric beds at the Department of Veterans Affairs medical center in Perry Point, Maryland;
   - (g) environmental enhancement at the Department of Veterans Affairs medical center in Salisbury, North Carolina;
   - (h) construction of an ambulatory care addition at the Department of Veterans Affairs medical center in Temple, Texas;
   - (i) construction of an ambulatory care addition at the Department of Veterans Affairs medical center in Tucson, Arizona;
   - (j) seismic corrections at the Department of Veterans Affairs medical center in Palo Alto, California; and
   - (k) seismic corrections at the Department of Veterans Affairs medical center in Long Beach, California.
2. Authorize major medical facility leases of a satellite outpatient clinic in Fort Myers, Florida and a National Footwear Center in New York, New York.

3. Authorize $28 million of already-appropriated funds for construction of an ambulatory care addition at the Department of Veterans Affairs medical center in Boston, Massachusetts.
4. Direct a report by the Secretary of Veterans Affairs on the health care needs of veterans in East Central Florida.

TITLE II—STRATEGIC PLANNING FOR HEALTH CARE RESOURCES

1. Require the Secretary of Veterans Affairs to report to Congress on the long-range health planning of the Department.
2. Expand the scope of information provided in the description of proposed construction projects.
3. Repeal subsection (b) of Section 301 of P.L. 102–405.
4. Make technical changes in statutory terminology.
5. Remove statutory requirements that the Veterans Health Administration be organized along certain clinical specialties.

BACKGROUND AND DISCUSSION

MAJOR CONSTRUCTION PROJECTS

Section 101 of this legislation authorizes major construction projects for fiscal year 1996.

The Committee has authorized $9 million for the renovation of several medical and surgical nursing units at the Lebanon (PA) VAMC. The renovation will provide for proper handicapped accessibility and patient privacy. It will also address the concerns of the increasing female veteran population at the facility by increasing privacy and updating the bathing and toilet facilities. Environmental conditions will also be improved by upgrading the facility's building infrastructure system.

The $11.5 million authorized by the Committee for the Marion (IL) VAMC will go towards complete renovation of four medical and surgical wards and the intensive care unit in Building 1 of the facility. Improvements to be made include patient privacy, patient environment, fire, life safety, handicapped accessibility and utility system corrections. Currently, congregate toilets and baths are used by patients in the nine- and four-bed rooms. These facilities will be eliminated and replaced with single and semi-private rooms with baths.

The Committee has authorized $17.3 million for the construction of a new 100-bed inpatient psychiatric building to replace the three current buildings at the Marion (IN) VAMC. The new facility will conform to current health care standards and will meet all applicable patient privacy, handicapped accessibility and space planning criteria. Because the original buildings are of significant historical value, renovation was prohibited.

The Committee's authorization of $15.1 million to Perry Point (MD) VAMC will go towards patient privacy issues and VA space planning criteria. Specifically, this project will eliminate congregate bathing facilities, change the location of nursing stations, meet handicapped accessibility requirements, provide additional support space on wards, upgrade infrastructure systems and replace the elevators.

The Committee has authorized $17.2 million at the Salisbury (NC) VAMC in order to renovate and modernize the facility. Cur-

rently, less than 10 percent of the building's existing nursing units have private toilets. This renovation will provide private and semi-private rooms with baths in order to allow privacy for patients, including the increasing female veteran population. The funding will also go towards making the facility handicapped-accessible and to upgrade indoor air quality.

The Committee has authorized $9.8 million for an ambulatory care addition at the Temple (TX) VAMC because the current outpatient area was designed for 78,000 annual visits; however, the workload for FY 1993 alone was over 150,000. Additionally, space restraints require outpatient functions to be performed throughout the hospital and patients to travel long distances for clinic care.

The Committee has authorized $35.5 million for an ambulatory care addition at the Tucson (AZ) VAMC to expand essential outpatient services and to resolve space deficiencies which impact quality of care and staff efficiency. The addition will provide over 90,000 square feet of new clinic and laboratory space for workload projections of 189,000 outpatient visits by the year 2005.

$36.8 million has been authorized to correct seismic deficiencies at the Palo Alto (CA) VAMC. Work will be done to replace the concrete roof, shore up the structural steel, adjust the partition, provide asbestos abatement, reinstall insulating materials and replace the ceiling and floor finishes. The heating system will also be replaced.

The Committee has authorized $20.2 million for seismic corrections at the Long Beach (CA) VAMC. The seismic upgrades include the addition of new shear walls, thickening of existing shear walls and enlarging of the existing columns beneath the existing shear walls. The funding will also go towards fire protections, ADA specifications and the correction mechanical and electrical code deficiencies. The buildings to receive these improvements are over 50 years old and are in serious need of seismic reinforcement.

Finally, the Committee has authorized already-appropriated funds for the construction of an ambulatory care addition at the Boston (MA) VAMC. A three-story facility, connected to the main hospital building, will be constructed to expand and improve ambulatory care services. Also, an additional 170 parking spaces will be provided for outpatient parking.

In addition to the above projects, H.R. 2814 would authorize up to $25 million for construction of an outpatient clinic in Brevard County, FL and up to $25 million for construction of an outpatient clinic at Travis Air Force Base, in Fairfield, CA. With respect to these two projects, the reported bill calls for the Secretary of Veterans Affairs to determine the needed scope of each of these clinics, and limits the Secretary's authority to obligate any funds for either project until the Secretary makes the required determination and certifies to the Committees on Veterans Affairs the amounts actually required (based on that determination) for each of the projects.

CONSTRUCTION AUTHORIZATION

H.R. 2814 would authorize some $279 million in funding for major medical construction projects at 13 VA facilities. The projects selected constitute a package, all of which were either proposed by the Administration or address areas which VA has deemed a high

priority. In authorizing these projects, the Committee has developed a balanced list, comprising projects to expand VA's ambulatory care capacity, to strengthen seismically vulnerable buildings, and to bring a number of aging facilities up to acceptable patient-privacy standards. In authorizing these projects, the Committee recognizes the many other facilities with similar construction needs, and the importance of refining VA's planning processes to review and address those needs on a priority basis.

EAST CENTRAL FLORIDA

The Committee attaches a high priority to meeting the needs of veterans in Florida, a state which has experienced and will likely continue to experience an increase in its veteran population. While Florida has seen a growth in VA's service-delivery capacity, efforts to meet the needs of the veterans in east central Florida remain in some limbo.

Last year Congress appropriated construction funds to convert the former Orlando Naval Training Center Hospital (which was transferred to the Department of Veterans Affairs) into a nursing home. VA currently operates an outpatient clinic at that facility, but has not begun construction of the nursing home care unit. Congress last year also appropriated $17.2 million for design of a 470-bed medical center and 120-bed nursing home in Brevard County, Florida. That project, developed and proposed by the Department of Veterans Affairs, called for 230 psychiatric beds, 60 intermediate care beds, and an ambulatory care clinic, as well as a number of surgical and internal medicine beds. The Conference Report on the fiscal year 1996 VA/HUD appropriations bill, however, called for allotting that design money, along with $7.8 million in new funds, for design and construction of a comprehensive outpatient clinic in Brevard County. The Committee believes that $25 million may exceed the construction costs VA will incur for this clinic; thus, section 101(b) of the bill limits the Secretary's authority to obligate these funds to the amount the Secretary determines is actually needed for this clinic. While having provided for veterans' outpatient needs, the conference report makes no provision for meeting inpatient care needs that were to have been addressed by the Brevard project. The lack of long-term psychiatric beds in the State of Florida, for example, makes imperative an examination of how the medical needs of veterans in east central Florida can appropriately be met.

In light of this recent Congressional action, the Committee believes that a reassessment of the health care needs of veterans in east central Florida is needed. Section 104 of the bill would require the Secretary to report to the committees on these veterans' needs. It would specifically require the Secretary to include in that report his views on how those needs could best be met through available appropriations (discussed above), to include that fraction of the monies appropriated for a clinic in Brevard County which may not be needed for construction of a comprehensive clinic. The Secretary's analysis should also include a re-examination, in light of changed circumstances, of the Secretary's plans for the former Orlando Naval Training Center Hospital.

STRATEGIC PLANNING FOR HEALTH CARE RESOURCES

Section 201 of the reported bill requires the VA to develop a five-year strategic plan for its health care system which specifically addresses the integration of planning efforts starting at the grass roots or local level, coordinated within a prescribed geographic network, and then formulated into a national plan. The plan is to be updated on an annual basis and is required to be submitted no later than January 31st of each year.

The VA strategic plan required by the bill must address such factors as population trends, resource distribution, cost of patient care, capacity of non-Federal providers within prescribed geographic networks, the missions of each facility with the network, and specifically, the distribution of specialized services on a network and national level.

Because of the unique needs of veterans, specialized services to treat and rehabilitate veterans with disabilities including spinal cord dysfunction, blindness, amputations, and mental illness are core programs, vital to the overall mission of the Department of Veterans Affairs. VA's core beneficiaries—service-connected disabled and medically indigent veterans—have a need for these services that cannot be easily or effectively met in the private sector. The Committee believes that planning for these services, although important at the geographic network level, must be part of a national VA strategic plan because of their cost and complexity.

With the understanding that the Veterans Health Administration has undertaken countless planning exercises over the years, the Committee views coordination and integration of the planning process as essential to effective execution of a strategic plan. The plan would be required to lay out how coordination will occur within and among networks. It should also delineate the mix of services VA will provide, such as services provided in-house and through contract, and the market penetration or the percentage of veterans it expects to serve. As part of this effort, the VA should develop goals to increase its efforts to address the needs of service-connected veterans.

In calling for the assignment of mission statements or changes to current missions, the Committee views this effort as part of the continuing shift to managed care to ensure that veterans health care is cost-effective and mirrors those practice patterns of the private sector that seek to promote quality care. There is also a broad consensus that effective planning and delineation of facility missions will speed the realignment process to reduce duplication of services and contribute to the more equitable distribution of resources. The Committee is very supportive of the efforts of the Under Secretary for Health as he implements his ''Vision for Change,'' and views the strategic planning requirement of the bill as parallel and complementary to the efforts of the Department. It is inherent that local health care facilities and networks have the authority and responsibility to operate programs in ways that meet veterans' needs.

With the understanding that the veteran population is undergoing significant change both as it ages and declines in absolute numbers, the planning efforts of the Department must begin to ad-

dress this phenomenon. The plan should also take account of changing practice patterns, including increased reliance on ambulatory care and also take account of the decreasing need for large inventories of hospital beds and even hospitals themselves. It is with this understanding that the Committee believes that strategic planning efforts must consider alternatives to ''bricks and mortar'' and rely more on such cost-effective, non-institutional alternatives to care delivery such as the Department's efforts to establish points of access in approximately 180 locations nationwide.

The Committee has expressed its concern on numerous occasions with VA's inability to provide for greater equity of access for veterans on a nationwide basis. VA's reports show greater availability and accessibility to care for veterans in so-called ''Rust Belt'' states than for those veterans residing in ''Sun Belt'' states. In an effort to correct this disparity, the bill would require the Department to specifically compare expenditures of resources to patients by network. The plan should also address how the mix of professionals and use of various classes of health care professionals affects the cost and quality of care delivered to veterans. The plan should also address how resources will be redistributed to move toward relative parity for veterans nationwide. The Committee understands the achievement of this particular goal may require time and the incremental shifting of resources currently tied to the operation of facilities and personnel.

Within the changing environment of health care, the excess capacity of non-Federal providers has taken on greater significance in the provision of cost-effective services and is a factor to be considered within the overall VA strategic plan. Other factors such as the increased use of contract care, opportunities for ''sharing'' arrangements, competition among health providers, and the desire of veterans to obtain health services within their local community, also merit continued assessment and consideration by VA and should be addressed in their strategic planning efforts.

Consistent with the position reflected in this provision, the Committee, in its report on the authorization of major medical construction projects for fiscal year 1995, to accompany H.R. 4425, highlighted the importance of bringing services to the veteran to the maximum extent possible. In that connection, the Committee cited the important role that small-scale community-based clinics can play in serving communities remote from VA facilities but with significant veteran populations. The report cited Dothan, Alabama as a case in point, with more than 38,500 veterans residing within a 50-mile radius, and with veterans having to travel over 100 miles to receive care at the nearest VA facility. While the Committee encouraged the Secretary ''to take a long look'' at establishing community-based clinics in Dothan and similar communities, it is regrettable that that need has not been met at Dothan. The Committee's review of the circumstances at Dothan strongly reflect a need for a community-based clinic and an active interest in the community and on the part of VA officials in developing a means of primary care access in Dothan. The Committee believes that the Tuscaloosa and Montgomery VA Medical Centers could work together to develop such a clinic, and directs the Secretary to establish this needed clinic.

CONSTRUCTION PROJECT PRIORITIZATION

The Committee's responsibility to authorize major medical construction projects and major medical leases makes it important that the Committee have objective tools with which to distinguish among the many competing VA construction projects awaiting authorization and funding. Tight budgets further heighten the Committee's need for reliable data regarding the relative need and priority of VA construction projects. The Committee is cognizant of the VA's longstanding efforts to refine a prioritization methodology aimed at providing an objective scoring system. Section 201 would provide for a compilation of, and reporting on, those projects which constitute, by category, the Department's current top 20 major medical construction projects. The measure calls for an annual report on the relative ranking of each project, compiled by category, and for each project, a description of the specific factors that account for the particular rank of each listed project. To assist the Committee and assure integrity to the process, the report is also to include a detailed explanation for any change in the rank and score of a project from one report to the next.

The annual authorization process requires the Committee to examine in detail VA's construction proposals and other pending projects. The information called for in this report, as well as the more detailed rationale for VA's construction proposals required by section 202 of the bill, will assist the Committee in both its authorization and oversight roles.

CONSTRUCTION AUTHORIZATION REQUIREMENTS

Under current law, adopted in Public Law 102–405, a project for construction, alteration, or acquisition of a medical facility involving a total expenditure of more than $3 million constitutes a ''major'' project, requiring congressional authorization.

The minor construction account provides a flexible source of funding—not subject to the authorization requirement—for projects which are not major in scope. That account has become increasingly important in helping VA move from an inpatient-care-focused system to one which relies more heavily on ambulatory care, in keeping with the health care delivery model in the community. Many VA facilities have recognized the need to convert underutilized or closed hospital wards into additional clinic capacity. In many instances, such projects cannot be carried out with minor construction funds because of the $3 million limit. While the major construction account continues to be critical to support ambulatory care additions, for example, the imposition of an authorization requirement for a ''minor'' project under $5 million to convert ward space into additional outpatient treatment capacity can be a cumbersome, time-consuming requirement. VA's experience with prior increases in the minor construction threshold, would suggest that an across-the-board increase above $3 million would tend to encourage many projects coming in at the higher level. But there is merit to increasing the threshold for projects focused solely on renovating space to increase ambulatory care capacity, an area which merits a high priority for commitment of construction funds.

Section 203(a) would effect that change in the authorization requirement.

In adopting a construction authorization requirement, the Congress in Public Law 102–405 also made provision for "grandfathering" projects for which funds were appropriated before the date of enactment. Since the law's enactment, Congress has appropriated additional funds for several "grandfathered" projects. Sufficient time has elapsed, however, to permit earlier-funded projects to win additional needed funding without the requirement for specific authorization. As such, there remains no justification for excepting projects, which may no longer merit priority, from congressional authorization and the review associated with the authorization process. Section 203(b) would thus repeal the "grandfathering" provision effective for fiscal year 1997 funding.

While seeking to refine its role in the authorization of construction projects, the Committee believes that its oversight role into the construction planning process should not confine its scope to project authorization. In that regard, the Committee anticipates that VA construction planning will necessarily change with the reorganization of the Veterans Health Administration and with implementation of the strategic planning process established under section 201. The Committee believes, however, that it can conduct more effective oversight through an additional measure that would review potentially large projects before the Department expends substantial sums in conceptual development. VA has long drawn on an advance planning fund to provide "seed money" to conduct preliminary development of future construction projects. The advance planning fund permits VA to do the complex developmental work including definition of specific requirements, development of alternative conceptual approaches for correcting perceived deficiencies, and (after selection of an appropriate concept) preliminary design drawings. The Committee does not seek to upset this process or to inject an authorization requirement into advance planning. Section 203(c) would, however, provide a role for targeted Committee review by requiring the Secretary to notify the committees of any proposed obligation in excess of $500,000 of Advance Planning Funds for project.

VETERANS HEALTH ADMINISTRATION HEADQUARTERS REORGANIZATION

With the submission in March 1995 of its proposed "Vision for Change" of the Veterans Health Administration, VA's Under Secretary for Health proposed a plan to reorganize both VA field facilities into "networks" (and replace the administrative layer of VHA Regional Offices), as well as to streamline VHA's "headquarters" office.

The Department submitted draft legislation on June 22, 1995, which, in pertinent part, would "facilitat[e] the reorganization of VHA's headquarters." VA's transmittal letter, in citing the need for such legislation, stated that the "current centralized management model for VHA, which is in part required by statute, impedes the system's ability to adapt to the rapidly changing health-care environment." The VA's draft legislation would eliminate statutory requirements identifying required specified clinical service positions

in the Office of the Under Secretary. The changes VA proposed were characterized as necessary to provide organizational flexibility.

Section 205 proposes many of the changes VA sought in its draft bill. While generally providing the Under Secretary the breadth of flexibility he requested, the reported bill adds language to ensure that that Office is sufficiently staffed to provide expertise the Committee believes is needed. Thus the reported bill provides that the Under Secretary ensure that that Office is staffed so as to provide appropriate expertise in clinical care disciplines generally as well as in the unique, specialized VA programs such as blind rehabilitation, prosthetics, spinal cord dysfunction, mental illness, and geriatrics and long-term care. This requirement would not be met, in the absence of staff dedicated to these program areas, by ad hoc arrangements such as the use of field consultants or field clinician work-groups.

SECTION-BY-SECTION ANALYSIS

Section 101(a) would authorize construction of 13 major medical facility projects.

Section 101(b) would limit the VA's authority to obligate funds for construction of outpatient clinics authorized in subsection (a). Funds could not be obligated with respect to either project (1) until the Secretary determines and certifies with respect to the project the amount actually required to construct a clinic of such scope as to meet the needs of veterans who would reasonably be expected to obtain care at such clinic, and (2) in an amount in excess of the amount certified to be needed.

Section 102 would authorize VA to enter into two major medical facility leases.

Section 103(a) would authorize $250.9 million for projects authorized in section 101; $28 million for construction of a project at the Boston, MA VA Medical Center, as authorized in Public Law 103–452; and $2.79 million for the leases authorized in section 102.

Section 103(b) would provide that the major construction projects provided for in title I could only be carried out using funds appropriated for fiscal year 1996 or a prior fiscal year.

Section 104(a) would require the Secretary to report to the Veterans Affairs Committees not later than March 1, 1996, on the health care needs of veterans in east central Florida, and to include in that report the Secretary's views as to the best means of meeting such needs (and particularly their needs for psychiatric and long-term care) using the unobligated amounts appropriated for fiscal years 1995 and 1996 to meet such veterans' needs.

Section 104(b) would limit the Secretary's authority to obligate funds, other than for working drawings, for the conversion of the former Orlando Naval Training Center Hospital in Orlando, Florida to a nursing home care unit until 15 days after the date on which the report required in section 104(a) is submitted.

Section 201 would amend section 8107 of title 38, United States Code, to eliminate the requirement that the Department provide an annual report on the Department's five-year medical facility construction plans, and substitute a broader report requirement on long-range health planning. The required report is to include (1) a

five-year strategic plan for provision of care (including provision of services for the specialized treatment and rehabilitative needs of disabled veterans) through networks of VA medical facilities operating within prescribed geographic service delivery areas; (2) a description of how such networks will coordinate their planning efforts; and (3) a profile of each network.

Such network profile is to identify (1) the mission of each medical facility, or proposed facility; (2) any planned change in any facility's mission and the rationale for the change; (3) data regarding the population of veterans served by the network and anticipated changes both in demographics and in health-care needs; (4) pertinent data by which to assess the progress made toward achieving relative equivalency in the availability of services per patient in each network; (5) opportunities for providing veterans services through contract arrangements; and (6) five-year construction plans for facilities in each network.

The report required by section 8107, as amended, is also to include information with respect to each VA medical care facility regarding progress toward instituting identified, planned mission changes; implementing managed care; and establishing new services to provide veterans alternatives to institutional care.

Section 201 would also amend section 8107 to require an annual report showing (1) the 20 most highly ranked madjor medical construction projects by category of project) and the relative rank and priority score for each; (2) a description of the specific factors that account for the project's ranking in relation to other projects within the same category; and (3) a description of the reasons for any change in the ranking from the last report.

Section 202 would amend section 8104(b) to require specified additional information to be included in the prospectus for each proposed medical facility construction project.

Section 203(a) would expand the definition of the term ''major medical facility project'' in section 8104(a) of title 38 in the case of a project principally devoted to altering a medical facility to provide additional space for providing ambulatory care, to mean a project involving a total expenditure of more than $5 million.

Section 203(b) would, effective with fiscal year 1997 appropriations, repeal a ''grandfather clause'' established in section 301(b) of Public Law 102–405.

Section 203(c) would require VA to provide the Committees on Veterans Affairs notice before it may obligate funds from the Advance Planning Fund in excess of $500,000, in the case of any one project, toward design or development of any major medical facility project.

Section 204 would make technical changes in nomenclature in sections 8101 and 8109 of title 38, regarding elements of the construction process.

Section 205(a) would delete the statutory requirement in section 7305 of title 38 that the Veterans Health Administration include specified clinical services, and would substitute language calling for an Office of the Under Secretary for Health and such professional and auxiliary services as the Secretary deems necessary; the provision would require the Under Secretary to ensure that there is included in the Office of the Under Secretary appropriate staff exper-

tise, including expertise in generally specified specialized medical programs and appropriate clinical care disciplines.

Section 205(b) would eliminate several of the provisions of section 7306 of title 38 which require that the Office of the Under Secretary include certain specified positions.

OVERSIGHT FINDINGS

No oversight findings have been submitted to the Committee by the Committee on Government Reform and Oversight.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

The following letter was received from the Congressional Budget Office concerning the cost of the reported bill:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, December 22, 1995.

Hon. BOB STUMP,
Chairman, Committee on Veterans' Affairs,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office (CBO) has reviewed H.R. 2814, a bill to authorize major medical facility projects and major medical facility leases for the Department of Veterans Affairs for fiscal year 1996, and for other purposes, as ordered reported by the House Committee on Veterans' Affairs on December 20, 1995.

The bill would not affect direct spending or receipts and thus would not be subject to pay-as-you go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1995. The bill would not affect the budgets of state or local governments.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

JUNE E. O'NEILL,
Director.

Enclosure:

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R. 2814.

2. Bill title: A bill to major medical facility projects and major medical facility leases for the Department of Veterans Affairs for fiscal year 1996, and for other purposes.

3. Bill status: As ordered reported by the House Committee on Veterans' Affairs on December 20, 1995.

4. Bill purpose: The bill would authorize 12 major construction projects and two major facility leases. It would also authorize appropriations for these projects and leases. There are several additional provisions that would not have a significant budgetary impact.

5. Estimated cost to the federal government:

The following table summarizes the budgetary impact of H.R. 2814, which would depend upon subsequent appropriations action.

[By fiscal year, in millions of dollars]

	1995	1996	1997	1998	1999	2000
SPENDING SUBJECT TO APPROPRIATIONS ACTION						
Spending Under Current Law:						
Budget authority [1]	354	0	0	0	0	0
Estimated outlays	541	423	385	317	232	155
Proposed Changes:						
Authorization level [2]	0	282	0	0	0	0
Estimated outlays	0	13	37	52	54	49
Spending Under H.R. 2814:						
Authorization level [1 2]	354	282	0	0	0	0
Estimated outlays	541	436	422	369	286	204

[1] The 1995 figure is the amount already appropriated.
[2] Amount for fiscal year 1996 is an authorization subject to appropriations action.

6. Basis of estimate: The estimate assumes enactment of the bill by February 1, 1996, and appropriation of the amounts authorized in the bill. The bill would authorize the appropriation of $279 million for 13 major construction projects and almost $3 million for two major leases. CBO used historical spending rates for VA major construction projects to estimate outlays.

7. Pay-as-you-go considerations: The bill would not affect direct spending or receipts, it would have no pay-as-you-go implications.

8. Estimated cost to state and local governments: None.

9. Estimate comparison: None.

10. Previous CBO estimate: None.

11. Estimate prepared by: Michael Groarke.

12. Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

INFLATIONARY IMPACT STATEMENT

The enactment of the reported bill would have no inflationary impact.

APPLICABILITY TO LEGISLATIVE BRANCH

The reported bill would not be applicable to the legislative branch under the Congressional Accountability Act, Public Law 104–1, because it would apply only to certain Department of Veterans Affairs programs and facilities.

STATEMENT OF FEDERAL MANDATES

The reported bill would not establish a federal mandate under the Unfunded Mandates Reform Act, Public Law 104–4.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

TITLE 38, UNITED STATES CODE

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PART V—BOARDS, ADMINISTRATIONS, AND SERVICES

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CHAPTER 73—VETERANS HEALTH ADMINISTRATION—ORGANIZATION AND FUNCTIONS

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Subchapter I—Organization

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§ 7305. Divisions of Veterans Health Administration

[The Veterans Health Administration shall include the following:

[(1) The Office of the Under Secretary for Health.

[(2) A Medical Service.

[(3) A Dental Service.

[(4) A Podiatric Service.

[(5) An Optometric Service.

[(6) A Nursing Service.

[(7) Such other professional and auxiliary services as the Secretary may find to be necessary to carry out the functions of the Administration.]

(a) The Veterans Health Administration shall include the Office of the Under Secretary for Health and such professional and auxiliary services as the Secretary may find to be necessary to carry out the functions of the Administration.

(b) In organizing, and appointing persons to positions in, the Office, the Under Secretary shall ensure that the Office is staffed so as to provide the Under Secretary with appropriate expertise, including expertise in—

(1) unique programs operated by the Administration to provide for the specialized treatment and rehabilitation of disabled veterans (including blind rehabilitation, spinal cord dysfunction, mental illness, and geriatrics and long-term care); and

(2) appropriate clinical care disciplines.

§ 7306. Office of the Under Secretary for Health

(a) The Office of the Under Secretary for Health shall consist of the following:

(1) The Deputy Under Secretary for Health, who shall be the principal assistant of the Under Secretary for Health and who shall be a qualified doctor of medicine.

(2) The Associate Deputy Under Secretary for Health, who shall be an assistant to the Under Secretary for Health and the Deputy Under Secretary for Health [and who shall be a qualified doctor of medicine].

(3) Not to exceed eight Assistant Under Secretaries for Health.

(4) Such Medical Directors as may be appointed to suit the needs of the Department, who shall be either a qualified doctor of medicine or a qualified doctor of dental surgery or dental medicine.

[(5) A Director of Nursing Service, who shall be a qualified registered nurse and who shall be responsible to the Under Secretary for Health for the operation of the Nursing Service.

[(6) A Director of Pharmacy Service, a Director of Dietetic Service, a Director of Podiatric Service, and a Director of Optometric Service, who shall be responsible to the Under Secretary for Health for the operation of their respective Services.

[(7) Such directors of such other professional or auxiliary services as may be appointed to suit the needs of the Department, who shall be responsible to the Under Secretary for Health for the operation of their respective services.]

[(8)] *(5)* The Director of the National Center for Preventive Health, who shall be responsible to the Under Secretary for Health for the operation of the Center.

[(9)] *(6)* Such other personnel as may be authorized by this chapter.

(b) Of the Assistant Under Secretaries for Health appointed under [subsection (a)(3)—

[(1) not more than two may be] *subsection (a)(3), not more than two may be* persons qualified in the administration of health services who are not doctors of medicine, dental surgery, or dental medicines[;].

[(2) one shall be a qualified doctor of dental surgery or dental medicine who shall be directly responsible to the Under Secretary for Health for the operation of the Dental Service; and

[(3) one shall be a qualified physician trained in, or having suitable extensive experience in, geriatrics who shall be responsible to the Under Secretary for Health for evaluating all research, educational, and clinical health-care programs carried out in the Administration in the field of geriatrics and who shall serve as the principal advisor to the Under Secretary for Health with respect to such programs.]

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PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

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CHAPTER 81—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY; ENHANCED-USE LEASES OF REAL PROPERTY

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Subchapter I—Acquisition and Operation of Medical Facilities

§ 8101. Definitions

For the purposes of this subchapter:

(1) The term "alter", with respect to a medical facility, means to repair, remodel, improve, or extend such medical facility.

(2) The terms "construct" and "alter", with respect to a medical facility, include such engineering, architectural, legal, fiscal, and economic investigations and studies and such surveys, designs, plans, [working drawings] *construction documents*, specifications, procedures, and other similar actions as are necessary for the construction or alteration, as the case may be, of such medical facility and as are carried out after the completion of the advanced planning (including the development of project requirements and [preliminary plans] *design development*) for such facility.

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§ 8104. Congressional approval of certain medical facility acquisitions

(a)(1) * * *

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(3) For the purpose of this subsection:

(A) The term "major medical facility project" means a project for the construction, alteration, or acquisition of a medical facility involving a total expenditure of more than $3,000,000, but such term does not include an acquisition by exchange, *and, in the case of a project which is principally for the alteration of a medical facility to provide additional space for provision of ambulatory care, such term means a project involving a total expenditure of more than $5,000,000.*

* * * * * * *

(b) In the event that the President or the Secretary proposes to the Congress the funding of any construction, alteration, lease, or other acquisition to which subsection (a) of this section is applicable, the Secretary shall submit to each committee, on the same day, a prospectus of the proposed medical facility. Such prospectus [shall include—] *shall include the following:*

(1) [a] *A* detailed description of the medical facility to be constructed, altered, leased, or otherwise acquired under this subchapter, including a description of the location of such facility and, in the case of a prospectus proposing the construction of a new or replacement medical facility, a description of the consideration that was given to acquiring an existing facility by lease or purchase and to the sharing of health-care resources with the Department of Defense under section 8111 of this title[;].

(2) [an] *An* estimate of the cost to the United States of the construction, alteration, lease, or other acquisition of such facility (including site costs, if applicable)[; and].

(3) [an] *An* estimate of the cost to the United States of the equipment required for the operation of such facility.

(4) Demographic data applicable to the project, including information on projected changes in the population of veterans to be served by the project over a five-year period and a ten-year period.

(5) Current and projected workload and utilization data.

(6) Current and projected operating costs of the facility, to include both recurring and non-recurring costs.

(7) The priority score assigned to the project under the Department's prioritization methodology and, if the project is being proposed for funding ahead of a project with a higher score, a specific explanation of the factors other than the priority that were considered and the basis on which the project is proposed for funding ahead of projects with higher priority scores.

(8) A listing of each alternative to construction of the facility that has been considered.

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(f) The Secretary may not obligate funds in an amount in excess of $500,000 from the Advance Planning Fund of the Department toward design or development of a major medical facility project until—

(1) the Secretary submits to the committees a report on the proposed obligation; and

(2) a period of 30 days has passed after the date on which the report is received by the committees.

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§ 8107. Operational and construction plans for medical facilities

[(a)(1) In order to promote effective planning for the orderly construction, replacement, and alteration of medical facilities in accordance with the comparative urgency of the need for the services to be provided by such facilities, the Secretary, after considering the analysis and recommendations of the Under Secretary for Health, shall submit to each committee an annual report on the construction, replacement, alteration, and operation of medical facilities.

[(2) Each such report shall contain—

[(A) a five-year strategic plan for the operation and construction of medical facilities—

[(i) setting forth—

[(I) the mission of each existing or proposed medical facility;

[(II) any planned change in such mission; and

[(III) the operational steps needed to achieve the facility's mission and the dates by which such steps are planned to be completed; and

[(ii) a five-year plan, based on the factors set out in subclause (i) of this clause, for construction, replacement, or alteration projects for each such facility;

[(B) a list, in order of priority, of not less than 10 hospitals that, in the judgment of the Secretary, after considering the

analysis and recommendations of the Under Secretary for Health are most in need of construction or replacement; and

[(C) general plans (including projects costs, site location, and, if appropriate, necessary land acquisition) for each medical facility for which construction, replacement, or alteration is planned under clause (A)(ii) of this paragraph.

[(3) The report under this subsection shall be submitted not later than June 30 of each year.]

(a) In order to promote effective planning for the efficient provision of care to eligible veterans, the Secretary, based on the analysis and recommendations of the Under Secretary for Health, shall submit to each committee, not later than January 31 of each year, a report regarding long-range health planning of the Department.

(b) Each report under subsection (a) shall include the following:

(1) A five-year strategic plan for the provision of care under chapter 17 of this title to eligible veterans through coordinated networks of medical facilities operating within prescribed geographic service-delivery areas, such plan to include provision of services for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness) through distinct programs or facilities of the Department dedicated to the specialized needs of those veterans.

(2) A description of how planning for the networks will be coordinated.

(3) A profile regarding each such network of medical facilities which identifies—

(A) the mission of each existing or proposed medical facility in the network;

(B) any planned change in the mission for any such facility and the rationale for such planned change;

(C) the population of veterans to be served by the network and anticipated changes over a five-year period and a ten-year period, respectively, in that population and in the health-care needs of that population;

(D) information relevant to assessing progress toward the goal of achieving relative equivalency in the level of resources per patient distributed to each network, such information to include the plans for and progress toward lowering the cost of care-delivery in the network (by means such as changes in the mix in the network of physicians, nurses, physician assistants, and advance practice nurses);

(E) the capacity of non-Federal facilities in the network to provide acute, long-term, and specialized treatment and rehabilitative services (described in section 7305 of this title), and determinations regarding the extent to which services to be provided in each service-delivery area and each facility in such area should be provided directly through facilities of the Department or through contract or other arrangements, including arrangements authorized under sections 8111 and 8153 of this title; and

(F) a five-year plan for construction, replacement, or alteration projects in support of the approved mission of each facility in the network and a description of how those

projects will improve access to care, or quality of care, for patients served in the network.

(4) A status report for each facility on progress toward—

(A) instituting planned mission changes identified under paragraph (3)(B);

(B) implementing principles of managed care of eligible veterans; and

(C) developing and instituting cost-effective alternatives to provision of institutional care.

[(b)**]** *(c)* The Secretary shall submit to each committee not later than January 31 of each year a report showing the location, space, cost, and status of each medical facility (1) the construction, alteration, lease, or other acquisition of which has been approved under section 8104(a) of this title, and (2) which was uncompleted as of the date of the last preceding report made under this subsection.

(d)(1) The Secretary shall submit to each committee, not later than January 31 of each year, a report showing the current priorities of the Department for proposed major medical construction projects. Each such report shall identify the 20 projects, from within all the projects in the Department's inventory of proposed projects, that have the highest priority and, for those 20 projects, the relative priority and rank scoring of each such project. The 20 projects shall be compiled, and their relative rankings shall be shown, by category of project (including the categories of ambulatory care projects, nursing home care projects, and such other categories as the Secretary determines).

(2) The Secretary shall include in each report, for each project listed, a description of the specific factors that account for the relative ranking of that project in relation to other projects within the same category.

(3) In a case in which the relative ranking of a proposed project has changed since the last report under this subsection was submitted, the Secretary shall also include in the report a description of the reasons for the change in the ranking, including an explanation of any change in the scoring of the project under the Department's scoring system for proposed major medical construction projects.

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SECTION 301 OF THE VETERANS' MEDICAL PROGRAMS AMENDMENTS OF 1992

SEC. 301. AUTHORIZATION REQUIREMENT FOR CONSTRUCTION OF NEW MEDICAL FACILITIES.

(a) * * *

[(b) APPLICABILITY.—The amendments made by subsection (a) shall not apply with respect to any project for which funds were appropriated before the date of the enactment of this Act.**]**

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