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HOUSE OF REPRESENTATIVES
REPORT
104–574

AUTHORIZATION OF MAJOR MEDICAL FACILITY PROJECTS AND MAJOR MEDICAL FACILITY LEASES FOR THE DEPARTMENT OF VETERANS AFFAIRS FOR FISCAL YEAR 1997, AND FOR OTHER PURPOSES

MAY 14, 1996.—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. 3376]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 3376) to authorize major medical facility projects and major medical facility leases for the Department of Veterans Affairs for fiscal year 1997, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

The amendment (stated in terms of the page and line numbers of the introduced bill) is as follows:

Page 8, line 3. strike out "15 days" and insert in lieu thereof "45 days".

INTRODUCTION

On March 21, 1996, the Subcommittee on Hospitals and Health Care received testimony on the fiscal year 1997 Department of Veterans Affairs (VA) medical care budget and construction priorities. Under Secretary for Health Kenneth Kizer testified at the hearing, and was accompanied by Mark Catlett, Assistant Secretary of Management and C.V. "Chuck" Yarbrough, Associate Chief Medical Director for Construction Management.

On March 29, 1996, the full Committee heard testimony on the VA's fiscal 1997 budget, including its construction priorities. Testifying were the Honorable Jesse Brown, Secretary of Veterans Affairs, accompanied by Dr. Kenneth Kizer, Under Secretary for Health; Mr. R.J. Vogel, Under Secretary for Benefits; Mr. Jerry Bowen, Director of the National Cemetery System; Mr. Mark

Catlett, Assistant Secretary for Management; and Mr. Robert Coy, Deputy General Counsel. Also testifying was the Honorable Frank Nebeker, Chief Judge of the U.S. Court of Veterans Appeals, accompanied by Mr. Robert F. Comeau, Clerk of the Court; Mr. James Caldwell, Chief Deputy Clerk, Ms. Sandra P. Montrose, Executive Attorney to the Chief Judge; and Ms. Ann Olson, Budget Officer. Additional witnesses were Mr. James Magill, Director, National Legislative Service, Veterans of Foreign Wars; Mr. Russell Mank, Legislative Director, Paralyzed Veterans of America; Mr. Rick Surratt, Assistant National Legislative Director, Disabled American Veterans; Mr. Robert Carbonneau, National Legislative Director, AMVETS; Mr. John Vitikacs, Assistant Director, Veterans Affairs and Rehabilitation Commission, The American Legion; and Mr. William Warfield, Deputy Director of Government Relations, Vietnam Veterans of America.

The Subcommittee on Hospitals and Health Care met on May 8, 1996 and ordered H.R. 3376, as amended, reported favorably to the full Committee by unanimous voice vote.

The full Committee also met on May 8, 1996 and ordered H.R. 3376, as amended, reported favorably to the House by unanimous voice vote.

SUMMARY OF THE REPORTED BILL

H.R. 3376 as amended would:

TITLE I—CONTRUCTION AUTHORIZATION

1. Authorize the following projects:
   (a) construction of an ambulatory care addition for mental health enhancements at the Department of Veterans Affairs medical center in Dallas, Texas;
   (b) construction of an ambulatory care addition at the Department of Veterans Affairs medical center in Brockton, Massachusetts;
   (c) construction of an ambulatory care addition for outpatient improvements at the Department of Veterans Affairs medical center in Shreveport, Louisiana;
   (d) construction of an ambulatory care addition at the Department of Veterans Affairs medical center in Lyons, New Jersey;
   (e) construction of an ambulatory care addition at the Department of Veterans Affairs medical center in Tomah, Wisconsin;
   (f) construction of an ambulatory care addition at the Department of Veterans Affairs medical center in Asheville, North Carolina;
   (g) construction of an ambulatory care addition at the Department of Veterans Affairs medical center in Temple, Texas;
   (h) construction of an ambulatory care addition at the Department of Veterans Affairs medical center in Tucson, Arizona;
   (i) renovation of nursing home facilities at the Department of Veterans Affairs medical center in Lebanon, Pennsylvania;
   (j) environmental improvements at the Department of Veterans Affairs medical center in Marion, Illinois;

(k) modernization of patient wards at the Department of Veterans Affairs medical center in Atlanta, Georgia;
(l) replacement of a psychiatric bed building at the Department of Veterans Affairs medical center in Battle Creek, Michigan;
(m) ward renovation for patient privacy at the Department of Veterans Affairs medical center in Omaha, Nebraska;
(n) environmental improvements at the Department of Veterans Affairs medical center in Pittsburgh, Pennsylvania;
(o) renovation of various buildings at the Department of Veterans Affairs medical center in Waco, Texas;
(p) replacement of psychiatric beds at the Department of Veterans Affairs medical center in Marion, Indiana;
(q) renovation of psychiatric wards at the Department of Veterans Affairs medical center in Perry Point, Maryland;
(r) environmental enhancement at the Department of Veterans Affairs medical center in Salisbury, North Carolina;
(s) seismic corrections at the Department of Veterans Affairs medical center in Palo Alto, California;
(t) seismic corrections at the Department of Veterans Affairs medical center in Long Beach, California; and
(u) seismic corrections at the Department of Veterans Affairs medical center in San Francisco, California.

2. Authorize major medical facility leases of a satellite outpatient clinic in Allentown, Pennsylvania; a satellite outpatient clinic in Beaumont, Texas; a satellite outpatient clinic in Boston, Massachusetts; a parking facility in Cleveland, Ohio; a satellite outpatient clinic and Veterans Benefits Administration field office in San Antonio, Texas; and a satellite outpatient clinic in Toledo, Ohio.

3. 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. Increase the threshold which defines a major medical facility project from $3 million to $5 million.

3. Repeal subsection (b) of Section 301 of P.L. 102–405.

4. Make technical changes in statutory terminology.

5. Remove the statutory requirements that the Veterans Health Administration be organized under certain clinical specialties.

TITLE III—OTHER MATTERS

1. Rename the Department of Veterans Affairs medical center Jackson, Mississippi as the "G.V. Sonny Montgomery Department of Veterans Affairs Medical Center."

2. Rename the Mountain Home Department of Veterans Affairs medical center in Johnson City, Tennessee as the "James H. Quillen Department of Veterans Affairs Medical Center."

3. Rename the Department of Veterans Affairs nursing care center at the Department of Veterans Affairs medical center in Aspinwall, Pennsylvania as the "H. John Heinz, III Department of Veterans Affairs Nursing Care Center."

4. Restore the VA's authority to establish Department of Veterans Affairs research corporations until December 31, 2000.

BACKGROUND AND DISCUSSION

MAJOR CONSTRUCTION PROJECTS

Section 101 of this legislation would authorize major construction projects for fiscal year 1997. Several of these projects were included in H.R. 2814, which was passed by the full Committee in December 1995 but not acted upon by the House.

The Committee proposes authorization of $28.2 million to modernize patient wards at the Atlanta VAMC. The modernization project would renovate psychiatric, medical and surgical patient ward areas in order to provide interior space and equipment modernization. By correcting these deficiencies, the increasing female veteran population would be better accommodated.

The Committee proposes authorization of $22.9 million for the Battle Creek (MI) VAMC to go toward the replacement of the psychiatric bed building. The current psychiatric treatment units at the facility were built in the 1920s and lack air conditioning, elevators and handicapped facilities. The proposed 120-bed replacement building would address all of these deficiencies and would provide patients with appropriate nursing stations, day rooms, treatment rooms, bedrooms, seclusion and restraint rooms.

The Committee proposes authorization of $9.5 million for the renovation of several medical and surgical nursing units at the Lebanon (PA) VAMC. The renovation would provide for proper handicapped accessibility and patient privacy. It would 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 would also be improved by upgrading the facility's building infrastructure system.

The Committee proposes authorization of $11.5 million for the Marion (IL) VAMC to go toward complete renovation for four medical and surgical wards and the intensive care unit in Building 1 of the facility. Improvements which would 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 would be eliminated and replaced with single and semi-private rooms with baths.

The Committee proposes authorization of $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 would conform to current health care standards and would meet all applicable patient privacy, handicapped accessibility and space planning criteria. Because the original buildings are of a significant historical value, renovation was prohibited.

The Committee proposes authorization of $7.7 million for the Omaha (NE) VAMC to provide ward renovation for patient privacy. Specifically, the project would renovate and upgrade four nursing units to meet current criteria for patient privacy and support facilities, including the provision of wheelchair accessible toilets and showers in each patient room, required patient, family and staff support areas on the nursing units and upgraded mechanical, plumbing and electrical systems.

The Committee proposes authorization of $15.1 million at the Perry Point (MD) VAMC for patient privacy issues and VA space planning criteria. Specifically, this project would 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 proposes authorization of $17.4 million for environmental improvements at the Pittsburgh (PA) VAMC. This project, an upgrade of three nursing units and a renovation of existing space, would provide patient privacy, patient environment, life safety, handicapped accessibility and utility system corrections. The current nursing units were constructed in 1954 and have seen little renovation since that time.

The Committee proposes authorization of $18.2 million at the Salisbury (NC) VAMC to renovate and modernize the facility. Currently, less than 10 percent of the building's existing nursing units have private toilets. This renovation would provide private and semi-private rooms with baths in order to allow privacy for patients, including the increasing female population. The funding would also go toward making the facility handicapped-accessible and to upgrade indoor air quality.

The Committee proposes authorization of $26 million for the renovation of direct care buildings at the Waco (TX) VAMC. This renovation would correct existing fire safety and environmental deficiencies. Additions would be built to each affected building in order to allow space to meet patient privacy and space requirements.

Additionally, the Committee proposes authorization of $28.8 million for an ambulatory care addition at the Asheville (NC) VAMC. This three-story ambulatory care addition would be constructed on the side of the main hospital building in order to replace and expand key outpatient services. The eye clinic, dental clinic and laboratory would be relocated to this area, while a new emergency care unit with a dedicated entry would be constructed. This addition would be constructed in response to severe space restrictions at the facility for outpatient services.

The Committee proposes authorization of $19.9 million for mental health enhancements at the Dallas (TX) VAMC. A multi-level mental health addition would be constructed on top of the existing two-level ambulatory care building. This new construction would enable the relocation of mental health inpatient nursing units into new space that meets applicable patient privacy, handicapped accessibility and space planning criteria.

The Committee also proposes authorization of $13.5 million for an ambulatory care addition at the Brockton (MA) VAMC. This ad-

dition would be constructed at the corner of the main hospital building and would replace and expand key outpatient services. This addition would be constructed because the existing outpatient space provides a poor patient care environment, as it is dispersed over three floors.

The Committee proposes authorization of $21.1 million at the Lyons (NJ) VAMC to go toward the construction of an ambulatory care addition. This project would address the need to provide additional space for veterans in need of outpatient services at the facility. The two-story addition would be constructed in a courtyard among three current buildings. A fourth building would be demolished to make room for the addition.

The Committee proposes authorization of $25 million for outpatient improvements at the Shreveport (LA) VAMC. A three-story ambulatory care addition would be constructed adjacent to the main hospital building to house expanded outpatient services, emergency services and to provide for relocation of radiology and nuclear medicine into new space that meets all applicable standards and criteria.

The Committee proposes authorization of $9.8 million for an ambulatory care addition at the Temple (TX) VAMC. 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 proposes authorization of $12.7 million for an ambulatory care addition to the Tomah (WI) VAMC. A two-story ambulatory care addition connected physically to Building 400 would be constructed to house primary and specialty clinics, as well as customary support functions. Included in these categories are ambulatory care, a mental health clinic, an outpatient pharmacy and a laboratory. This addition would replace the existing ambulatory center, which currently operates with architectural and mechanical systems dating back to the 1940s.

The Committee proposes authorization of $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 would provide over 90,000 square feet of new clinic and laboratory space for workload projections of 189,000 outpatient visits by the year 2005.

The Committee also proposes authorization of $20.2 million for seismic corrections at the Long Beach (CA) VAMC. The seismic upgrades would include the addition of new shear walls, thickening of existing shear walls and enlarging of the existing columns beneath the shear walls. The funding would also go toward fire protection, Americans With Disabilities Act specifications and the correction of mechanical and electrical code deficiencies. The buildings to receive these improvements are over 50 years old and are in serious need of seismic reinforcement.

The Committee proposes authorization of $36 million to correct seismic deficiencies at the Palo Alto (CA) VAMC. Work would 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 would also be replaced.

Finally, the Committee proposes authorization of $26 million for seismic corrections at the San Francisco (CA) VAMC. A number of buildings have seismic deficiencies and are in dire need of correction. The addition would be built in order to accommodate a mental health clinic and alcohol treatment clinic, a day treatment center, a hospital director's suite addition, the psychiatry service administration and psychology, research and fiscal departments. A study determining the cost of seismically upgrading existing buildings concluded that it would be cost-effective to replace the buildings instead.

MAJOR CONSTRUCTION LEASES

The Committee recognizes the need for the VA to enter into lease agreements to serve veterans' communities across the country. Accordingly, H.R. 3376 would authorize the lease of a satellite outpatient clinic in Allentown, Pennsylvania for $2.159 million, a satellite outpatient clinic in Beaumont, Texas for $1.94 million, a satellite outpatient clinic in Boston, Massachusetts for $2.358 million, a parking facility in Cleveland, Ohio for $1.3 million, a satellite outpatient clinic and Veterans Benefits Administration field office in San Antonio, Texas for $2.256 million and a satellite outpatient clinic in Toledo, Ohio for $2.223 million.

CONSTRUCTION AUTHORIZATION

H.R. 3376 would authorize $422.3 million for major medical construction projects at 21 VA facilities. Another $12.236 million would be authorized for the Medical Care account to fund six leases. 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 proposing to authorize these projects, the Committee has developed a balanced list, comprising projects which would expand VA's ambulatory care capacity, strengthen seismically vulnerable buildings, and bring a number of aging facilities up to acceptable patient-privacy standards. In proposing to authorize 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 question.

Two years ago, 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 also appropriated $17.2 million for the 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 intermediate 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, to design and construct a comprehensive outpatient clinic in Brevard County. The Committee believes that $25 million may exceed the construction costs VA will incur 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 an examination of the medical needs of veterans in east central Florida imperative.

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 moneys 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 of other uses for the Orlando facility such as the interim use of the facility to meet inpatient needs, including acute medical surgical and psychiatric, in light of the changed circumstances for construction of an inpatient facility for those veterans residing in the catchment area of east central Florida.

STRATEGIC PLANNING FOR HEALTH CARE RESOURCES

Section 201 of the reported bill would require 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 would be updated on an annual basis and submitted no later than January 31st of each year.

The VA strategic plan which would be required by the bill would 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 serv-

ices 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 would occur within and among networks. It would also delineate the array of services VA would provide, such as those provided in-house and through contract, and the market penetration or the percentage of veterans it would expect to serve. As part of this effort, the VA would 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 would 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 address this phenomenon. The plan would also account for changing practice patterns, including increased reliance on 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 of patients by network. The plan should also address how the mix of professionals and use of various classes of health care professionals would affect 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 under-

stands that the achievement of this particular goal may require time and the incremental shifting of resources is 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 an example, 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 the 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 Tuskegee and Montgomery VA Medical Centers could work together to develop such a clinic, and directs the Secretary to establish this needed clinic.

In this same vein, the Committee also notes the need for outpatient health care services in LaSalle, County, IL. The problems of access to care were highlighted during an April 22, 1996 Subcommittee on Hospitals and Health Care field hearing which examined the problem in depth. Currently 12,000 veterans reside in LaSalle County, a rural farm area approximately 80 miles from Chicago which is served by the Hines VA Medical Center. A recent cost study by the LaSalle County Veterans' Assistance Council showed that annually $30,000 are expended to transport veterans to the Hines Medical Center and that the costs for 1996 will exceed $50,000. Testimony by the Veterans Integrated Service Network director (VISN 12) and other community and veterans groups strongly supported the establishment of an ambulatory care access point within the county. The Committee believes that the establishment of a community care clinic supports the overall goals of the Veterans Health Administration to provide accessible, cost-effective care for eligible veterans and therefore directs the Secretary to establish this needed clinic at the most appropriate site to serve veterans in La Salle County, IL.

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 long-standing 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 would call 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, for example, can be a cumbersome, time-consuming 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 1998 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 which would be 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 it would generally provide the Under Secretary the breadth of flexibility he requested, the reported bill adds language which would ensure that that Office is sufficiently staffed to provide expertise the Committee believes is needed. Thus, the reported

bill requires the Under Secretary to ensure that that Office is staffed 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.

RENAMING OF THE VA MEDICAL CENTER IN JACKSON, MISSISSIPPI

This section of the bill would change the name of the Jackson, Mississippi, VA Medical Center to the G.V. Sonny Montgomery Department of Veterans Affairs Medical Center.

In recognition of Mr. Montgomery's extraordinary thirty years of service in the House of Representatives, and his monumental contributions not only to the veterans of Mississippi, but to all of America's veterans, the entire Mississippi State Delegation in concert with the veterans service organizations of the State of Mississippi and the citizenry of Jackson, Mississippi, have requested that the Jackson VA Medical Center be re-designated the G.V. Sonny Montgomery Department of Veterans Affairs Medical Center. In so honoring Mr. Montgomery, the Congress would establish a fitting recognition of this unique member's 30 years of distinguished House service, his extraordinarily productive fourteen-year chairmanship of the Veterans Affairs Committee, and twenty-five years of vigorous, dedicated work on the Armed Services and National Security Committees for a strong national defense and on behalf of America's servicemen and women.

Sonny Montgomery's career has been one of extraordinary service to his country. His service in World War II and later in the Mississippi National Guard shaped a lifelong commitment to a strong national defense. As an advocate of peace through strength, Montgomery has consistently urged that if the nation is to be strong and realize true security, it must treat its defenders with dignity. That principle has guided Montgomery's actions throughout his long congressional career.

It is entirely fitting that the Jackson VA Medical Center be named for this individual, because Representative Montgomery's record of service to America's defenders, its soldiers, sailors, airmen, and its veterans of the armed forces, is virtually unparalleled. In fact, it has earned him the appellation, "Mr. Veteran." That title celebrates his dedication to a cause, and his record of constancy, relentless advocacy, and legislative initiative. But it also celebrates the enormity of his accomplishments.

Those achievements have not necessarily come easily. Montgomery, a retired major general, waged relentless campaigns to win enactment of his two most widely acclaimed legislative victories, enactment of the Montgomery G.I. Bill, an educational assistance program for our nation's veterans, and establishment of the Veterans Administration as a Cabinet-level department of government. The Montgomery GI Bill is providing millions of young Americans the opportunity to earn money for college through service in our nation's armed forces, thus enhancing their transition from military

to civilian life. Additionally, this program serves as an effective recruitment and retention tool for the military services. Elevating VA to the Cabinet has given veterans affairs a level of stature, access, and advocacy not seen since World War II. Both legislative initiatives have, thus, had deep, lasting impact in strengthening vital government programs and improving the lives of millions—young servicemen and women and veterans of the nation's armed forces.

Montgomery's achievements have not been limited, however, to high-visibility, high-stakes campaigns. His legislative record is foremost one of steady, patient, incremental progress, consistently a product of hard work and consensus-building. While only a small number of bills among the voluminous body of legislation he has authored has commanded major headlines, the totality of his record is staggering. As Chairman of the House Committee on Veterans Affairs, Montgomery led the development of a remarkable body of laws. It may fairly be said that he has left a legacy to America's veterans through his relentless efforts to protect, improve, and expand their special benefits and services.

In addition to his unending work on behalf of veterans, the qualities of leadership, commitment, and dedication in this rare man led him to champion the search for answers to the wrenching questions regarding America's missing in action. In 1975 and 1976, he chaired the House Select Committee on Missing Persons in Southeast Asia. He traveled to Hanoi in 1977 as a member of the presidentially-appointed Woodcock Commission seeking additional information about missing servicemen. He was appointed Chairman of the Special House Committee on Southeast Asia in 1978 to conduct further efforts on behalf of the MIAs. In all, this quest led him on 14 trips to Vietnam. In 1990, he led the House delegation that successfully negotiated with the North Korean government to bring home the first set of remains of U.S. servicemen missing in action during the Korean War.

Paralleling his service to the veterans of this country and his work on behalf of such deeply-felt causes as the tragedy of America's missing-in-action, Montgomery has long been a key participant in shaping national security policy. With twelve terms on the Armed Services Committee (now the National Security Committee), Montgomery has become the senior Democrat member on both the Military Personnel and Compensation Subcommittee and the Military Installations and Facilities Subcommittees. In this arena, Montgomery has been a tireless and outspoken advocate for National Guard and Reserve Affairs.

In the Congress, Sonny Montgomery has been more than the sum of his legislative and related accomplishments. He has been a leader, a forger of alliances, a consensus-builder, a figure to whom other members looked for advice. He has been an institution within the institution, freely sharing his thoughts with colleagues—whether from his familiar seat on the aisle on the House floor, or at such gatherings as the Congressional Prayer Breakfast.

These qualities have certainly not escaped recognition. Rep. Montgomery's record of public service has earned him many awards of honor. These include the Distinguished Service Citation by the Reserve Officers Association of the United States, the Con-

gressional Award by the Veterans of Foreign Wars, the Silver Helmet Congressional Award from the AMVETS of World War II, the Harry S. Truman Award from the National Guard Association of the United States, and the "Champion of VA Research Award" from the National Association of Veterans' Research and Education Foundations. He recently was presented the Department of Defense Medal for Distinguished Public Service, the highest award presented to any civilian by the Secretary of Defense.

Prior to his election to Congress, Montgomery served for ten years in the Mississippi State Senate, where his accomplishments include the introduction and enactment of legislation creating the Mississippi Authority for Educational Television. He was first elected to the U.S. House of Representatives in 1966.

Representative Montgomery is a retired Major General in the Mississippi National Guard, having served more than 35 years in the military. His active and reserve service included duty in World War II in the European Theater. He was a company commander in the 31st National Guard Infantry Division when it was called to active duty during the Korean Conflict; however, the Division was not sent overseas. Among his military awards are the Legion of Merit, Meritorious Service Medal, Bronze Star of Valor, Combat Infantry Badge, Army Commendation Medal, and the Mississippi Magnolia Cross Award.

He was born in Meridian, Mississippi, and was educated at the Meridian Public Schools, the McCrallie School in Chattanooga, TN; and Mississippi State University, where he received a B.S. degree.

RENAMING OF THE VA MEDICAL CENTER IN JOHNSON CITY, TENNESSEE

H.R. 3376 would rename the Mountain Home Department of Veterans Affairs Medical Center in Johnson City, Tennessee as the "James H. Quillen Department of Veterans Affairs Medical Center."

Congressman Quillen is retiring after 34 years as a distinguished Member of Congress from eastern Tennessee. A World War II veteran of the United States Navy, he is a member of numerous veterans' organizations and has fought tirelessly for the veterans in his district in across the nation.

James Quillen was born on January 11, 1916 near Gate City, Virginia, one of ten children born to tenant farmers. The family moved to Kingsport, Tennessee shortly thereafter. At the age of 19, he started his own newspaper, and at one time was the youngest newspaper publisher in the nation.

Just as he was getting his newest venture, a daily, off the ground, his country called. From 1942 until 1946, he served in the United States Navy, rising in rank from Ensign to full Lieutenant. His tour of duty took him from the Naval Air Station in Brunswick, Maine to the aircraft carrier *U.S.S. Antietam*.

After the war, Mr. Quillen was active in the real estate, construction and insurance businesses. In 1952, he married Cecile Cox.

Soon after, he was elected to the Tennessee Legislature, where he served on the Legislative Council and was Minority Leader in

1959 and 1960. He was elected to the House of Representatives in 1962, where he has served ever since. He is the dean of the Tennessee delegation and holds the state record for longest continuous House service.

Since 1965, Mr. Quillen has been a member of the prestigious Rules Committee. In that capacity, he has fought for budget restraints, lower taxes, workable health care, education and veterans' issues. In the beginning of the 104th Congress, he was named Chairman Emeritus of the Committee.

He has been awarded numerous awards from organizations and groups throughout Tennessee. In 1986, he was named Tennessee Statesman of the Year, and Interstate Highway 181 in Northeast Tennessee is named in his honor as a Parkway.

Above all, Congressman Quillen has been devoted to improving health care for citizens of Tennessee and throughout the country. His battle to establish a medical school at East Tennessee State University was successful, and the school has been named the James H. Quillen College of Medicine. Another medical facility, the James H. and Cecile Cox Quillen Center for Rehabilitative Medicine in Johnson City, was dedicated in 1991. Additionally, in 1994, the Holston Valley Hospital and Medical Center in Kingsport named its new cardiac wing in honor of the congressman as the James H. Quillen Regional Heart Center.

Congressman Quillen's work on behalf of veterans clearly warrants this action. Chairman Stump, on April 25, 1996, introduced legislation authorizing the renaming of this VAMC to honor Mr. Quillen. This bill, H.R. 3320, was cosponsored on a bipartisan basis by the entire Tennessee delegation and by every member of the Veterans' Affairs Committee, and was incorporated into H.R. 3376.

RENAMING OF THE VA NURSING CARE CENTER IN ASPINWALL, PENNSYLVANIA

John Heinz was a respected and valuable Representative and Senator who served Pennsylvania with vigor for 20 years. His tragic death in a plane crash in 1991 was shocking and heartbreaking to the millions of Americans who knew him or knew of his work. It is with great respect to his memory that the Committee recommends that the Aspinwall VA Nursing Care Center be renamed the "H. John Heinz, III Department of Veterans Affairs Nursing Care Center."

Senator Heinz, an Air Force veteran, was known for his work on behalf of the elderly. He helped establish the House Select Aging Committee in the 1970s and was steadfast in his advocacy of Social Security and Medicare.

Senator Heinz was born in Pittsburgh in 1938 and graduated from Yale University in 1960. He received a graduate degree from Harvard Graduate School of Business Administration in 1963. In 1971, he ran for and won a House seat in a special election to replace a deceased Member. In 1976, he was elected to the United States Senate, where he was re-elected twice and served until his untimely death.

Late last year, Rep. Michael Doyle introduced legislation providing for this name change. The bill, H.R. 2760, was cosponsored by the entire Pennsylvania delegation.

VA RESEARCH CORPORATIONS

In 1988, Congress, in Public Law 100–322, authorized the Department of Veterans Affairs to establish nonprofit corporations at individual VA medical centers in order to facilitate and foster the conduct of VA medical research. The establishment of such corporations was intended to create mechanisms which could accept public and private grants, and administer funds, for support of VA-approved research. These corporations have served as flexible mechanisms to enable VA clinicians to carry out research projects for which funding might not be available through VA's own research appropriation. The now more than 80 corporations are self sustaining and require no appropriation.

Research corporations at some of VA's major hospitals have received and administer relatively substantial sums—more than $1 million at many of the largest. For calendar year 1994, VA research corporations received a total of almost $49 million (up from $37 million in 1993).

During 1994, more than 950 VA investigators conducted some 1700 research initiatives supported by donations and grants to VA research corporations. The overwhelming majority of corporation-funded research is clinically focused and has a direct impact on patient care. While these efforts further the advancement of medical knowledge, they also bring additional resources that benefit veterans' care. For example, the physicians and nurses who carry out this research also provide care to veterans during the course of their research studies. Also, the research funded through the corporations often brings veterans access to the latest drugs and technology. In helping to provide equipment, treatment, and staff, while defraying the cost of overhead for conducting research, the corporations help VA to serve veterans without cost to the VA budget.

With the expiration in 1992 of VA's authority to establish additional research corporations, a significant number of VA facilities, including several major VA medical centers, do not have a research corporation to support their research programs. Section 304 of the reported bill would extend VA's authority to establish additional research corporations until December 31, 2000.

SECTION-BY-SECTION ANALYSIS

Section 101(a) would authorize 8 major medical facility ambulatory care addition projects.

Section 101(b) would authorize 10 major medical facility environmental improvement projects.

Section 101(c) would authorize 3 major medical facility seismic correction projects.

Section 102 would authorize the VA to enter into 6 major medical facility leases.

Section 103(a) would authorize $422.3 million for projects authorized in section 101 and $12.236 million for 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 1997 or the previous year.

Section 104(a) would require the Secretary to report to the Veterans' Affairs Committees not later than 60 days after the date of enactment of this Act, 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).

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 in Orlando, Florida to a nursing home care unit until 45 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 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 major 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 1998 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 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 expertise in generally specified specialized medical programs and appropriate clinical care disciplines.

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

Section 301(a) would name the Department of Veterans Affairs Medical Center in Jackson, Mississippi as the "G.V. Sonny Montgomery Department of Veterans Affairs Medical Center."

Section 301(b) specifies that such a name change shall take effect at noon on January 3, 1997, or the first day on which Representative Montgomery is no longer a Member of the House.

Section 302(a) would name the Mountain Home Department of Veterans Affairs Medical Center in Johnson City, Tennessee as the "James H. Quillen Department of Veterans Affairs Medical Center."

Section 302(b) specifies that such a name change shall take effect at noon on January 3, 1997, or the first day on which Representative Quillen is no longer a Member of the House.

Section 303 would name the Department of Veterans Affairs Nursing Care Center in Aspinwall, Pennsylvania as the "H. John Heinz, III Department of Veterans Affairs Nursing Care Center."

Section 304 would extend the VA's authority to establish Department of Veterans Affairs research corporations to December 31, 2000.

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, May 10, 1996.

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. 3376, a bill to authorize major medical facility projects and major medical facility leases for the Department of Veterans Affairs for fiscal year 1997, and for other purposes, as ordered reported by the House Committee on Veterans' Affairs on May 8, 1996.

H.R. 3376 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 1985. The bill contains no intergovernmental or private-sector mandates as defined in Public Law 104–4, and would impose no direct costs on state, local, or tribal governments.

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

Sincerely,

JUNE E. O'NEILL,
Director.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R. 3376

2. Bill title: A bill to authorize major medical facility projects and major medical facility leases for the Department of Veterans Affairs (VA) for fiscal year 1997, and for other purposes.

3. Bill status: As ordered reported by the House Committee on Veterans' Affairs on May 8, 1996.

4. Bill purpose: The bill would authorize major construction projects and several major facility leases. It would also authorize appropriations for these projects and leases. In addition, the bill includes a number of 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. 3376, which would depend upon subsequent appropriations action.

[By fiscal year, in millions of dollars]

	1996	1997	1998	1999	2000	2001	2002
SPENDING SUBJECT TO APPROPRIATIONS ACTION							
Spending Under Current Law:							
Budget Authority [1]	129	0	0	0	0	0	0
Estimated Outlays	418	350	235	123	44	11	3
Proposed Changes:							
Authorization Level [2]	0	435	0	0	0	0	0
Estimated Outlays	0	2	70	135	126	78	17
Spending Under H.R. 3376:							
Estimated Authorization Level [1 2]	129	435	0	0	0	0	0
Estimated Outlays	418	352	305	258	170	89	20

[1] The 1996 figure is the amount already appropriated.
[2] The amount for fiscal ear 1997 is an authorization subject to appropriations action.

6. Basis of estimate: The estimate assumes enactment of the bill and appropriation of the authorized amounts. The bill would authorize the appropriation of $422 million for 21 major construction projects and $12 million for six major facility leases. CBO used historical spending rates for VA's major construction projects to estimate outlays.

7. Pay-as-you-go considerations: The Balanced Budget and Emergency Deficit Control Act of 1985 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts through 1998. This legislation would not affect direct spending or receipts. Therefore, it has no pay-as-you-go implications.

8. Estimated cost to state, local, and tribal governments: H.R. 3376 contains no intergovernmental mandates as defined in Public Law 104–4 and would impose no direct costs on state, local, or tribal governments.

9. Estimated impact on the private sector: This bill would impose no new federal private-sector mandates, as defined in Public Law 104–4.

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].

* * * * * * *

[(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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SUBCHAPTER IV—RESEARCH CORPORATIONS

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§ 7368. Expiration of authority

No corporation may be established under this subchapter after December 31, [1992] *2000*.

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PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

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SUBCHAPTER I—ACQUISITION AND OPERATION OF MEDICAL FACILITIES

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§ 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) * * *

* * * * * * *

(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] *$5,000,000*, but such term does not include an acquisition by exchange.

(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 detailed] *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 estimate] *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 estimate] *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.

* * * * * * *

(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.

* * * * * * *

§ 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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§ 8109. Parking facilities

(a) * * *

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(h)(1) * * *

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(3)(A) * * *

(B) Subparagraph (A) of this paragraph does not apply to the use of funds for investigations and studies, surveys, designs, plans, [working drawings] *construction documents*, specifications, and

similar actions not directly involved in the physical construction of a structure.

* * * * * * *

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.**]**

○