DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE SYSTEM

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHT CONGRESS

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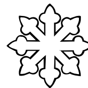

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DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE SYSTEM

WEDNESDAY, JANUARY 29, 2003

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

The committee met, pursuant to call, at 2:12 p.m., in room 334, Cannon House Office Building, Hon. Christopher H. Smith (chairman of the committee) presiding.

Present: Representatives Smith, Simmons, Brown of South Carolina, Boozman, Bradley, Beauprez, Ginny Brown-Waite of Florida, Renzi, Evans and Filner.

OPENING STATEMENT OF CHAIRMAN SMITH

The CHAIRMAN. The committee will come to order. Good afternoon.

Last night President Bush reported that the State of the Union was strong. Today we will examine the state of veterans' health care to see if it is equally strong.

Only days ago the Department of Veterans Affairs announced that for the first time it would use its authority to curtail new enrollments for veterans' health care. VA reported that at least, and I emphasize at least, 200,000 veterans are waiting 6 months or longer for their first appointment with a VA doctor, and that estimate doesn't count those still waiting to enroll in the system. Many of those waiting are 100 percent disabled and paralyzed veterans. In fact, when Secretary Principi sent one of his deputies, Gordon Mansfield, a decorated Vietnam veteran paralyzed in combat, to try and enroll in VA health care, he was turned away in state after state due to overcrowding.

Earlier this month Chairman Buyer and committee staff visited one medical center in Florida and discovered that over 2,700 veterans are waiting to be scheduled to see a VA audiologist, over 4,000 veterans are waiting to see an eye specialist, and almost 700 are waiting to see a cardiologist. More than half of these veterans were high-priority veterans in categories 1 through 7. All reports indicate that a similar situation exists at a majority of VA medical centers throughout the country. Care delayed, I would respectfully submit, is care denied.

At the same time there remain at least 275,000 homeless veterans who—and that is a VA estimate, the VSO has put the number even higher—who desperately need a helping hand, yet VA is unable to fully fund programs that Congress approved less than 2 years ago. The VA has closed over 1,500 long-term care beds at a

time when World War II and Korean War veterans are most in need of assistance. Despite an increase in the number of veterans who have service-connected mental illnesses such as post-traumatic stress disorder, VA is providing less care overall than it did in previous fiscal years. And most troubling of all, according to the VA's own published documents in the Federal Register of January 17, the VA will be short, $1.9 billion in their health care budget for this fiscal year, and that assumes that the VA will receive the full $23.9 billion for health care approved last year by both the House and the Senate Appropriations Committees.

Let me emphasize what I just said. The VA projects that it needs other $1.9 billion this year to meet the health care needs of veterans already enrolled. To put this in perspective, $1.9 billion is the annual cost of providing care to roughly 422,000 veterans from all priority groups, veterans who are already in the system.

How does the VA plan to make up the difference this year? The only proposal to date is the freeze on enrollment of new priority 8 veterans, a move that the VA projects could save at most $130 million this year.

Some have suggested that Congress is to blame for the shortfall in funding for the veterans' health care, but the record over the past 5 years is clear that each Administration request has been a budget floor, while Congress has added funds above the request each and every one of those years. For fiscal year 2003, the Administration requested a 6 percent increase. The House passed and the Congress is expected to approve an 11 percent increase. That is $1 billion above the VA budget request. Over the past 5 years Congress has consistently provided greater funding than was requested by the Administration, on average over $300 million each year. In addition, last year Congress passed a supplemental appropriation that included $417 million for VA health care. Regrettably, the Administration refused to accept $275 million of that supplemental targeted for veterans' medical care.

Others have suggested that the VA's problems are driven by enrollment of veterans who were not injured during their service, so-called lower-priority veterans in category 8. However, it is clear that even if VA had never offered priority 8 veterans the opportunity to receive care from the VA, it would still be swamped with service-connected and low-income veterans who are in the high-priority categories.

According to the VA, the number of high-priority veterans enrolled in VA health care is projected to rise by 384,000, or 7.5 percent this year, and by 281,000 next year. A total of 5.8 million high-priority veterans will be enrolled for VA health care next fiscal year, and this trend will not diminish for several more years.

The word "crisis" is often overused in this town, but clearly VA health care is in crisis, the funding of VA health care, and it is at a crossroads. Last year I, along with my good friend Lane Evans, offered several bills seeking long-term solutions to VA health care funding problems. H.R. 4939 would have allowed the VA to be reimbursed by Medicare for providing care to Medicare-eligible veterans. H.R. 5250 would have made VA health care funding a formula-driven budget item, based upon demand and medical inflation rather than a discretionary budget item. H.R. 5392 would have al-

lowed the VA to recover costs of medical care from third parties in the same manner as if VA were a preferred provider organization. And finally, H.R. 5530 would have enhanced the right of the VA to recover payments from third parties for providing non-service-connected care.

We are again preparing to introduce legislation on a bipartisan basis to provide long-term solutions to VA's funding problems, but before we can arrive at solutions, we first need to agree on the nature and scope of the problems. For some, the Secretary's decision to cut off enrollment of 164,000 category 8 veterans was a solution. To me and many others it is a problem.

So I return to the central question of today's hearing: How well is VA fulfilling its statutory mandate to provide the full range of health care services that veterans have earned? Are service-connected disabled and paralyzed veterans receiving timely and comprehensive care, including access to the latest advances in medicine and technology? Is VA meeting its obligations to indigent veterans, those who have fallen on hard times, including those suffering from drug addiction and mental health problems? How about our elderly veterans? Many who fought on the beaches of Normandy or in the forests of the Ardennes, and the across the frozen Chosin Reservoir, are they receiving the long-term care Congress mandated for them in the Millennium Health Care and Benefits Act of 2000? (Which again, was passed by a previous Congress and remains to be adequately acted upon by the administration).

Many of you have heard of the American Legion's project called "I Am Not a Number." It is helping to put a human face on veterans' health care issues rather than just focusing on numbers such as budget allocations and enrollment projections. It reminds me of a saying often used by Mark Twain, and it is quite appropriate for today's hearing. Twain said there were three kinds of lies: Lies, damn lies, and statistics. I think that Mr. Twain and the American Legion have it right: Veterans are not numbers, their health is not a statistic, and our Nation's debt to them must be more than just words. We can do better, and I do believe we will.

[The prepared statement of Chairman Smith appears on p. 45.]

The CHAIRMAN. I would like to yield to Mr. Evans for any opening comments he might have.

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

Mr. EVANS. Thank you, Mr. Chairman and members of this committee. I welcome the new members of the committee who are joining us for the first time today.

I am also deeply disappointed to learn that Secretary Principi had recently decided to bar those highest-income veterans who had not already enrolled for care from applying for VA services. I was particularly disappointed, Mr. Chairman, given our bipartisan recommendation to the Budget Committee to increase the President's request for VA funding levels fiscal year 2003 by $2.2 billion. Unfortunately the appropriation that is before us is below that level and will only aggravate the VA's health care problems.

But, Mr. Chairman, there is a solution. You and I introduced H.R. 5250, the Veterans Health Care Funding Guarantee Act of

2002, which would have established a mandatory funding stream for the VA health care.

I want to reaffirm my commitment and ask for yours in working together to address any obstacles that have been set in our path in getting this legislation reintroduced in the near future. I look forward to working with you, Mr. Chairman.

I yield back.

The CHAIRMAN. Thank you for your comments.

[The prepared statement of Congressman Evans appears on p. 46.]

The CHAIRMAN. I would like to introduce our very distinguished Under Secretary for Health, Dr. Robert Roswell, who was confirmed by the Senate on March 22, 2002. Dr. Roswell has directed the VA's health care network for Florida and Puerto Rico since 1995. Dr. Roswell previously held positions as Chief of Staff at the VA medical centers in Birmingham Alabama, Oklahoma City; and held leadership positions in other VA facilities and VA central office in Washington.

He is a 1975 graduate of the University of Oklahoma School of Medicine, where he completed his residency in internal medicine, and a fellowship in endocrinology and metabolism.

Dr. Roswell served on Active Duty in the U.S. Army from 1978 to 1980 and is currently a colonel in the Army Reserve Medical Corps.

Thank you for being here. We look forward to your testimony.

STATEMENT OF HON. ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Dr. ROSWELL. Mr. Chairman, members of the committee, I am pleased to be here today to discuss the challenges facing VA in meeting the current demand for VA health care services. With your permission, I will provide a brief summary of my formal statement and ask that the formal statement be included in the record.

Today's VA health care system is one of the most effective and successful health care systems in the Nation. VA's performance now surpasses many government targets for health care quality as well as measured private sector performance. For 16 of 18 indicators critical to the care of veterans and directly comparable externally, VA is now the benchmark for the entire Nation. VA is also leading the way in assuring safe health environments and health care delivery, and we are continuing our efforts to achieve additional cost efficiencies.

Today VA has nearly 1,300 sites of care and is providing care to nearly 48 percent more veterans than in 1997. At the same time we have reduced the cost of care per veteran by 26 percent through more efficient and effective care delivery.

VA continues to place a strong emphasis on comprehensive speciality care, but we now also emphasize coordination of care through primary care providers. With this transformation, and by employing new models of care coordination and delivery, veterans have gained access to an integrated health care system focusing on addressing their health care needs before hospitalization becomes necessary.

Mr. Chairman, while the changes in the VA health care system have been profound, and the benefits have been recognized both inside and outside the Department, we also face significant challenges. VA is currently experiencing an unprecedented demand for health care services. We had nearly 800,000 new enrollees in fiscal year 2002 alone, and currently we have almost 6.6 million veterans enrolled. We currently project that we will provide care to 4.6 million veterans this year. This represents a 70 percent increase since 1996. Continued workload growth of this magnitude is clearly unsustainable within VA's current level of available resources.

As discussed in my formal statement, VA has taken steps to assure priority access to service-connected veterans, veterans who are poor and those with special needs.

And recently we announced our decision to suspend enrollment of new Priority 8 veterans. We did not reach this decision easily. However, it was a decision that had to be made in order to maintain the quality of health care we provide to currently enrolled veterans and those higher-priority veterans who have yet to enroll, and to assure that our system will be ready and able to meet any and all needs of veterans of a future conflict, should one occur.

The Secretary has also announced that work is under way with the Department of Health and Human Services to determine how to give Medicare-eligible Priority 8 veterans who cannot enroll in VA's health care system access to a VA+Choice Medicare plan which would include prescription drug benefits very similar to the type of plan the President mentioned last evening. Our goal is to have this option available by the end of the year.

During much of the past year, we have had over 300,000 patients on waiting lists to receive medical care. Currently, about 200,000 veterans are on those lists. VA has made concerted efforts to reduce waiting times and eliminate excessive waits. With the additional funding requested for fiscal year 2003 and the enrollment decision, we expect to significantly reduce these waits this year.

We must also continue to find better ways to deliver care. We need new ways to partner with patients to more effectively manage health care continuously. This approach will involve a fundamental change in how we view health care from a provider-centric to a patient-centric focus. Implementing this approach will have a substantial impact on primary care, but an even more profound impact on long-term care. Institutional long-term care is very costly and may impair the long-term spousal relationships and reduce quality of life.

The technology and skills exist to meet a substantial portion of long-term care needs in noninstitutional settings. Nursing home care should always be the option of last resort.

To oversee many of the initiatives needed to implement a new patient-centered model for care in long-term care, I have created the new Office of Care Coordination. This office will have in its charge such issues as the use of technology and care coordination and the development and implementation of policy and initiatives for chronic disease management and long-term care.

But while there is much that VA can do on its own, we also need the committee's assistance. For more than 30 years VA has developed a continuum of institutional and noninstitutional services to

meet the extended care needs of veterans, including VA-provided contracted and State home services. I believe that the capacity requirement included in the Millennium Act should be updated to reflect VA's current direction in the provision of all types of long-term care.

We also need your help to assure VA's ability to remain competitive in pay and work force innovations. We expect to experience increasing difficulties in the year ahead in maintaining our nursing work force, and we currently expect to face severe challenges in recruiting physicians, especially in scarce specialties. VA's current pay authorities are stretched to the maximum and the Department can no longer offer competitive salaries for many medical specialties.

We are developing a comprehensive work force improvement proposal that would improve our ability to recruit and retain physicians, nurses and other health care occupations. The administration expects to submit this proposal by late spring of this year.

Mr. Chairman, the current state of VA health care is excellent. We have—but we have much to do to maintain and build upon that excellence. My vision of the future of VA health care is positive, but we must deliberately address the challenges I have outlined today or risk a very different future.

This concludes my statement. I will be happy to answer any questions you or other members of the committee have. Thank you.

[The prepared statement of Dr. Roswell appears on p. 56.]

The CHAIRMAN. Thank you very much Dr. Roswell.

Let me just begin by congratulating you on a very, very difficult job that you have undertaken. I think you do it with great passion, but unfortunately, you get handicapped by the resources that you have at your disposal and fault for that certainly can be spread in a number of areas. OMB always comes to mind. Congress comes to mind. I mean, it seems to me that our endeavor needs to be to marry up the need with sufficient resources so that rationing, however unwittingly, doesn't happen.

In the Secretary's interim final rule, if I read the numbers correctly, is how we derive that shortfall of $1.9 billion. I hope that you work with us, notwithstanding OMB's direction, to try to get that additional money.

I know the appropriations bill is moving, and it won't even come close to meeting that. But supplementals are something that happen frequently, or at least maybe once a year, and it seems to me that once again, the veterans are voting with their feet. They are choosing VA health care because of the services provided, in some cases because of the pharmaceutical benefit which is significant for the category 7s and 8s. But the sense is that there is a good health care delivery network. They want to be a part of it. The CBOCs have made it possible as access points for many veterans who may not have even thought of it before to now become consumers of veterans' health care.

As you and Secretary Principi have so ably pointed out, especially for our senior population, it is a good deal for the government when they use VA health care—25, 30 percent less per capita per patient than if they used a Medicare provider in a more traditional sense or setting. It seems to me that when Uncle Sam, this spigot,

Medicare or some other spigot, or General Treasury funds, is paying, we can't a case that we get a better utilization of our tax dollar going into VA health care. I continue to be baffled. Why we can't make that case sufficiently to get these resources?

And so, generally you know where I'm coming from, because we have had this discussion, but I hope maybe you can just speak to it a little more and maybe talk about the $1.9 billion—is that the shortfall for this coming year? Are we reading these papers correctly?

What is the estimation going forward? I know the budget has not been submitted yet. We will have our budget hearing, but give us a sense of what kind of resources, year after year, we are going to need to meet the need.

Dr. ROSWELL. Well, thank you, Mr. Chairman.

Using an actuary's full-demand projection model, the 1.9 billion shortfall you spoke about is roughly correct. But it is important to understand, as much as I support and appreciate your advocacy for veterans and your leadership in this committee and your tireless efforts to generate the resources that are needed to provide care, at this point in time it is more than simply resources. We have reached a point with our VA health care system where the fundamental nature of the system has shifted because of recent demand for care and years of chronic underfunding.

Today we must rebuild the system. We have to hire new physicians, new specialists and new nurses, and we have to go back and reexamine our tertiary care capability. We have had tremendous demand for care, for pharmaceutical benefits and for outpatient care. But over half of the new enrollees in the system have sought just prescription drug benefits.

That shifted precious, limited resources away from our tertiary care mission. It has created primary care clinics and prescription drug delivery systems that are not at the fundamental nature of our core system.

If, God forbid, we have a war with Iraq, and if we have, God forbid, new veterans returning with combat-related disabilities and injuries, we must have in place the tertiary care system that will meet those full and comprehensive needs. I'm sorry to say, Mr. Chairman, that today we don't have those specialists and we have underfunded and neglected the tertiary medical equipment needs that will create such a system to meet that need.

We need a standdown. We need time to recruit specialists to bring on new capacity and to rebuild and replenish our tertiary equipment capability.

The CHAIRMAN. I think you make our case, though, Dr. Roswell, that funds are policy. I mean, notwithstanding the enrollment moratorium that Secretary Principi—and he has fully had the discretion to do so; I think he did so in very good faith, even though I disagree. But I think he has the veteran at heart and especially, you know, the service-connected and the indigent veteran. But it seems to me that chronic underfunding in the past should not become perpetual. We need to break that cycle and break it decisively. And why not in the 108th Congress? Why not now? If not us, who?

My question is: with this budget that we will soon get, knowing that we have a $1.9 billion demand-model shortfall for this year, won't that only get exacerbated as we move forward?

Please work with us because we are only one part. I mean, half of our budget is mandatory, thank God, and that is why when we do a GI bill, it does get fully funded because it is mandatory. And the benefits work that our new Chairman Brown will be working on, so much of that is, if we do it, it happens. But, unfortunately, the health care remains discretionary, and that has led to these chronic shortfalls, as you describe them.

But let's not let the past, I would respectfully request, color our future. We need sufficient resources and we will fight and the Administration can put the marker down.

Last night I was very proud of the President on the AIDS crisis. I am on the International Relations Committee; I am Vice Chairman of it. We have been working to get an AIDS bill passed that will put more money, especially in Africa where you have an explosion, 25 to 30 million people carrying the HIV virus within their bodies. And that will only get worse; you need to put a tourniquet on that. And the President announced a $10 billion increase for that, $15 billion in total.

It seems to me that we have a chronic shortfall, and it goes through previous Administrations, no doubt about it. Congress ponied up more money, but not enough. We can break that cycle now and do it in a bipartisan way. The Presidential Task Force—and you might want to speak to that, and then I will yield to my colleague for any questions he might have—will be making its recommendations.

I know they are looking at the mandatory scheme and other schemes as possible solutions. I would hope that maximum input would be made that what they produce won't be like so many GAO reports that get put on the shelf and nobody ever acts on it. We need a real change now, and I think the time has come.

Dr. ROSWELL. Thank you. Certainly we have worked and continue to work closely with the Presidential task force. We don't know what their final recommendations will be. But let me tell you that the concept of a VA+Choice benefit that the Secretary recently announced actually had its genesis, its beginning, in discussions with the chairperson of the Presidential task force, Gail Wilensky, the former HCFA Administrator.

So we have been maintaining very close communication with the Presidential task force. We are working to implement concurrently many of the areas of interest and many of what we believe will be their recommendations. Clearly, I think their interim report showed that to maximize VA-DOD sharing we have to improve access to the VA health care system which is, in large measure, resource-related. But at this point, because we have saturated our capacity, we also need time to hire those physicians and nurses. And in the health care field, the time to recruit and bring on additional health care professionals can sometimes be lengthy.

The CHAIRMAN. I see my time is up, so I yield to Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman. I have a disturbing question to ask.

If we are already in debt to a great degree and are not providing enough funding for the next fiscal year, how are we going to have enough if this war gets very heated and starts costing us casualties. Particularly since a lot of the same people who are serving as backfill are often the supply troops behind our lines?

Do you have any comment about that situation?

Dr. ROSWELL. Well, Congressman Evans, I share your concerns. As many as 8 percent of VA personnel could be deployed with a full deployment, and that would create a critical shortage of very vital health care professionals at a time when we most need them. I don't have any solutions, but I can tell you that we are eager and ready to begin an active recruitment program. If we receive the 2003 appropriation in the near future, we will activate that full effort to bring on a substantial number of additional nurses, as many as 1,300 additional nurses this fiscal year, as many as 500 additional physicians.

We have worked with OPM to develop policies to rehire annuitants to come back and work on a part-time basis in the event of a need to activate the DOD contingency mission. I have instructed all of our network directors to begin to identify ways to accelerate recruitment, bringing on additional personnel, bringing back retired or former employees in the event that we have that need.

But, yes, Mr. Evans, it is a very serious concern and one I share, but one which will only get worse lacking an adequate appropriation this fiscal year.

Mr. EVANS. Dr. Roswell, you have also referenced outsourcing as a possible source of significant savings for VA this year. What sort of services are you investigating for potential outsourcing?

Dr. ROSWELL. Competitive outsourcing is a component of the President's management agenda, but I am pleased to tell you that the only areas where we are looking at competitive sourcing as a possible vehicle to outsourcing would be in nonclinical areas. Currently, we are looking at laundry services; soon we will be looking at grounds maintenance and facility maintenance and management issues. We will also be looking at such things as food service, though not professional dietitian care for our patients.

Our agenda to address competitive sourcing and possible outsourcing is strictly apportioned away from the health care delivery within the VA health care system.

Mr. EVANS. All right.

Thank you, Mr. Chairman.

The CHAIRMAN. Chairman Simmons.

Mr. SIMMONS. Thank you, Mr. Chairman. Thank you, Doctor.

Mandatory benefits. What's the position of the VA on the issue of mandatory benefits which has been discussed by this committee, shifting that into health care?

Dr. ROSWELL. You are referring to H.R. 5250 from the 107th session?

Mr. SIMMONS. Yes, or similar legislation.

Dr. ROSWELL. I can't say that the Department has an official position on the bill. Obviously, the bill died with the termination of the last session.

Certainly, the concept is one that is interesting to me. It would require us to look at the specifics of the bill. One of the things that

we have determined is that in a typical year, our expenses increase 6 to 7 percent by new enrollment in Priorities 1 through 7. In addition to that, increased utilization, because the veteran population ages, and health care expenditures and health care utilization increase. With every increasing year of age, particularly in an elderly population, we have another 2 to 3 percent incremental cost every year. So a 7 percent increase associated with enrollment in our highest priority groups, coupled with another 2 to 3 percent of increased utilization costs, coupled with a conservatively estimated health care inflation rate of 4.5 or 5 percent, yields a 13 or 14 percent per year increase in the money available to take care of just our core population of veterans.

The mandatory funding bill would have to index the incremental rate to reflect those needs, and certainly, working with the committee staff, we have addressed that. I think that the concept of mandatory funding is one that philosophically I embrace, but obviously the Department would have to look at the specifics before there could be any direct, express support for that. It is interesting that we tend to treat VA health care as an entitlement, but we certainly don't fund it that way.

Mr. SIMMONS. And that is the whole point. Veterans tend to treat it as an entitlement as well—in other words, as part of the promise. In some cases, it is hard to find where the promise was actually made, but that is the understanding. And so, like any entitlement, you are going to have a fixed cost which may escalate based on access to the system. But certainly we deal with that with other entitlement programs in other parts of the government including health care programs.

Secondly, efficient use of resources. I am sure every Member of this Committee has experienced a situation where there may be military health care facilities in their district and there may also be Veterans Administration health care facilities in their district, and perhaps even other venues. It just seems to me that in numerous instances, these entities don't know about each other's activities. They don't coordinate their acquisition of very expensive equipment, and so on and so forth. What effort can we make within the next couple of years to assess where these resources are located and work to combine some of these resources with a common purpose of providing better health care? Not only for veterans, but maybe for the active component.

Dr. ROSWELL. Well, I am pleased to tell you that there is a great deal that has already been accomplished to move us towards that goal. Working with the Department of Defense, we have this past year created the Joint Executive Council as well as a Health Executive Council, that is specifically addressing those opportunities. We have implemented a contractual arrangement that sets a fixed discounted rate for any sharing between DOD facilities and VA facilities, a national rate schedule that eliminates the need for local negotiation that we hope will greatly facilitate that.

VA is undergoing a comprehensive process to examine its capital assets, its inventory of hospitals and clinic. Three representatives from the Department of Defense actually serve on the CARES oversight steering committee, so that they have full participation and DOD utilization in that process as a mandatory step in the devel-

opment of the market plans that the VISNs are now working on. So a lot is going on.

Also, I might add that the VA+Choice program that the Secretary announced is an initial effort to really begin to, first time, leverage Federal health care benefits across the Medicare program and into the VA program. I totally agree with the agenda you have laid down, and I am pleased to tell you that we are working aggressively on a variety of fronts to achieve those goals.

Mr. SIMMONS. Final question, I have always been confused about the fact that veterans applying to the VA for prescription drugs often are told they have to go through a complete rediagnosis of their condition. As somebody who travels a fair amount and, for a while, was on asthma medicine, if I presented a prescription just about anywhere in the country at a drug store, I could get what I needed. I don't know why this same concept can't apply to veterans going to VA.

What can we do to simplify that process and give them access to prescription drugs without going through a lengthy, time-consuming and expensive rediagnosis?

Dr. ROSWELL. Currently, the law restricts VA from providing drugs to any beneficiary unless the prescription is written by a VA provider except in certain very unique circumstances. So it would take a fundamental change in legislation.

But more importantly, the provision of prescription drug benefits through the VA allows us to oversee the quality of care being provided, our comprehensive system of clinical oversight. And the sophisticated, computerized patient records system allows us to monitor patients for drug/drug interactions which can seriously affect health.

We also make sure that we provide the necessary clinical and therapeutic monitoring that is required with many of the new medications. And that affords a much higher quality of care and patient safety to veterans in the VA health care system. For that reason, we oppose filling prescriptions written by non-VA providers who may not be familiar with VA formulary or VA's clinical monitoring and oversight processes.

I also would have to question, given finite resources, if that is the best utilization of the VA dollar when we truly need to rebuild this tertiary capacity, this comprehensive capacity in our systems.

Over the last several years, through no strategic direction, by no intent or policy, VA has shifted from a comprehensive tertiary health care system meeting a full spectrum of veterans' needs to a system that has focused and shifted towards primary care and prescription drug benefits. And while that is laudable if we have the resources to do it, we can't let the system shift and be stripped of the resources that would be necessary to meet the needs of both current, high-priority, disabled veterans and possible future combat-disabled veterans.

Mr. SIMMONS. Thank you, Mr. Chairman. My time has expired.

The CHAIRMAN. Thank you very much. Mr. Filner.

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman. As I listen to the testimony and the questions, I am struck by almost an unreal world I think we are living in at this moment.

Dr. Roswell, you said, God forbid, if we go to war. The chairman spoke of the President's very great proposal of AIDS funding. The President declared war last night, and we are going to go to war, it looks to me. And all these other discussions have no meaning because there is not going to be money for AIDS if we are at war, and there is not going to be the money that we are all talking about. So in some respects, it is an unreal world we are talking about.

More practically, Dr. Roswell, I think you said with the increase we will get in fiscal year 2003, we will be okay.

I don't see any increase coming. You know there is no increase coming. The omnibus bill was cut across the board. There may be even more cuts in VA, for all we know; in fact you may be on a CR for the rest of the year. Now, under any of those scenarios, which seem more real than anyone has been suggesting here, you are in trouble. And I would like to know what you are requesting us to do about it.

It looks like there are going to be to have layoffs and other such incredibly difficult measures. You are going to have to cut off more veterans, and that is the real world we live in.

Everybody's talking about this increase that is coming. It isn't coming. If we are at war, there aren't going to be any of these other things that are even going to be discussed. So I would like you to respond to that if you want to.

In addition, I see several of the freshmen here still. I want to point out the order of our panels has an impact on our hearings, and several of the subcommittees in this committee at certain times have said, why don't we hear from the public first, from the VSOs, and then from the administration, because then they raise really good questions and important questions, and we could have him answer those. This way, he goes first and then all the members leave and the VSOs are left by themselves without us really getting their expertise; and the kind of questions that ought to be asked of Dr. Roswell or Secretary Principi are simply not asked. So I would hope, Mr. Chairman, that at least we vary the rotation of these panels at times and have the public members and the VSOs first. These people work day in and day out for the veterans, and then they come here and testify and there is no one here listening to them. I just want everybody to keep that in mind as we proceed with the year's hearings.

The CHAIRMAN. Will the gentleman yield on that point?

Mr. FILNER. Yes.

The CHAIRMAN. Because we have done that in the hearings. I think it is a good idea. But even when they go second and third, we do listen and we listen carefully. But thank you.

Mr. FILNER. We try to listen. But many of the top VA administrators—I don't know if you are leaving, Bob, but they depart so they don't hear. They are in and out. And they don't hear all the testimony, although I am sure they get reports of it.

So under the real, more realistic scenario, you have cut off Priority 8. We have 300,000 waiting for their first appointment. We have a quarter million homeless on the street. We may not even have a budget for fiscal year 2003. So you are on a CR basis. What is going to happen? And are you going to insist on a supplemental for 2003?

Dr. ROSWELL. The situation is dire without a budget this year. Certainly, the omnibus bill you alluded to, resulting in the 2.9 percent cut in the House-Senate mark would significantly impact our ability to operate during the current fiscal year. We anticipate that we would need to see almost a quarter of a million fewer patients. We would have almost 2 million fewer outpatients visits and our efforts to reduce the waiting list would virtually be totally ineffective. It would require us to really refocus on addressing emergent and urgent care needs, and it is not a situation that truly provides the comprehensive, quality health care that our veterans need and deserve.

Mr. FILNER. I think you are right, and I think we have to face that reality here on this committee.

Another reality, and I know you have worked on this for a time, we are about to send 150,000 troops into an area where, the last time we sent them, 200,000 came back with something we are calling Persian Gulf War illness. We have neither a cure nor an explanation of what occurred.

As you know, my opinion has been that DOD especially, but also VA, have stonewalled—trying to get an answer to this, because maybe people would be embarrassed by the answers—for example, the vaccines that were given to the young men and women who were in the Gulf.

We are about to do this again. Do we have any better answer than we had? We are sending folks back in; we don't even know what happened to them last time.

Dr. ROSWELL. It is a fair question.

Mr. FILNER. Is that a fair summary that I gave?

Dr. ROSWELL. It is an appropriate question. It is a legitimate question. It is one that we have given a great deal of consideration to.

We have worked very carefully with the Department of Defense. VA has asked and been assured that full deployment health survey information will be obtained on all personnel being deployed and that that information would be provided to the VA. During the 10-year interval between Gulf War I and the current conflict that we are looking at as a possibility, tremendous strides have been made in our ability to identify hazards associated with the use of chemical-biological agents. There would be enhanced monitoring. There would be enhanced surveillance. DOD has taken steps, I am told, to implement a way to track the location of personnel assigned to the theater of operations which will allow us to better coordinate potential risk exposures.

Mr. FILNER. You are learning this job of obfuscation very well. If you look at the transcript that comes out, I asked, do we have any explanation for what happened?

Dr. ROSWELL. We don't have an answer for the Gulf War illnesses.

Mr. FILNER. We could be sending the guys right back into what happened before. Now, I have asked again for the historical record—I would appreciate if I could have 1 more minute, Mr. Chairman.

The CHAIRMAN. Just one, and then we will go to Mr. Brown.

Mr. FILNER. We had asked—many years ago—DOD if they had the a record of the inoculations that were given to each of the servicemen and -women. They claimed—I cannot accept the truth of this—that they didn't have such records, which is beyond the pale of credibility.

Now, one of your colleagues, at a hearing, mentioned these records; and I said, Oh, can I get them, because they told me they didn't have them. And she said, Sure. I never heard from her again, by the way.

We are claiming we have no record of the past situation in terms of injections, vaccines given, and yet we are going right out again.

We don't have any answers for these folks. People have suggested answers, and VA and DOD have refused to look at them. That is what gets my dander up, that there have been legitimate scientists and researchers who have said, We think we know why, and nobody will give them the opportunity to prove it. And we are going to have another 125,000 come back.

Dr. ROSWELL. I agree with your frustrations, and I share those frustrations. There has been over $200 million committed to research into Gulf War-related illnesses. In fact, we have recently announced as much as $20 million to be made available by fiscal year 2004 to focus on the sequelae of Gulf War illnesses. We have just created a commitment to fund a Neuroimaging Center of Excellence to look at neurodegenerative diseases that may be associated with environmental exposures, including Gulf War types of exposures. We have a new research advisory committee that we take very seriously concerning their recommendations about continuing to explore the causes of Gulf War illnesses.

So there is an unprecedented level of cooperation with DOD. We have renewed our commitment to research. We have redoubled our efforts to focus on those illnesses.

But, yes, this is a major concern, which is exactly why I feel so strongly about making sure that what finite resources are available to the Department are redirected to the services we know we will need if we have men and women injured or disabled by a future combat experience.

The CHAIRMAN. Thank you. Chairman Brown.

Mr. BROWN. Yes, thank you.

Dr. Roswell, thank you for coming today and thank you for all you do for the veterans of this Nation. My question would be, how is the pilot project working now, where we allow veterans to use, you know, outside medical facilities to meet their needs?

Dr. ROSWELL. We have a couple of efforts in that regard Chairman Brown. We have an emergency hospital benefit that is available to all veterans who may need emergency care and haven't been able to get it through the VA. On the other hand, routine care in non-VA hospitals is usually restricted to veterans with service-connected disabilities.

We do have one pilot program operating in Florida that was authorized by this committee several years ago that basically allows veterans treated at this particular clinic location in Brevard County, Florida, to receive hospitalization in the community. Because we don't have access to Medicare as a primary payer, like TRICARE For Life beneficiaries do, that pilot program has proven very costly for veterans who have third-party insurance. It is very manageable for the small number of veterans who have no health care benefits or insurance, we are able to cover that, but for the veterans who are Medicare-eligible, because we can't coordinate Federal health care benefits, we have to ask those veterans to self-refer; otherwise, the cost would be prohibitive.

I think we have learned a lot from that pilot program. A full report has been submitted to this committee during a past session, and it is certainly something that we continue to monitor.

Mr. BROWN. I know my particular reason—I think we talked about it personally, but we had—one part of our district was some 100 miles or so from primary care. They have to make appointments and commute that long distance. And if there was available, you know, the health care delivery right there in that location, it would certainly be of some benefit to those veterans that have to travel.

And also I think the variety of care that could be offered, rather than just the, you know, specialized care, I guess, that is being offered at the veterans hospital itself.

So do you think there is any chance that we could maybe coordinate those benefits with Medicare and private pay and—to meet some special needs for the veterans?

Dr. ROSWELL. I think we could. I think there are two possible encouragements, and with regard to the Myrtle Beach area that you refer to, certainly the CARES process will allow us to examine that. We are undergoing that process and we expect to have final recommendations approved by the Secretary by November of this calendar year. So that is one effort that will address the specific needs in your home State.

With regard to the coordination of benefits, I am optimistic TRICARE For Life, a benefit approved by this Nation for military retirees, essentially is a benefit that allows Medicare to be the first payer and DOD to be the second payer. If it is good enough for military retirees, why isn't it good enough for veterans? If we could let Medicare be a primary payer and VA be a secondary payer where we had to use non-VA facilities to meet a dire need for care, then why would we waste appropriated VA health care dollars to pay the full cost of care if Medicare could be the primary payer?

The legislation has precedent. Certainly I would like to work with the committee to seek that benefit.

The CHAIRMAN. Mr. Chairman, are you finished?

Mr. BROWN. Yes, sir. Thank you.

The CHAIRMAN. Thank you very much.

The Chair recognizes Mr. Boozman.

Mr. BOOZMAN. Dr. Roswell, I do want to thank you and your staff. You have got a very difficult job and we have always found you very, very helpful in the problems that we have come across. I think one of the committee's concerns is that we would like to

know a little bit about your plans as far as the relationship between the Office of Research Compliance and Assurance and the Office of Research and Development.

Mr. ROSWELL. We created the Office of Research Compliance and Assurance in 1999 because of concerns with the conduct of human research. Human research in safeguarding our subjects is one of our highest priorities. But since the creation of the Office of Research and Compliance in 1999 we have continued to have significant, potentially serious problems with the conduct of human research. The Office of Research Compliance and Assurance, or ORCA, which is easier for me to say, was set up as an independent entity within the Veterans' Health Administration to look at compliance and facilitate compliance through education and policy formulation.

What we have found since 1999 is that ORCA has been very effective at determining compliance. But because it is a separate entity the ability to formulate needed policy changes that will facilitate compliance and then provide the necessary education not only to investigators but to research administrators and support staff has not taken place because of ineffectual communication between the ORCA office and the Office of Research and Development. Therefore, we have recently taken an effort to integrate to a certain, but very limited, extent the ORCA office and the Office of Research and Development. ORCA will still have a separate budget, a separate funding stream. They won't have any programmatic responsibilities over research funding or administration. They will keep their evaluation responsibilities, but they will report dually to the Chief Research and Development Officer and to my office.

Then in addition, to make sure that we have sufficient external oversight, we have contracted with a National Committee for Quality Assurance, or NCQA, to do independent audits and certification of our research programs at every location in the Nation. We also have independent external accreditation that is exercised by the Office of Human Research Protection in the Health and Human Services Department as well as our own Inspector General and in many cases the Food and Drug Administration as well.

With these four types of external oversight, we believe that the ORCA efforts will be more effective in facilitating the needed policy changes and education of staff that will allow us to finally reach full compliance by having it better integrated with the Office of Research and Development.

Mr. BOOZMAN. Okay. Again, in looking through this it does appear that the committee has been very interested in keeping that unbiased objective and along those lines. It appears that you might have a conflict though if basically people are working with each other, maybe for each other and then trying to regulate the entity that they are potentially working for. Is that not——

Mr. ROSWELL. I understand your concern. But let me assure you that there is no one in the Department of Veterans' Affairs, VHA, and certainly not in the Office of Research and Development, who wants anything more than to absolutely totally protect the rights of patients who are involved in the conduct of research. This is not the fox watching the hen house. The fox watching the hen house wants to eat the chickens. In this case the Office of Research and

Development is doing everything it can to protect the research investigators, and that is the intent of both programs, to make sure that the integrity of our research programs is absolutely beyond reproach. But the inspection could be separate, and I understand that. But when inspection after inspection continues to identify problems and we don't make progress in facilitating changes, then it is time to figure out how to integrate those efforts so they are more effective.

Mr. BOOZMAN. I understand. I haven't been here a long, long time and yet sadly I have sat through hearings where, you know, somebody in your position several years ago probably was making the same statements and yet things were being done that never should have been done, okay? Now, are you going to at some point then report to Congress your changes as to how you are proposing to do this or are doing it now?

Mr. ROSWELL. Yes, sir. In fact, tomorrow we have a meeting with the Oversight Subcommittee staff to address some of the proposed changes and we will be certainly making all of our progress towards that end. We will be communicating on a regular basis, most likely through the Subcommittee on Oversight.

Mr. BOOZMAN. Okay. Thank you.

The CHAIRMAN. Mr. Bradley.

Mr. BRADLEY. No, thank you at this time.

The CHAIRMAN. Mr. Beauprez.

Mr. BEAUPREZ. Thank you, Mr. Chairman. Dr. Roswell, forgive me as a freshman if my questions are overly naive or perhaps repetitious, but I have two questions I would like to raise. I am from Colorado. Are you familiar with the Fitzsimmons Army Base and the redevelopment of that site?

Mr. ROSWELL. Yes, sir, I am.

Mr. BEAUPREZ. A rather glorious project I assume you would agree. And I assume from your response that you are also familiar with the ongoing efforts to relocate the existing Veterans' Administration Hospital from Denver out to the Fitzsimmons base.

Mr. ROSWELL. Yes, sir.

Mr. BEAUPREZ. I think that holds, from my admittedly biased perspective, holds a tremendous opportunity for improved health care for our many veterans in that area, in that region, certainly an opportunity for them to access quality health care by the many other providers at that site and partner with non-VA providers, as you have indicated apparently a growing willingness to do. Our veterans are very excited about that, and what put me over the edge in supporting it is the relatively short-term recovery of the initial cost by improved operational overhead and expense. So I am pleased to see that you are aware of it and hope that somehow we can collectively move that project forward and see it to fruition.

Mr. ROSWELL. Well, I am delighted with your support for the project and I am pleased to tell you that we are very interested in the project. We have actually taken it a level beyond the VA because the Air Force and the Department of Defense have also expressed interest in relocating to the University Hospital Colorado site at the former Fitzsimmons Army Center. We have recently created a task force that includes both DOD and VA representation to explore feasibility and options to begin a relocation to that cam-

pus, and within the next 2 weeks I will personally be meeting with the chief executive officer of the facility to discuss some of the specifics of that relocation effort.

Mr. BEAUPREZ. Good. I appreciate that. Let me explore one other avenue with you. I was taken last night in the President's comments by his concern for drug addicts and their needs and certainly for some of the most needy in our society. The question comes up about homelessness, and especially the 250,000 to 300,000 veterans that sadly are homeless every night. What is the VA doing? Are we being proactive enough or are we simply reactive or is it a problem that just won't go away and we are simply not addressing it actively enough at all?

Mr. ROSWELL. We have aggressive efforts to address the problem but it is not a simple answer. Solving homelessness is not simply a matter of providing housing. Homeless veterans are homeless because of an underlying problem, and to be able to break the cycle of homelessness it is absolutely essential that we take the time and effort to understand what the underlying problem is—often it is substance abuse—and make sure that the veteran gets the needed therapy and treatment to assure that that cycle is broken in addition to providing transitional housing and a resocialization, retraining, reeducation, reintegration model into society.

We have had a very effective homeless grant and per diem program that provides grants for nonprofit agencies to create transitional beds. But sadly sometimes they haven't had the rehabilitation services effectively integrated. We continue to expand that program, and I am pleased to say that this year we are adding $10 million in benefits for dental care for homeless vets to help with much needed dental care. We are adding an additional $5 million to a program to integrate homeless care through the Department of Health and Human Services and HUD along with VA to address that. We are adding $2.5 million to address the fire and safety issue, life safety issue in the existing homeless beds that we have. But I have asked our Homeless Advisory Committee, not once but on two separate occasions, to help me address how we break the cycle of homelessness to make sure that the rehabilitation services, the substance abuse treatment, the treatment for serious mental illness is available throughout the transitional housing process because that is where we continue to have recidivism and the homeless veteran winds up back on the streets.

Mr. BEAUPREZ. I would hope that in my time on this committee that I could see progress made in breaking that cycle. I have very close personal experience with that tragedy, and it impacts not only certainly the veteran but the veteran's family, and it is a tragic cycle.

Doctor, thank you very much. Mr. Chairman.

The CHAIRMAN. Mr. Beauprez, would you yield on that, on the question of homeless veterans?

Mr. BEAUPREZ. Yes.

The CHAIRMAN. Perhaps you could elaborate further, Dr. Roswell, because, as you know, the homeless assistance legislation that we enacted and the President signed, authorized over a 5-year period approximately a billion dollars. It was a bipartisan effort and it had the dental benefit in it. Maybe you might want to elaborate on

that $10 million. Is that a proposal in the budget that will come to us in a week or so or is that something you are doing with existing funds?

Mr. ROSWELL. No. We have authorized dental care, which we anticipate will probably—when fully annualized will probably—our best estimates are 12- to $14 million a year, but we anticipate because that has now been fully implemented that the dental health care benefit for homeless veterans will probably reach about $10 million this fiscal year. So that, coupled with the 2.5 million for fire and life safety issues, coupled with the 5 million we have recently made available to the HUD-HHS joint project, really is beginning to seriously address the kind of commitment that is needed.

The CHAIRMAN. That is encouraging. Last month I met with the Secretary and I asked him if he would help us secure $36 million for additional homeless programs, and I wonder what might be the status of that. And secondly, it is my understanding of the 270 grant applicants only 52 or approximately 50, maybe 52 is the right number, so one in five, and I am sure more than one in five were deemed credible and ought to be funded if the money were available. What is the status on that? And I thank my friend for yielding his time.

Mr. ROSWELL. Well, in fact, many of the grant applications are not ready to be funded because of the nature of the nonprofit organizations, which are often well-intentioned and very dedicated and compassionate community leaders; they don't have the experience in grant development and we really need to provide help. Many of the grants simply don't meet the standards that would allow us to provide the money and assure the safety and ongoing welfare of the veterans who might be housed there. To that end we have made available another $750,000 this fiscal year to specifically offer technical assistance to those individuals who seek to apply for a homeless grant program. So we are really addressing this in a comprehensive way to build over a multi-year period a much more comprehensive homeless program.

The CHAIRMAN. Again, if the gentleman would continue to yield. If you could get back to us on the $36 million, because we had that itemized as to how we would have hoped that money would be spent. And you might recall, and I am glad the 750,000 is being used, that is how we had it in the bill because there is a technical assistance that is required or helpful for these NGOs to get the job done. But on the issue of the domiciliaries, which is another homeless issue that we found—and as a matter of fact it was the VA itself that gave us the input from the existing doms that they were working so well. But we need more of them. And I have been to doms. I have seen how well they work, how they train up our formerly homeless veterans as they matriculated back into society by teaching life skills and really getting those good habits deeply impressed into them. We had authorized 10 more. What is your thought on that?

Mr. ROSWELL. We are looking at that through the CARES process. Let me point out if I may, Mr. Chairman, the distinction between the VA dom and the transitional beds provided through the homeless grant. That is exactly what I am talking about. When we have a homeless program situated in a domiciliary collocated with

a VA medical center we have that access to substance abuse treatment, to counseling, and we are able to provide the intensive services that really provide the needed therapy for many of the underlying problems that have triggered homelessness. And that is an excellent model. The problem is that sometimes our doms aren't located where homelessness is a problem. I recently visited one of our medical centers that had a large domiciliary. And yet it was in a very wealthy neighborhood, and as I was talking to one the clinicians, I said, you know, you would have to drive up and down the street for the better part of a month to find one homeless veteran in this neighborhood. So we have to sometimes look at the mismatch between where the doms are, where the need for transitional housing is because homeless veterans have certain biases. They tend to be regional. And we have to look at the geographical location of where the doms could be and should be to address homelessness. But we are doing that, I am pleased to tell you, through our CARES process.

The CHAIRMAN. Just for the record, it has been my experience that proximity to where one was homeless is not a determinative factor for many, even a place like Vets Haven, which Mr. Ryan and I visited. We found not to our surprise that most of the veterans who were there who are homeless and now getting the needed care were from North Jersey and this is in South Jersey. So it is a matter of putting them into a bus. They are living in the facility.

Mr. ROSWELL. Relocation sometimes can be effective, I would agree.

The CHAIRMAN. Okay. Ms. Brown-Waite. And thank you, Mr. Beauprez.

OPENING STATEMENT OF HON. GINNY BROWN-WAITE

Ms. BROWN-WAITE. Thank you very much. Dr. Roswell, I come from an area where we have waiting lists of up to 18 months for the initial appointment. And I think one of the saddest constituent cases I had was a woman whose husband was at the 16-month period of waiting, had another 2 months, and she realized he was so sick he couldn't wait that extra 2 months. He had cancer. Had he had an appointment sooner, he would be here today, but he is not. While you talked about reducing the waiting period, I am afraid it is not geographically spaced and that it is not geographically relevant to where people are moving to. They are obviously moving to the Sun Belt. They are moving to Arizona. They certainly followed me to Florida, and I have a large number of veterans in my area. I would like to know, A, what you are doing about having geographic representation of whittling down those waiting lists.

And number two, on the specialty care, if you are looking for specialists, I hear complaints that at the VA clinics that there are no dermatologists in the Sunshine state, that the wait for an audiologist is well—once you get in then you have to wait another 2 years to see an audiologist. And if you are looking to recruit specialists, let me share with you that I am hearing from doctors, because of the high cost of medical liability insurance, that they are very anxious to join the VA system because they would get sovereign immunity. So this may be the time to encourage the specialists to come

to the VA and have a retention program. I would like to know what you are doing there also.

Mr. ROSWELL. Thank you for both of those questions, and certainly your district is an area that I am familiar with from my previous experience. Let me begin with the misallocation of funds, if you will. We recognize that waiting lists are distributed inequitably or variably around the country. That is exactly why we use a resource allocation model to distribute Medicare dollars to those regions of the country that have greater workload. We have asked each of the VISN directors to develop a certification plan based on the expected 2003 budget. The director of VISN–8, the area you are from, has done a remarkable job within finite resources of addressing the waiting lists throughout Florida, but he clearly needs the additional resources that will be brought with the 2003 appropriation at the full House and Senate mark to allow him to build the capacity that will eliminate those waiting lists this year. The VERA model, that is the Veterans Equitable Resource Allocation model, that distributes those funds with the full House-Senate appropriation mark would distribute a minimum of 5 percent additional dollars and a maximum of 12 percent additional dollars to various portions of the country. VISN–8, your region, would receive the full 12 percent increase in allocation, which is about at much as can be effectively used on an incremental basis in a single year, and that would really allow Network 8 to address the waiting list in a way that we believe would come very close if not completely eliminating those lists by the end of this fiscal year.

With regard to the specialists, I still haven't been able to find dermatologists in Florida who would come to work for VA salaries. In some specialities you are absolutely right. Certainly VA offers a remarkable practice setting for many physicians in an increasingly litigious society. We recognize that. But we also recognize with some of the scarcer specialities, such as a dermatologist, in Florida VA's pay schedules, pay latitude is still insufficient to attract them. That is exactly why we need the committee's support with the physician and nurse pay legislation package that will be forwarded later this year.

Ms. BROWN-WAITE. Just for a follow-up question, what assurances do we have that we won't be hearing the same thing next year, that I won't be going home at the end of this year and hearing the same, and I mean this, the same stories that rip your heart out because we need to act and we need to act now. The woman that I told you about, she not only lost her husband, but she then had extensive bills because she ended up taking him to a non-VA facility. I don't want that to ever happen again. And she called me and she said, I am just letting you know, this at the time I was a Senator. She said, senator, I am just letting you know so that you realize, please don't let this happen to anyone else. I will never forget that call that she made to me. I don't want this year to be over and not have that take place. So what do we need to do? And that may be a very naive question for a freshman but I need your help in answering that, please.

Mr. ROSWELL. It is a very appropriate question and it is one that I feel just as strongly as you do. First, let me assure you that our policies are that any veteran on any waiting list who has an urgent

need for care will receive that care and no veteran to my knowledge has been turned away who had an urgent need for care. The waiting list is intended to be used solely for those people who are seeking elective primary care and access specialty care. The audiologist you spoke of, in fact, that wait is often predicated by veterans who are seeking hearing aids because they have had hearing loss associated with increasing age, like happens to all of us. But you are absolutely right, we have got to make sure that that doesn't happen again. That is why we need to take a suspension in enrollment of priority 8 veterans and use the additional dollars in the 2003 appropriation with the special pay authority that is very much needed to be able to recruit additional primary care physicians and specialty physicians, build the nursing and support staff that will absolutely guarantee we don't have waiting lists a year from now.

Ms. BROWNE-WAITE. Thank you.

The CHAIRMAN. Thank you very much. Appreciate it, and I just had a couple of additional questions before we go to our second panel, if you could, Doctor. The four major organizations from the Independent Budget, the AMVETS, PVA, DAV and VFW, signed a letter dated today, January 29, to Speaker Hastert strongly asking him for the $23.9 million that was approved initially by the Veterans' Subcommittee of the Appropriations Committee. And as they point out, H.J. Res. 2, the Senate bill, has been subjected to a $700 million across-the-board cut, which would be devastating. Again if my math is right, if we use the demand model even the 23.9 is $1.9 million less than what really is needed. So they are asking modestly for this 23.9 and it is unclear whether or not that will even be forthcoming.

Is the Administration running the full court press to try to ensure that this amount of money minimally is available for fiscal year 2003, 23.9?

Mr. ROSWELL. Certainly we are deeply committed to that funding level. As I have tried to express today, the almost 700 million cut that would be imposed by the Senate bill would have serious impacts, and Congressman Brown-Waite, it would not allow us to address the waiting list and there would be waiting lists a year from now if, in fact, we receive no more than what the Senate bill provided in this fiscal year.

The CHAIRMAN. Again, the more high level it is in terms of what catastrophe awaits if this is not corrected.

Earlier you had indicated to Chairman Simmons that philosophically you thought the mandatory funding bill had merit. I wonder if you could either orally and/or for the record, provide us—I mean you have to manage an incredibly large number of health care assets in the country. It has got to be a daunting challenge with an ever increasing demand that is being put on that health care delivery system. The mandatory gives you a capitation model. It gives you an ability to have some predictability rather, I mean, and I assume total goodwill on the part of the appropriators and others. They are always between a rock and a hard place of not having enough money. If you don't know how much you have from one given year to the next, how do you plan? I wonder if you could provide us—and I would hope and I say this sincerely that it not go

through every clearance—I need to know from you as a manager, as a leader, as an Under Secretary of Health, why this would be needed philosophically. If you can't get into the actual numbers without a thousand and one clearances, that is fine. But we need to know. I mean all that matters is how do we, in the most transparent way possible, as lawmakers, who take our oath of office very seriously, get this money to where it should be gotten to, to meet our obligations and our duty to our veterans? I know you share that.

If you could provide an answer to this question, I would be deeply appreciative. I think when the President's Task Force is making its recommendations we need a grand debate on a sustainable funding formula that is not subjected to the crowding out and the competition within the VA appropriations that ordinarily goes on.

You know, Jim Walsh is very dedicated to veterans' health care expenditures. He is between a rock and hard place as he looks at his allocation that says how do I do it. He wants to, but how does he do it? I don't envy him and the difficult choices he has to make (which he makes with the best of intentions). We need to think outside the box perhaps. But we need that input from you, because you are a very able leader and your wisdom would be deeply appreciated by this committee. So if you could do that perhaps orally now or if you wanted to provide that for the record so it is as detailed as possible, we would appreciate it.

Dr. ROSWELL. Certainly I would like to get back with you on that, but, Mr. Chairman, we appreciate your leadership and your advocacy for full funding. As in the past, I pledge to you that we will do everything we can to work with you in seeking sufficient resources to assure the quality of care for veterans and will certainly be pleased to work with the committee staff.

I think one of the difficulties we face is the unpredictability of health care. We don't know where veterans will seek care because it is related to economic conditions, it is related to situations that may be regional in nature; and even though we used the very best actuaries we can obtain to help us predict a full demand model, we don't always hit that with the exact precision we like. And then you impose other factors, not only the economic conditions but, for example, the mobilization of health care personnel through a military deployment. There are so many unpredictable factors that impact upon this that our ability to accurately project funding needs and get that through the OMB and appropriation process with sufficient lead time to accurately address needs is difficult at best.

I think that some of the merits of a model that you have spoken of would do a tremendous—would make tremendous strides to help address that. We will be delighted to work with you.

The CHAIRMAN. I appreciate that.

Mr. FILNER. May I have additional questions?

The CHAIRMAN. As soon as I am done.

And if I could, last May, in response to questions that I posed to the Secretary, he pointed out that if additional funds are added to VA's medical care appropriation I can assure you that the funds needed to restore the VA's nursing home capacity to the '98 levels will be used for that.

And, again, this is another issue, the 1,500 beds that have evaporated over the last 5 years or so, perhaps could you get back to us, if you would, with your recommendations or plan maybe within a month or so? Because, obviously, we are losing core capacity at a time when we have an aging World War II and Korean veterans' population in need of those beds.

Dr. ROSWELL. I would be pleased to get back with you, but if we have time now I would like to share with you that since 1998 our total long-term capacity has actually increased by almost 10,000 beds, or 10,000 average daily census. Most of that or virtually all of that expansion has been in the noninstitutional care. But using now interactive technology we believe that we can continue to make significant strides to address that full demand for long-term care in the World War II and Korean-era population.

We will clearly always need institutional beds, but today, despite the fact that we aren't meeting the ADC requirements associated with the mil bill, we have staffed, but empty, VA nursing home beds in certain locations around the country because the demand for an institutional level of care is not there at the VA location. So we would like to work with the committee to explore a variety of ways to expand both institutional and noninstitutional care for long-term care needs of the veteran population.

The CHAIRMAN. I appreciate that.

Let me ask you another question with regards to the emergency preparedness centers. As you know, that legislation was signed by the President. It establishes those centers of excellence and also would establish an office which takes a minimal amount of funds to get up and running. You do have plans for that, I hope?

Dr. ROSWELL. Yes, sir, Mr. Chairman. I am glad you brought that up.

The provisions of Public Law 107–287 that addressed centers for emergency preparedness is something that we have paid a great deal of attention to. In our Office of Environmental and Occupational Health we have already put together a concerted plan to begin to identify an oversight committee, a steering committee that will be meeting in the very near future to develop criteria for which we would issue a request for proposals, asking people to submit proposals.

We anticipate with the needed funding, which as you know is a statutory requirement to move forward on that, we would then issue that RFP and begin a review process, identifying no later than June or July of this year the location of the center selected and would expect to provide funding and initiative activation of the centers by the end of the fiscal year.

The CHAIRMAN. Thank you for that. Thank you for moving ahead so aggressively on that. Mr. Filner.

Mr. FILNER. Just briefly, Doctor, what is the status of the congressional mandate for the VA to provide chiropractic care for our veterans?

Dr. ROSWELL. We have——

Mr. FILNER. Ms. Brown-Waite, you said, am I going to have to wait until the next year? We mandated—I don't know how many years ago—chiropractic care, and it has been I don't know how many years since we passed legislation. This stuff takes forever. I

hope you are not disappointed at the end of this year, but you have to sometimes keep on them.

Again, we passed legislation—I think two pieces of legislation to mandate this, and it just hasn't happened.

Dr. ROSWELL. Well, the Chiropractic Advisory Committee has been appointed. We are eagerly anticipating their recommendations.

Mr. FILNER. That is another way to slow down the process, but go ahead.

I mean, we see things differently. All you have to do is hire chiropractors, but you didn't do it, so now you have to set up a chiropractor advisory committee. I mean, this is not rocket science here; and yet we can't seem to do it.

Dr. ROSWELL. We have policy that allows hiring of chiropractic and the use of chiropractic on a consultative basis in our medical centers.

Mr. FILNER. As I understood it, we mandated the availability of that for all our veterans; and it is still not available for the vast majority of veterans. Is it mainly because your doctors don't like chiropractors, or somebody in your upper administration? I just can't understand why you can't say, just do it.

Dr. ROSWELL. We have issued that guidance. I think it is more— my sense is it is more an issue of local implementation whether a directive is looked at and chiropractic care is available but it is not readily utilized. That is why we needed advisory committee to sort through what the barriers are to full utilization of chiropractic care where it has clinical applications and would benefit the veteran population. But I certainly will look into that and be happy to report back to you with more detailed information.

Mr. FILNER. Yes, I know you will.

Again, when we put people on the committee who are committed not to have chiropractic care, it is unlikely that we are going to get a lot of rapid progress out of that committee as we have tried to tell the Secretary. There were lots of experts in this field available to serve. You chose not to pick them but to pick people who had doubts about chiropractic. So now, Congresswoman Brown-Waite, it will be I don't know how many years before we see that one.

The CHAIRMAN. Would the gentleman yield?

Our legislation, as you know, Doctor, mandated one program per visit. We did not have a time certain for when it actually had to be established, and perhaps that was an oversight. But we expect good faith that this is something that Congress in a bipartisan way hopes would happen.

Without any further questions from our panelists and Members, Doctor, thank you so much for your coming and I look forward to working with you and going forward. I appreciate all of your good work on behalf of our veterans.

I would like to ask our second panel if they would come to the witness table: Dennis Cullinan, who is the Director of the National Legislative Service for the Veterans of Foreign Wars, the VFW. Mr. Peter Gaytan, who is the Principal Deputy Director of the American Legion; and he works with the Veterans' Affairs and Rehab Commission. And Mr. Joseph Violante, who is the National Legislative Director for the Disabled American Veterans.

STATEMENTS OF DENNIS CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS; PETER S. GAYTAN, PRINCIPAL DEPUTY DIRECTOR, VETERANS' AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; AND JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

The CHAIRMAN. Dennis, if you could begin.

STATEMENT OF DENNIS CULLINAN

Mr. CULLINAN. Thank you, Mr. Chairman.

Members of the committee, on behalf of the 2.7 million members of the Veterans of Foreign Wars of the United States and our Ladies Auxiliary, I thank you for conducting and including us in a hearing of vital importance to America's veterans today.

Mr. FILNER. Could you just yield for a second?

I want the record to show, in follow-up to my statement, that you should have been on an hour and a half ago, that there are four members of the committee here, there are only one-third of the press here. Dr. Roswell is a trooper. But, again, the kind of environment in which the VSOs get the maximum attention is just practically not here. If we had had a vote in between, nobody would be here. I know the chairman agrees with me, at least in part, that we can rotate this around——

The CHAIRMAN. And I have done it before. Mr. Cullinan.

Mr. CULLINAN. The Department of Veterans' Affairs medical system is now in crisis. Amid the climate of rising health insurance premiums and costly prescription drugs, open enrollment under the Health Care Eligibility Reform Act and a shift from primarily inpatient care to outpatient care has flooded the health administration's facilities with millions of new users. The growth produced by these reforms quickly outpaced existing facilities and clinics capacity to provide access to quality, timely health care for veterans.

Mr. Chairman, last night President Bush, in addressing the state of health care for our seniors in this Nation, stated, Medicare is the binding commitment of a caring society. It is the conviction of the men and women of the Veterans of Foreign Wars that VA health system represents the spirit and substance of this Nation's sacred obligation to care for her defenders in this time of need, and it is clear to us that this most hallowed trust is not being met.

Successive years of improper budgeting and inadequate appropriations, coupled with the impact of soaring demand, have forced VHA to ration care, turning a once national treasure into a national tragedy. The most obvious manifestation of health care rationing has been the lengthening of appointment waiting times.

Mr. Chairman, I would ask, how long do any of us have to wait for us to see our doctors? I know that in my case 24 hours is more than enough time. But what about those veterans who rely on the VA health care system? According to a recent VHA survey, there is currently a backlog of over 200,000 veterans waiting 6 months or more for nonemergency clinic visits. It takes over 12 years in parts of the country to even access the system. Of course, it is impossible to truly know how many veterans are being denied care because VA's data bases are so severely deficient. We do know that

Americans veterans must wait way too long for medical care departmentwide. The situation is deplorable.

Most recently, the Secretary of Veterans' Affairs was compelled to suspend enrollment of Category 8 veterans in order to focus inadequate resources on, quote, those with service-connected disabilities, the indigent and those with special health care needs. It is our belief that no veteran should ever be left behind. The enrollment announcement would not have been necessary had past budgets been truly adequate, not just historic. As one VFW member stated, we need a White House budget that adequately reflects the demand for veterans' health care, congressional budgets that mirror the administration's adequate budget request, and final appropriations that meet or exceed these amounts, and we need these funding levels now.

In the end, Mr. Chairman, I believe the blame lies with all of us. Somehow we should have done more toward ensuring that VA has all the resources necessary to fully and compassionately provide veterans with the care and services they need and have earned. And it is toward this end that the VFW has joined forces with the American Legion and Disabled American Veterans, along with numerous other veterans and military organizations, to secure passage of legislation that would guarantee mandatory funding for all enrolled users of the VA health care system.

We thank you, Mr. Chairman, and the ranking member for introducing legislation that would have accomplished this goal last Congress; and we are hopeful that such legislation will be reintroduced this Congress, where it will once again enjoy our full support.

The health care needs of millions of veterans depend upon the Nation's courage to adopt and stick to policies that will produce the optimal results over the long run. Unequivocally, the Veterans of Foreign Wars is committed to the proposition that no veteran should be denied VA medical treatment due to budgetary shortfalls or, worse yet, a lack of commitment or caring.

Mr. Chairman, once again, on behalf of our entire membership, I thank you. That concludes my oral remarks.

The CHAIRMAN. Thank you very much for your testimony and for the good work you do.

[The prepared statement of Mr. Cullinan appears on p. 65.]

The CHAIRMAN. Mr. Gaytan.

STATEMENT OF PETER S. GAYTAN

Mr. GAYTAN. Thank you, Mr. Chairman. I appreciate the opportunity to present the American Legion's views on the VA health care system's capacity to meet the growing demand for health care.

Mr. Chairman, with more than 200,000 veterans currently waiting in line to receive health care through the Department of Veterans' Affairs, the importance of this committee to offer real solutions to this problem is overwhelming. Although VA has made progress in reducing the incredible backlog of veterans awaiting care, much more must be done.

As you mentioned earlier, and we appreciate your recognition of our efforts, the American Legion has initiated a national campaign to collect stories from actual veterans who are being forced to wait as long as a year to receive health care through the VA. Dubbed

the “I am not a number campaign,” as you mentioned earlier, this national program provides surveys to all 15,000 American Legion posts to collect firsthand accounts of these veterans who make up this incredible backlog of patients seeking care from the VA.

The information we are receiving in the returns of the surveys reflect what Congresswoman Brown-Waite mentioned earlier, that she may have a constituent who has waited 18 months to receive care. We are hearing this over and over again in these surveys that we are receiving back. We are hearing that they are waiting up to 18 months, which is unconscionable; that they are receiving phone calls from the VA about rescheduling two, three, maybe four times before they receive their first appointment; and in some cases some veterans who have to travel to meet their—to their VA medical centers when they arrive they are learning that their appointments were rescheduled or even canceled and they are not learning that until they arrive at the VA facility. Of the survey responses that we received, this is a growing trend that we are receiving back.

And even of more interest than the information that we are receiving, National Commander Conley—if you remember during the joint session last year in September when Commander Conley took over, he committed to you and to your colleagues to visit VA medical facilities nationwide during his term as National Commander. Over the last 4 months, Commander Conley has visited over 25 facilities in 17 different States. In his visits to VA medical centers he is hearing directly from the VA facility directors that their waiting times are excessive, that many facilities are struggling to meet the demand for health care due to staff shortages, and budgets are being realigned to acquire much-needed nursing and medical staff.

The American Legion is extremely concerned that veterans are suffering because funding for VA health care is inadequate for VA to meet current demand for care. The American Legion hopes that this committee will consider several different possibilities that will serve to improve VA’s ability to provide quality health care in a timely manner. Designating VA health care as a mandatory spending item will guarantee yearly appropriations for the earned health care entitlement of enrolled veterans, especially those severely disabled service connected veterans.

The American Legion fully supported H.R. 5250, the Veterans Health Care Funding Guarantee Act, introduced in the 107th Congress; and we look forward to working with this committee to develop legislation that will change funding for VA health care from discretionary to mandatory.

Medicare reimbursement for VA will also serve to improve VA’s capacity to meet current demand. The American Legion urges Congress to authorize VA to bill, collect and retain third-party reimbursements from CMS for treatment of Medicare allowable, non-service-connected medical conditions of Medicare-eligible veterans.

Since Medicare is a federally mandated prepaid health insurance program, the American Legion believes Medicare-eligible veterans should be allowed to choose their health care provider. If VA is an enrolled Medicare-eligible veteran’s health care provider of choice, then VA should be reimbursed for that care.

The American Legion also recommends that VA explore the possibility of offering premium-based health care plans to eligible vet-

erans. Offering premium-based health care plans would create a new revenue stream for VA and allow veterans the opportunity to access the full continuum of care offered by VA.

The American Legion realizes the struggles being faced by the Secretary, and we applaud his efforts to reduce the backlog of veterans waiting for health care. We do not, however, agree that rationing care is the answer. Squeezing the system to meet the budget is not the solution. Providing a budget adequate enough to allow VA to meet the demand is.

Mr. Chairman, again thank you for this opportunity; and that concludes my testimony.

The CHAIRMAN. Thank you very much, Mr. Gaytan, for your testimony and your fine work.

[The prepared statement of Mr. Gaytan appears on p. 69.]

The CHAIRMAN. Mr. Violante.

STATEMENT OF JOSEPH A. VIOLANTE

Mr. VIOLANTE. Thank you, Mr. Chairman and members of the committee. I appreciate this opportunity to discuss the Department of Veterans' Affairs health care system today.

The timely access to VA health care is a matter of paramount importance to the 1.2 million members of the Disabled American Veterans. The effectiveness of a VA health care system is dependent upon sufficient funding and resources for the timely delivery of medical benefits.

Ten years ago, the DAV, along with nine other organizations, formed a partnership for veterans' health care reform. At that time we petitioned Congress to reinvent the VA health care system because it was not serving veterans properly, it was not cost effective, and we got part of what we had asked for, a reform of the system. However, at that time we also said that if you do reform this system, guaranteed funding was a requirement. Ten years later, we are still asking for the same thing.

I was very encouraged by what I have heard here today, particularly from Dr. Roswell. Although he did not come out and formally endorse guaranteed funding that was introduced last year, much of what he said certainly should give this committee and the veterans' community some hope that you are on the right track. I believe the formula that was set out in that bill would address many of Dr. Roswell's concerns with regards to the increases that he believes are needed annually. Also, it would address the uncertainty that VA faces year in and year out with regards to what is going to come out of OMB in regards to their funding level. Your legislation would guarantee VA would have assurances by midsummer as to what their budget is going to be on October 1 and what they will receive.

Mr. Chairman, I would like to thank you and the ranking member, Mr. Evans, for taking that bold step to introduce that legislation last year. I would like to thank all the members of this committee who signed on to that legislation, and I would hope that this year we can see that bill reintroduced and all the members of this committee as well as bipartisan support from the rest of the Congress to be behind that legislation because I believe without it we are not going to be able to solve the problems of VA and veterans.

There is decisive action that is needed now. Now is the time to tackle this problem. I believe in your opening remarks you commented that it is up to this Congress, the 108th, to take those steps; and I am very encouraged by that.

The alternative to this situation is to see exactly what the Secretary has done and that is to cut off enrollment and possibly even disenroll veterans in the future. That is an unacceptable solution. I don't blame the Secretary for what has happened. I believe his hands are tied. But, again, I would encourage this committee to move forward with the guaranteed funding bill.

In closing, just let me say again thank you for your strong advocacy on behalf of veterans. We appreciate the bipartisan spirit that has been rekindled in this committee over the last couple of years.

That concludes my testimony, and I would be happy to answer any questions.

The CHAIRMAN. Thank you very much for your testimony.

[The prepared statement of Mr. Violante appears on p. 77.]

The CHAIRMAN. As you know, based on your previous testimonies and that of the DAV, with the full support of the other VSOs, that was the genesis of the bill in the first place. I looked at it as primarily a management reform. If you are going down a hospital system, if you want that hospital system or health care delivery system to be world class, you need sufficient funds. When it is discretionary and however well-meaning and good-willed—and we always assume that on the part of both sides of the aisle and presidents, including Clinton, who underfunded for whatever reason, you assume goodwill. But they are faced with budget priorities and shifting amounts that are available, and it seems to me this is first priority.

That is why the mandatory scheme, while it has some kind of shock effect on some people, mandatory, as in—you know, we are talking about an entitlement that is already there for service-connected and indigent veterans especially. It is there. Why not fund it in a way that is rational, with predictability, so that Dr. Roswell and any other undersecretary of health can manage a system so that there is no loss of quality of care. Because that has to be an issue here as well. When you don't know what is coming, how do you plan so that the best utilization of those dollars can be realized?

I do have one question. You know, the estimates from the Office of Management and Budget and from CBO were wildly different. The gulf was very, very extreme. If my memory is right, the number of enrollees anticipated over the next decade from OMB was about 15 million; for CBO was in the order of magnitude of about 10 million. Big difference. It seems to me that some people are looking at it from a worst-case scenario, if you want to call it that. I am loathe to do that.

In terms of utilization I think it is good if people are utilizing it. That is why it is there. If they are not using VA, people are going to get sick and be in need of care, they are going to utilize something. So health care dollars will be expended, and if they are elderly it will be most likely Medicare. If they are poor, most likely Medicaid. So Uncle Sam will be paying one way or the other in most instances.

What is your sense in terms of enrollees? I ask you to factor into that if we do indeed this Congress, the 108th, pass a prescription drug benefit. Whether it be the $350 billion anticipated by the Republicans or the 800 to a trillion anticipated by the Democrats, I think this year something will pass. So the magnet for the 8s and 7s disappears to some extent in terms of enrollees wanting to use the system.

We do get back down to core mission. What about this wild gulf and what is your sense, are they getting it right? Mr. Cullinan.

Mr. CULLINAN. Thank you, Mr. Chairman.

The $15 million figure struck us as being phenomenally high. For one thing, a significant portion of the veteran population already has insurance. You know they would, of course, use Medicare. $15 million, that is something like three-fifths of the entire veteran population. There are a lot of veterans that won't use VA because at this point in time they can't bring their dependents in. So $15 million on the face of it is absolutely absurd. $10 million struck us as being somewhat high. $15 million is out the question.

As you just pointed out, there are other changes in reforms in the air that affect the entire population that also mitigate against that particular figure. It is inconceivable to us that that many veterans would turn to VA.

Mr. GAYTAN. Although those numbers may be considered high, it is a reality that we need to consider and realize that the number is increasing.

A conversation I had with a veteran over the weekend, he served 34 years in the Navy, retired as a three-star. We were discussing health care. In his retirement position he doesn't consider VA as an option. I was discussing with him some of the problems we are dealing with right now with VA health care, and his statement as a veteran who served 34 years in the military was that he understands that veterans are dying at a rate that we don't need to consider their health care needs.

I had to explain that, although the veteran population of the United States may be decreasing, the number of enrollees is increasing. That section of veterans that was discussed earlier, the Vietnam veterans, they are the next generation that will be seeking health care at the VA. That number is going to increase, and we need to be ready for that. No matter what the projections are from any agency, we need to be ready for those individuals who knock on the VA's door and say we need to be taken care of.

Mr. VIOLANTE. I don't think there is any real way to make a projection. However, I believe the ones that have been made are extremely high. As you know, we haven't made any changes to the VA's mission or how they provide that service. The only thing that is changing is the funding source and, hopefully, and I have to believe it would, improve the timeliness standards. That may cause more veterans to seek care from the VA, but I don't think we will see anywhere near the projections that have been made.

The CHAIRMAN. Appreciate that. Chairman Simmons.

Mr. SIMMONS. Thank you, Mr. Chairman.

To the two members of the panel who are Vietnam veterans, welcome home.

Now let's get some health care. In the memo that was issued by the Chairman at the beginning of today's meeting and hearing, he said at the bottom that the Subcommittee on Health plans to continue reviewing the status of the VA health care system with a series of hearings early in Congress focusing on access, pharmaceutical policy, human resource needs, and so on and so forth. I look forward to working with the Ranking Member to explore some of these issues in further detail, more detail than we can perhaps get into today because of timing issues.

There are a couple of things that intrigue me about your testimony. First of all, Mr. Gaytan talks in some detail about Medicare reimbursement and the issue that, for many of our veterans who are Medicare eligible, they go to the VA for service. We know about the waiting lines, we know about the difficulties in getting through the bureaucracy, but then at the end of the day VA itself picks up the tab. There is no Medicare reimbursement.

I have had discussions with my colleague, the Dean of the delegation in Connecticut, Nancy Johnson, who also happens to be the Chair of the Health Subcommittee of Ways and Means; and she has done some research on this and related issues.

I guess my question to you gentlemen is as follows, and all three can answer if you wish: In the past when I discussed with veterans such issues as the provision of health care and if the VA system may be cooperating with other elements of the health care community, whether it be military or civilian, and the issue of reimbursement under Medicare, Medicaid and other provisions, there was a tendency for them to say, "well, we want to keep it all in VA." We don't want to reach out. We don't want to be involved with other systems.

What kind of feedback are you getting from that? Is that an accurate statement? Or, in fact, do veterans today look forward to looking for other methods to fund VA for reimbursement and work with VA and other health care providers to get the job done?

Mr. GAYTAN. Well, sir, I can say that the American Legion does have an organizational resolution that supports Medicare reimbursement through the VA; and all of our resolutions are voted on by our members. So, yes, the feedback we are receiving from veterans who are seeking health care through the VA is that they want VA to allow them to bring their Medicare benefits to the VA.

Mr. SIMMONS. Thank you. The other organizations?

Mr. CULLINAN. Mr. Simmons, the VFW has a resolution calling for Medicare reimbursement. Clearly, our membership supports bringing their Medicare dollars with them, particularly among military retirees. They rather insist on being able to bring their Medicare dollars with them into the VA system. We want to facilitate that end as well.

Mr. VIOLANTE. The DAV's position, under the present scheme of things, would support Medicare reimbursement to supplement the VA's appropriations. Under a guaranteed funding stream, I am not sure if it is necessary to have to shift monies from one pot to another, but if Congress was to determine that the lower priority veterans in coming to the system would benefit the system by bringing their Medicare dollars—we certainly would support that, although

we don't believe with guaranteed funding it would be absolutely necessary.

Mr. GAYTAN. I want to add, with any Medicare program, be it the VA + Choice that is being developed by VA or full Medicare reimbursements being the key to any successful joint venture between Medicare and VA, would be to make sure that the reimbursement rates are adequate to cover the cost of care to the VA.

Mr. SIMMONS. I certainly agree with that last statement. You know, there was a time when one government entity, if you will, did not seek reimbursement from another government entity because it all seemed to be government.

I remember years ago when I was a staff person in the Congress we had franking privileges, and you know there were all sorts of activities that were not funded. Let's say, in the case of franking, your mailing privilege put you into the U.S. Postal Service and they essentially gave you free mail.

In recent years, and I think appropriately so, different organizations need to account for their costs. That is why one government entity will actually charge another government entity, so there is an accounting system and we can keep control of costs. I certainly support that. I would be interested to work on that issue in this session of the Congress.

The CHAIRMAN. Mr. Filner.

Mr. FILNER. Thank you, Mr. Chairman.

Mr. Simmons, that issue has been around for a long time, the decade that I have been here. And I know it was introduced because San Diego—some San Diego veterans wrote a Medicare subvention bill in 1990, 1988, and these guys are too polite to say what is happening. You need to go visit your chairman of your Ways and Means Committee—he has blocked it up until now. So there has been a lot of support, but Mr. Thomas hasn't liked it.

Mr. SIMMONS. Is he from California?

Mr. FILNER. Yes.

Mr. SIMMONS. So you must get along very well with him.

Mr. FILNER. Yes, sir.

Mr. SIMMONS. I have got the Subcommittee Chairmanship from Connecticut, so maybe you can cut a deal.

Mr. FILNER. Don't use my name when you talk to him.

Which brings me—actually, it was a good segue in terms of your politeness—look, we are in a crisis. You guys fight every day for your constituents who are the veterans who served our Nation. And you do a great job. I have always felt, I think I have told you over the last few years, you have power in terms of your membership that you have not unleashed. That is, they live in every district, they are voters in every district, and you have got to name names and take some prisoners here and let your constituents know what is going on in this House.

Generally, I think you use kid gloves. I don't know if you are afraid you are going to lose something, but, look, we can't lose much more at this point. Look, when people vote for an authorization and say how much they are for veterans and vote against an appropriations that would in fact implement it, tell your members that. And have them go visit, go sit in, if necessary, at the office of those Members. Come to Washington and camp out for a while

during the appropriations process until we do what the veterans need. I think you have power that you've got to unleash in terms of your grass-roots support. That is the only thing that Congresspeople understand, is that if their own constituents know what is happening and tell them that based on that knowledge they are either angry or they like it or whatever, for good or for bad.

I think too often you end up pulling your punches at the very end of the process. When the compromise is made, you think you have to support it because you hope you will be working with us in the future. I think you have to take us on a little bit more directly. Because we are in a crisis, and we are going to sacrifice veterans more if there is no noise from them.

You lobby every day, and you are doing a great job, but if there is no noise from our districts, they are going to cut, and they are going to cut, and they are going to cut. I don't see any other, frankly, tactic or strategy for you to take. You got millions of members. Let's use them.

You can respond or not as you want.

Mr. VIOLANTE. I will go ahead and respond to that, Mr. Filner.

I appreciate your comments, and when the situations do arise and there are certainly lines that can be seen, we have in the past tried to mobilize our members. One of the prime examples was back 5 or 6 years ago with the tobacco issue and the transportation by—we put those who voted for us and those who voted against us in our magazines. Unfortunately, what that translates into is if you look at the surveys that are out there, people may not like what Congress is doing in general but they seem to like what their Members are doing particularly; and I think that affects the veteran population also. So it is very difficult.

Mr. FILNER. But you have to tell them. When Members come home on Memorial Day and Veterans Day and say how wonderful everybody is but they just voted to cut everything out of here, we have to name those names. And when you give awards to folks in previous Congresses who help to block funding but because they are chair of the committee, not the present chair, because they are chair of the committee you want to be nice to them. You give them an award when they are the ones that stopped the funding. We have to, I think, be a little bit more direct.

Frankly, again, there is nothing more to lose. They are going to cut and lay off people and do all kinds of things that are going to hurt your members if we don't speak up from the grass roots.

I didn't mean to interrupt you all.

Mr. VIOLANTE. That is quite all right. I think I was finished.

We have mobilized our members on the issue of guaranteed funding. I think that that snowball is coming down the hill, and more and more of our members are bringing it up. They are going to be in here in less than 4 weeks for a midwinter conference. I am hoping we will have some legislation introduced before then. Because I know they are going to be meeting with their Members and discussing that issue.

Mr. GAYTAN. I also appreciate your comments. The American Legion understands the importance of a grass-roots effort. We have a legislative council that has been in effect for years. We have

legionaires in every State and every district that we can reach out to, that our legislative director here in DC. Reaches out to and communicates with them and lets them know what is going on here on the Hill and what their Members of Congress and Senators are doing. It has been very effective.

As Joe mentioned, we have made progress on the duty to assist issue in the past and the tobacco issue. We realize that our strongest weapon, if you will, on achieving anything on the Hill is our communication with the grass roots and their ability to get out and let it be known how they feel about the decisions that are being made by their Members of Congress.

So the American Legion as well is continuing to relay the information on what we are doing up here, what you are doing up here. And, again, we are having our Washington conference where thousands of legionaires will be here on the Hill in the beginning of March. Our secret weapon this year will be the Commander's report on the I am Not a Number campaign, the information we are receiving firsthand from veterans.

These people, they are not numbers that we kick around every day. These are people in line waiting. These are individuals who have worn the uniform that are entitled or do receive health care through the VA. We are making an example of that. We are reminding those veterans that we are here to help them.

Mr. FILNER. I was getting all these e-mails about concurrent receipt which said, you have to vote for this, pass this. Concurrent receipt was cut down in secret by a few people. We need to identify who did that, for example. People wrote us and they have no idea what happened in that situation. The House passed concurrent receipt, the Senate passed concurrent receipt, we didn't get concurrent receipt. What happened in that conference committee? How did it get to the floor like that?

I don't know who did it, frankly, but we should find that out and make sure the people who are writing about concurrent receipt know. All of a sudden, it is gone. There are no fingerprints anywhere.

Mr. SIMMONS (presiding). Have the gentlemen finished their responses? Mr. Bradley? Mr. Beauprez?

If I could just briefly comment, I am a life member of the VFW and also a life member of the American Legion. It has been my experience over the years that I have been involved with both organizations that they could do more to identify Members' voting records. The Legion actually has been pretty successful on the flag amendment of listing who supports and who does not. But there is nothing to prevent any of the veterans' service organizations from adding health care issues to the list of those issues where they identify Member votes.

I think we have a third panel that we are going to be dealing with today, and I would like to take this moment to thank the panelists for their testimony. I look forward to seeing them again before the subcommittee before too much longer, and we can perhaps explore some of these issues in greater detail. Thank you, gentlemen.

Mr. Richard Fuller, who is the Deputy Executive Director of the Paralyzed Veterans of America. He will be joined by Mr. Richard

Jones, who is the National Legislative Director of American Vets, or AMVETS. And they will both be joined by the most distinguished and honored Dr. Linda Spoonster Schwartz who is the Chair of the Health Care Committee, Vietnam Veterans of America, and also a resident of the great State of Connecticut.

Welcome to all three of you and thank you for being here.

Mr. FILNER. Let the record show that we still have Dr. Roswell pinned down here.

STATEMENTS OF RICHARD FULLER, DEPUTY EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA, ON BEHALF OF JOHN C. BOLLINGER, DEPUTY EXECUTIVE DIRECTOR; RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS; AND DR. LINDA SPOONSTER SCHWARTZ, CHAIR, HEALTH CARE COMMITTEE, VIETNAM VETERANS OF AMERICA

Mr. SIMMONS. How would you like to proceed?

STATEMENT OF RICHARD FULLER

Mr. FULLER. I am Richard Fuller, National Legislative Director for Paralyzed Veterans of America. I am sitting in today for our Deputy Executive Director, John Bollinger, who is under the weather.

Paralyzed Veterans of America appreciates this opportunity to present our views on VA's efforts to meet current health care demand. PVA is the only national veterans' service organization, chartered by the United States Congress and recognized by the Department of Veterans' Affairs, to represent and advocate on behalf of our members and all Americans with spinal cord injury or dysfunction. All of PVA's members, in each of the 50 States and Puerto Rico, are veterans with spinal court injury or dysfunction. Because of the unique nature of these disabilities and the highly specialized care provided through VA's network of spinal cord injury centers, up to 80 percent of PVA's members use VA for all or part of their care. This is a higher utilization rate than any other veterans' service organization can claim.

According to a recent study, VA spinal cord injury programs provide more acute rehabilitative and sustaining services with higher quality and at lower cost than any other comparable system in the world.

Mr. Chairman, I think that my colleagues have pretty well laid out the groundwork of the discussion of what this hearing is all about, the crisis that is facing VA health care and the serious and constant underfunding that the system has experienced for many, many years. But I would just like to raise a couple of points here which haven't been made, which are potentially Paralyzed Veterans of America specific, but I think also underscore the problems that we are facing.

PVA was saddened by the decision to curtail enrollment for new Category 8s. Still, that decision would have at first glance very little impact on most PVA members. Under current enrollment regulations, veterans who are classified as catastrophically disabled are eligible to enroll as Category 4, which is currently a protected classification. On a second look, however, PVA members have not

found a safe haven in the VA enrollment system seeking services. Those who gain entry into the system are just as much at risk of losing access to services as those who are seeking care for the first time. Budget strains are affecting every aspect of health care the VA now provides.

This committee and the Congress over the years have certainly recognized the threat to VA's expensive impatient specialized services programs such as those provided in VA spinal cord injury centers. Rising costs, increasing demand and the shifting of resources from inpatient to outpatient programs has seriously eroded the ability to fund beds and staff in these centers.

Mr. Chairman, I was interested and encouraged to hear Dr. Roswell's comments on this very fact. Since 1995, when the VA began the shift from inpatient to outpatient programs and opened up hundreds and hundreds of outpatient centers across the country, because of the finite amount of resources that shift reduced the ability of inpatient tertiary programs of which the specialized services of spinal cord injury are one.

We greatly appreciate the efforts of this committee in recognizing that situation and requiring VA to maintain the capacity of this core VA program by putting the capacity requirement in the statute. We have worked diligently with the Department to help shape a directive that has gone out to the field setting specific capacity levels for beds and staff, and we have monitored and report on capacity levels on a monthly basis.

Statutory capacity language notwithstanding, VA has never met the capacity requirements defined in its own directive. According to our most recent survey in December, the directive calls for a staff bed requirement of 824 acute and sustaining beds in the system. In December, 2002, VA only had 747 staffed acute and sustaining beds. As for staffing, the December report showed a deficit of 117 registered nurses in spinal cord injury centers below the capacity requirement.

The point we are trying to make here is that underfunding is not a new threat to the system. It has been around for years and years.

The Independent Budget which you all will be receiving in about 2 weeks, the annual budget policy analysis published by AMVETS, DAV, PVA and VFW, is now in its 17th year. The Administration and the Congress have never met the Independent Budget recommendations that are determined on need-based formulas and annual projections for the cost of health care services. The VA funding shortfall has been and still is a major cause of concern for all of these years.

In closing, I would just like to reiterate something that my colleague from the DAV, Joe Violante, mentioned; and this goes back to Mr. Filner's concern that the more things change the more things stay the same. But back in 1993 when the Administration and the Congress were debating the future of a national health care system, the 10 major veterans organizations, including PVA, joined together to form something called a Partnership for Veterans' Health Care Reform. Our object was to make certain that if national reforms were to take place the VA and veterans' health care would have to be part of that solution. Among a list of rec-

ommendations we made at that time was to guarantee VA health care funding on an annual basis.

Citing chronic underfunding, the partnership—and this particular brochure has probably now become a collector's item—said the following, quote: "Funding must be guaranteed for the provision of a comprehensive benefits package to all eligible veterans who choose VA. Rationing must stop. Congress must make VA health care accounts nondiscretionary, set at risk adjusted capitated rates that reimburse VA adequately for care provided. Unlike today's situation, currently eligible veterans must be guaranteed provision of promised services," unquote.

Mr. Chairman, those words were true 10 years ago; and they are even more so today.

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

Mr. SIMMONS. Thank you very much.

[The prepared statement of Paralyzed Veterans of America, with attachments, appears on p. 84.]

Mr. SIMMONS. I think we will go through each of the witnesses and save questions for the period after.

STATEMENT OF RICHARD JONES

Mr. JONES. Mr. Chairman, members of the committee, on behalf of AMVETS National Commander Bill Kilgore I am pleased to appear before you and the distinguished members of the committee to examine the VA's health care system's capacity to meet current demand for health care.

The VA health care system is a unique and irreplaceable national treasure. It is critical to the Nation and its veterans. Many veterans consider health care to be one of the most important benefits they receive for their military service. Frankly, the VA health care system's capacity to meet demand is in critical condition. AMVETS has reported this situation over the years. We have served to bring the report about chronic underfunding shortfalls that have resulted in denial, delay, and rationing of veterans' health care.

We do not believe these circumstances represent what you and your full committee have collectively fought for on behalf of veterans. Last year, your committee's bipartisan leadership presented a solid recommendation for funding the VA health care system. Unfortunately, as VA entered fiscal year 2002, over a quarter million veterans seeking health care were waiting more than 6 months for an appointment.

Today, as we discuss the condition of the VA health care system, funding for the current fiscal year remains uncertain. Unless better things happen, the picture remains troubled. Last week, the Senate recommended a 2.9 percent across-the-board cut in veterans' health care. If allowed to go forward, it is estimated that a total of 400,000 veterans would be denied health care over the next 9 months.

To further underscore this critical challenge facing VA's health care, the administration dropped a bombshell on January 17 by announcing a policy to ban future access to the system for so-called Category 8 veterans who had not previously enrolled in the system.

Prior to the ban on enrollment, VA had implemented a policy aimed to ensure that severely disabled veterans receive prompt care. AMVETS gave its full support to this policy, and AMVETS continues, as always, to support the core mission of VA health care. But we are deeply troubled by the decision to ban access.

Blocking access for a certain segment of veterans is not the answer. Instead of discouraging veterans from seeking health care, AMVETS would like to see VA present a budget sufficient to cover its true costs, instead of seeing, as we saw in VHA Directive 2003–003, issued on January 17 in sentence 4(d), a directive for health care workers to refer veterans in need of health care services who are not enrolled in VA to community social work for assistance.

Chronic underfunding has stretched the system like a rubber band, and it is ready to pop. A partial solution beyond adequate appropriations would be to allow VA to accept Medicare payments for those veterans who are eligible and wish to be treated for VA facilities. Frankly, a large majority of those seeking treatment for non-service-connected disabilities are Medicare eligible.

We hear a lot about veterans being older than the regular stream of people seeking health care. That is the definition of veteran. It is an individual who spent his youth in the military service.

Another suggestion supported by AMVETS is to provide mandatory funding. Clearly, discretionary funding has proven fickle and inconsistent. AMVETS believes mandatory funding of VA health care provides a comprehensive solution to the current funding problem. Once health care funding matches the actual average cost of care for veterans enrolled in the system with annual indexing for inflation, the VA can fulfill its mission.

Mr. Chairman, as we continue to move forward together we believe the sustained availability of quality health care is central to VA's mission. AMVETS calls on the administration and Congress to provide the resources needed to care for American veterans. We believe that adequate funding will remain central to VA's ability to sustain the timely delivery of quality health care to the men and women who have sacrificed and served in the military.

This concludes my testimony. Thank you for extending the opportunity to appear before you today. Thank you for your support of veterans.

Mr. SIMMONS. Thank you.

[The prepared statement of Mr. Jones appears on p. 103.]

Mr. SIMMONS. And now Dr. Schwartz.

STATEMENT OF DR. LINDA SPOONSTER SCHWARTZ

Ms. SCHWARTZ. Good afternoon, Mr. Chairman. Let me congratulate you from Pawcatuck, Connecticut, on your election as the chairman of the Subcommittee on Health. I look forward to working with you.

As some of you may not know, I don't live here in Washington. In the Vietnam Veterans of America, our leadership comes from the lay leadership. So I am, in essence, not only on the faculty of the Yale School of Nursing, I am also the Chair of Health Care for Vietnam Veterans of America.

I was looking at—Richard and everyone before me have made a very good a case for your consideration, but I would like to share with you some information.

During our last board meeting we did a trajectory on how many veterans in America do not have health care insurance, because this has been a topic today. Just so you know, our actuarial figures indicate that there is about 4.1 million veterans in America who don't have health insurance; and as far as the mandatory funding category goes, that is our number one legislative priority for this year.

I was back there in 1993, walking the halls with Richard. At that time, we looked for some overhaul of the VA health care system. When we had the prescription of change, some of the changes occurred which did actually improve the service to veterans, but it did—there was not the massive savings that were envisioned then, that all of the changes have really come at the expense of America's veterans.

Dr. Roswell has been very candid, and I thank him for that today. As a nurse who cared for battle casualties during World War II, I wish—during Vietnam, I actually did take care of casualties just as they came out of Vietnam, both as a flight nurse and stationed at Tachikawa. So I can tell you the idea of battlefield casualties coming to VA hospitals is indeed frightening, and that is what we are looking at right here.

The lack of a consistent, reliable budget has, in essence, obstructed VA's capacity to respond to the changing needs of the health care system, to efficiently grow, as Dr. Roswell pointed out, to acquire competent personnel and maintain a viable service infrastructure. VVA enthusiastically joins with the other veterans' service organizations in endorsing the need to upgrade the VA health care system from the discretionary funding category to the more binding commitment of the mandatory funding classification. We believe that this action is necessary to abate what usually amounts to the annual funding frenzy that VHA faces in its attempts to balance their mission to protect and safeguard veterans in their care and keeping.

Truthfully, I guess I can bring you the perspective that most people in America believe that it is an obligation of this government to care for veterans. When you say it is in the discretionary category, they are shocked. They can't believe that that is what has happened here. They believe that this is an obligation of our government to those men and women who step forward to defend freedom in this Nation.

I would just say at a time when we just sent a nephew off to war and when our President is asking this new generation to bear the brunt of war, we need we must keep faith with their dedication by making the commitment to ensure that the funds to care for their injuries and disabilities is not relegated to a discretionary duty of this government and country that they have sworn to defend.

Budgets are a reflection of the values and priorities of the administrators who design and legislators who approve them. What does discretionary funding for the care of men and women who defend this country say about us, say about America, say about our beliefs?

I would just like to quickly share with you this recent issue of Consumer Reports. On it, it says, how safe is your hospital? What you need to know that hospitals don't reveal. And to capsulize it just a little bit and to take it out of the money category and talk about the people, let me just say any risk of receiving substandard care must be taken seriously.

There are three crucial factors that were identified by the Journal of the American Medical Association and reported here, and Dr. Roswell was a perfect lead-in to this: sufficient staff, especially RNs; a good system of organized care; experience with your particular medical condition. That makes the most difference in both patient satisfaction and recovery.

And hospitals with ample nursing staffs have 9.4 percent fewer cases of cardiac arrest and shock than hospitals with lower staffing levels. Let me just finally say, and I have said it before, in the discussion to provide for the health care of America's veterans, this really does boil down to a question of honor. For, in essence, this committee and both Houses of Congress are the board of trustees of the largest health care system in the world. It does not matter what you, this body authorizes for insurance organ transplants or any other health care legislation. Congress does not bear the responsibility to those issues as directly as specifically as absolutely as the health care of the men and women who defend this nation. The question of honor is not their honor, but how Congress and this country honors them. Thank you, Mr. Chairman, that concludes my testimony.

Mr. SIMMONS. Thank you, Dr. Schwartz.

[The prepared statement of Dr. Schwartz appears on p. 107.]

Mr. SIMMONS. A quick question to Mr. Fuller. You made reference to a set of recommendations made in 1993 and I think you had a copy of a booklet that was published at that time. I hope we could have a copy for the record.

Mr. FULLER. These are very rare, but I will see what I can do. (See p. 91.)

Mr. SIMMONS. I will put it in the custody of the Full Committee so that all Members have access to it at one point or another, perhaps to make a point, but I would be interested to see it. Secondly, your organization is probably one of the most substantial consumers of tertiary care. There may be some other categories of veterans out there that are also consumers of that. But I think you would probably be one of the greatest consumers. You heard the testimony of the Veterans Administration earlier today on that subject. Do you have any comments that you would like to make about Dr. Roswell's concerns about tertiary care?

Mr. FULLER. Well, I think I would like to underscore that this is what we have been saying and what the committee has been saying for 6 or 7 years, that as the VA began to reinvent itself going from an inpatient hospital-based program to an outpatient-based program, that was wonderful for a lot of veterans but the shift in resources going to outpatient primary care, obviously with a finite pot of money, had to come at the expense of the expensive in-patient specialized services, like spinal cord injury care. Dr. Roswell knows very well that we beat this drum constantly. But it is the only way that we have been able to get the attention of the

Committee and the VA to actually set parameters now on what the capacity is. Because the strain is on at every hospital that has an SCI center, constantly trying to find ways to shift those resources around when they only have so much. So that is why we run into problems and why we have agreed on a directive that Dr. Roswell sent out saying this is how many beds you need, how many staff you need to actually meet the committees' requirement.

Mr. SIMMONS. When we look at the issue of mandatory funding for veterans health benefits under VA, is there any thought that certain types of services should be funded in a mandatory fashion? Should other types of services which are more complicated that might involve tertiary care be left discretionary so that the Administrators have a full range of options for those categories of veterans?

Mr. FULLER. Well, if we were to leave part of the VA mandatory and the other part discretionary in a Congressional sense I would fear having to go to the appropriators every year and having to say, "Hi there."

Mr. SIMMONS. Thank you. That is a good answer. For Dr. Schwartz, I think the third or fourth page of your testimony, you state that Vietnam Veterans of America supports the efforts of Secretary Principi to stabilize VHA by suspending enrollment of category 8 veterans until such time as there are resources adequate to take care of service disabled veterans, combat veterans, and indigent veterans. It seems to me that position is somewhat different from what we are hearing from some of the other VSOs. Would you like to comment on that position?

Ms. SCHWARTZ. Let me just say that I think in the past, some of the secretaries and some of the administrators before they were secretaries, really didn't move fast to try to make any changes. But I have to say that I am impressed with some the things that Secretary Principi has done, especially with trying to reduce the backlogs with his taking a real pragmatic look at what I do have. And I think, in essence, what he has said because I don't think this decision came to him easily. He said he is tapped out. The system is tapped out. Because of the way, I mean no one foresaw when Secretary Derwinsky very nicely said I would like to give veterans a break and let's give them a low co-pay of $2 on all their pharmaceuticals. He didn't realize they would grow into the largest growing group of people.

A friend of mine showed me a senior citizens health letter that goes all over the United States telling them to go to the VA because they have such low, if you are a veteran, here is one of your benefits, go and get your medication. I don't think they realized they have to see VA doctors in order to rewrite the prescriptions. That is a problem that we have heard too. And as someone who is both a disabled veteran and also uses Tri-Care, I get my prescriptions that are written by the VA is actually filled at the Navy Groton hospital. So there is that question, and also the question of what could you possibly do to alleviate it.

And I think the run on VA health care is more of a symptom of a larger social ill which is adequate funding for medication for people who now have—their lives depend on medications. I saw some-

body yesterday taking 15 drugs. She says I have to or I can't stay alive. That is what we have evolved in.

So I know perhaps it is not, but we have had to be pragmatic, and if people remember VVA has always had the position that him who has borne the battle is our number one—and her, who has borne the battle is our number one priority, and I think when Secretary Principi talks about core constituency, he is talking about the poor and the patriots. And he is telling us that if you want us to do all the rest of this, okay, I need a little bit more commitment from this Congress on the funding. That is what is the problem here. The first time I ever met Tony Principi, he said the problem with Washington is they give you—you have 5 years of problems on one, and you go on an annual budget and so you can't really solve your problems. And that was in 1992 when I was just a mere girl.

Mr. SIMMONS. Thank you very much. Mr. Filner.

Mr. FILNER. Just briefly, just to make sure you know my connections. I have taken courses at the Yale School of Medicine.

Ms. SCHWARTZ. Uh -oh. Okay.

Mr. SIMMONS. What was the nature of those courses?

Mr. FILNER. I am a historian of science, and history of medicine was taught through that school there. I don't know if it still is.

Ms. SCHWARTZ. Yes, it is.

Mr. FILNER. Just briefly, I have said all I need to say today, I think. But regarding your last comments on honor, in an ideal world I think you can rely on the honor of us politicians here. We are all honorable men and women, but the political system responds to pressure. Everybody wants to do everything. And everybody is honorable. But people have to make choices and they have to vote. And they vote by the pressure that is exerted on them. So I wouldn't trust totally the honor. I would get your members after us.

Ms. SCHWARTZ. Well, let me just say, you mentioned that before and we do have in operation right now an identification of all of the ZIP codes of our members and who are their congressional representatives. But I think sometimes, and I don't live here in the city and I try not to drink the water because I don't want to become jaded. But the point is, the point is, I do think that sometimes people who serve in this Congress and people who serve in the Senate forget that. And I have a very burning thought in my mind. If we cannot affect the change for mandatory funding for VA health care while we are sending men and women overseas to serve this country, shame on us.

Mr. FILNER. I agree. Shame on us for not doing it. But also shame on you if you don't apply the pressure to get it done. That is, you know, American politics.

Ms. SCHWARTZ. I said shame on us.

Mr. FILNER. I mean shame on us if we don't do it.

Ms. SCHWARTZ Us, not you. Us.

Mr. FILNER. Okay. Shame on all of us.

Ms. SCHWARTZ. Yes. If we can't get it now, when are we going to get it.

Mr. FILNER. Well, we aren't going to get it.

Mr. SIMMONS. Thank you, Mr. Filner. Mr. Bradley.

Mr. BRADLEY. I have no—excuse me. I have no questions. But this has been a very interesting debate and I certainly feel very welcome to be on the committee and look forward to working with all of you on these health care issues that are so important to our Nation. Thank you.

Mr. SIMMONS. I thank you all very much. I thank our panelists and I note for the record that Dr. Roswell has been sitting in the second row listening carefully and taking notes. You know, I am a freshman in the House, but spent a number of years as a Senate staffer, and it's often that public officials come in and make their statements, answer the questions and disappear out the door with a great flurry and entourage following along. It is very refreshing to see somebody who is sufficiently interested in the issues on the table today that he will stay for the full hearing and listen to all of the testimony. So I note that for the record. I thank the Doctor. I thank all of our participants here today and this hearing is now concluded.

[The statement of Hon. Jeff Miller appears on p. 51.]

[The statement of Hon. Cliff Stearns appears on p. 54.]

[Whereupon, at 4:42 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CHAIRMAN SMITH

Last night, President Bush reported that the State of the Union was 'strong'. Today, we will examine the state of veterans' health care to see if it is equally strong.

Only days ago, the Department of Veterans Affairs announced that for the first time it would use its authority to curtail new enrollments for veterans' health care. VA reported that at least—and I emphasize *at least*—200,000 veterans are waiting six months or longer for their first appointment with a VA doctor, and that estimate doesn't count those still waiting to enroll in the system. Many of those waiting are 100 percent disabled and paralyzed veterans. In fact, when Secretary Principi sent one of his deputies, a decorated Vietnam veteran paralyzed in combat, to try and enroll in VA health care, he was turned away in state after state due to overcrowding.

Earlier this month, Chairman Buyer and Committee staff visited one medical center in Florida and discovered that over 2,700 veterans are waiting to be scheduled to see a VA audiologist, over 4,000 veterans are waiting to see an eye specialist, and almost 700 are waiting to see a cardiologist. More than half of these veterans were high priority veterans in categories 1 to 7. All reports indicate that a similar situation exists at a majority of VA medical centers throughout the country. Care delayed is care denied.

At the same time, there remain at least 275,000 homeless veterans who desperately need a helping hand, yet VA is unable to fully fund programs that we approved less than two years ago. VA has closed over 1,500 long-term care beds at a time when WWII and Korean War veterans are most in need of assistance. Despite an increase in the number of veterans who have service-connected mental illnesses, such as Post Traumatic Stress Disorder, VA is providing less care overall than it did in previous fiscal years.

And most troubling, according to VA's own published documents in the Federal Register of January 17, VA will be short $1.9 billion in their health care budget for this fiscal year—and that assumes VA will receive the full $23.9 billion for health care approved last year by both the House and Senate Appropriations Committees. Let me reemphasize what I just said—VA projects that it needs another $1.9 billion this year to meet the health care needs of veterans already enrolled.

To put this in perspective, $1.9 billion is the annual cost of providing care to 422,000 veterans—from all priority groups—veterans who are already in the system. How does VA plan to make up the difference this year? The only proposal to date is the freeze on enrollment of new priority 8 veterans, a move that VA projects could save at most $130 million this year.

Some have suggested that Congress should be blamed for the shortfall in funding for veterans health care, but the record over the past five years is clear that each Administration request has been a budget floor, while Congress has added funds above that request every single year. For FY 2003, the Administration requested a 6 percent increase; the House passed, and Congress is expected to approve, an 11 percent increase—that's 1 billion above VA's budget request. Over the past five years, Congress has consistently provided greater funding than was requested by the Administration, on average over $300 million each year.

In addition, last year Congress passed a supplemental appropriation that included $417 million for VA health care. Regrettably, the Administration refused to accept $275 million of that supplemental targeted for veterans' medical care.

Others have suggested that VA's problems are driven by enrollment of veterans who were not injured during their service, so-called "lower priority" veterans in category 8. However, it is clear that even if VA had never offered priority 8 veterans the opportunity to receive care from VA, it would still be swamped with service-connected and low-income veterans who are in the "high priority" categories.

According to VA, the number of "high priority" veterans enrolled in VA health care is projected to rise by 384,000, or 7.5 percent, this year and by 281,000 next year. A total of 5.8 million "high priority" veterans will be enrolled for VA care next fiscal year and this trend will not diminish for several more years.

The word crisis is often overused in this town, but clearly VA health care is in crisis and at a crossroads.

Last year, I, along with my good friend Lane Evans, offered several bills seeking long-term solutions to VA's health care funding problems. H.R. 4939 would have allowed VA to be reimbursed by Medicare for providing care to Medicare eligible veterans. H.R. 5250 would have made VA health care funding a formula driven budget item—based upon demand and medical inflation—rather than a discretionary budget item. H.R. 5392 would have allowed VA to recover costs of medical care from third parties in the same manner as if VA were a preferred provider organization. And finally, H.R. 5530 would have enhanced the right of VA to recover payments from third parties for providing non-service-connected care. We are again preparing to introduce legislation—on a bipartisan basis—to provide long-term solutions to VA's funding problems.

But before we can arrive at solutions, we first need to agree on the nature and scope of the problems. For some, the Secretary's decision to cut off enrollment of 164,000 category 8 veterans was a solution; to me, and many others, it is a problem.

So I return to the central question of today's hearing: how well is VA is fulfilling its statutory mandate to provide the full range of health care services that veterans have earned. Are service-disabled and paralyzed veterans receiving timely and comprehensive care, including access to the latest advances in medicine and technology? Is VA meeting its obligations to indigent veterans, those who have fallen on hard times, including those suffering from drug addiction and mental health problems? How about our elderly veterans, many who fought on the beaches of Normandy, in the forests of Ardennes, and across the frozen Chosin Reservoir; are they receiving the long-term care Congress mandated for them in the Millennium Health Care and Benefits Act of 2000?

Many of you may have heard of The American Legion's project called "I am not a number". It is helping to put a human face on veterans' health care issues, rather than just focusing on numbers, such as budget allocations and enrollment projections. It reminds me of a saying, often used by Mark Twain, and appropriate for today's hearing. Twain said that "there are three kinds of lies: lies, damn lies and statistics."

I think that Mr. Twain and The American Legion have it right: veterans are not numbers, their health is not a statistic, and our Nation's debt to them must be more than just words.

PREPARED STATEMENT OF CONGRESSMAN EVANS

Good afternoon. Mr. Chairman, and members of the Committee on Veterans Affairs. Welcome to the new members of the Committee who are joining us for the first time today.

Mr. Chairman, you have chosen a timely matter to inaugurate this Committee in this Congress. Many of us have seen recent press that discusses Secretary Principi's decision to only allow those "highest income" veterans who have already enrolled for care in the Department of Veterans Affairs (VA) to apply for services. It is obviously a deeply disappointing decision to veterans, as well as to the Members of Congress.

It is particularly disappointing given the bipartisan efforts of this Committee to improve the funding for VA health care. Mr. Chairman, as you recall, we forwarded views and estimates to the Budget Committee asking them to increase President Bush's request for VA health care funding for FY 2003 by $2.2 billion. We still haven't passed an appropriation, but reports indicate the conferees may pass a bill that adds only $400 million to VA's health care budget. This will seriously aggravate VA's existing problems with access, even with the new rationing mechanisms in place, and threaten the high level of quality the struggling system has managed to uphold through years of uneven funding.

Mr. Chairman, you and I stood ready to do something about this in the dwindling days of the last Congress. Together, we introduced H.R. 5250, the Veterans Health Care Funding Guarantee Act of 2002 which would have established a mandatory funding stream for VA health care. You are to be commended for your leadership in tackling this issue. Every veterans' organization testifying today has applauded our efforts to champion this legislation. It was the right thing to do, Mr. Chairman. I want to reaffirm my commitment to working together to address any obstacles that have been set in our path and getting this legislation re-introduced in the near future.

STATEMENT OF
BOB FILNER

RANKING DEMOCRATIC MEMBER
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS AFFAIRS

HEARING ON DEPARTMENT OF VETERANS AFFAIRS HEALTH SYSTEM
January 29, 2003

Good morning. Thank you, Mr. Chairman for holding this important hearing today. I am looking forward to fleshing out many of the topics this hearing will raise in further detail in future Subcommittee on Health hearings this year.

I have read the testimony of the veterans' groups who will appear before us today. They do an excellent job of laying out the problems confronting the VA health care system—namely in identifying the impacts of unpredictable and insufficient funding on a system that is experiencing record growth in demand for its services. Clearly, from all perspectives, this situation is unsustainable. But if something has to give, it seems clear from the Bush Administration's point of view, it will once again be the veterans.

Let's take a quick look at the record. The Independent Budget recommended Congress appropriate $24.7 billion (including funds for its contingency missions, as a backup for the Defense Department and taking on duties under federal emergencies) for fiscal year 2003. The President requested an appropriation of about $23.9 billion. Part of this proposal was predicated upon passage of a "rationing mechanism" that

Deleted: Homeland Security

would have required Priority 7 veterans to pay a $1500 deductible to use VA services. His budget also sought for VA to identify another $316 million through vaguely defined "management efficiencies".

During this past fiscal year, the President did agree to request, as supplemental funding for FY 2002, the $142 million VA required to continue to allow Priority 7 veterans to use the VA. Yet he failed to designate as emergency spending an additional $275 million Congress appropriated.

Back in the 107th Congress, House and Senate appropriators agreed to fund the President's request and either of the proposals would have thankfully restored funds for a misbegotten Priority 7 $1500 deductible proposal. But, after the new House and Senate GOP leadership met with the President, we have heard that they agreed that $10 billion overall would be eliminated from the Senate's bill in the omnibus appropriation that may eventually fund VA. (The formerly Democratic Senate had added $10 billion to fund its highest priorities). Without the buffer, Congress may have to cut another $700 million from the bare bones budget proposed for VHA for the remainder of this fiscal year. So, in the final analysis, how much could the GOP leadership in the White House and Congress provide VHA for fiscal year 2003? A measly $400 million over fiscal year 2002! Even worse, we

could end up on a continuing resolution for the rest of the fiscal year! Either scenario will require VA to cut off thousands more veterans. It will also confound agency plans to eliminate VA's waiting times by the end of this fiscal year. Forget about preparing for the troops that are, as we speak, being deployed abroad.

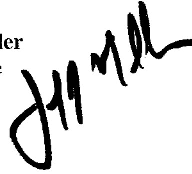
Now we hear how great the Administration's fiscal year 2004 budget request is supposed to be. Oh, really? So great we have to continue to cut off veterans? We understand that the request includes yet another and larger cut for "management efficiencies" and counts, as part of the great $1.9 billion "increase" more premiums for remaining Priority 7 and 8 veterans.

Dr. Roswell, I hope you will take this message back to your leadership. VA's recent budgets for veterans have been turkeys, and turkeys don't fly. Bring us a budget that meets your needs. We don't add as much to VA funding as I would like, but we usually give you what you ask for and often significantly more.

As far as I am concerned, our funding process this year has been a case study for why the VA needs and must have a health care budget from a mandatory funding stream. Mr. Chairman, it is no secret that the Republican leadership wants

to end the discussion about guaranteed funding. So I want to applaud your strong leadership on this issue and hope that you will continue to work with us across the aisle and just as importantly with the veterans groups with us today. I commit to continuing to advocate guaranteed funding for VA health care as the right solution. Thank you.

Statement of Representative Jeff Miller
House Veterans Affairs Committee
Hearing on VA Health Care
January 29, 2003



Mr. Chairman, it continues to be my honor to serve with you and the other distinguished members of the House Veterans Affairs Committee. I extend a warm welcome to our newest committee members, to this, our first hearing of the 108th Congress. We look forward to having you join the charge to strengthen our nation's veterans' health care programs. With 22 networks providing care to over 6.8 million veterans, this is obviously no small task and one that we must be vigilant in working to achieve.

As many of you know, I represent the first Congressional district of Florida, which is located in the largest of the 23 VISNs within the Veterans Health Administration. My district includes 2 of the top 10 concentrations of veterans populations; Pensacola and the Number One concentration nationwide, Fort Walton Beach. I represent more veterans than reside in any other Congressional district in the nation. In addition, many of our thousands of active servicemembers at Naval Air Station Pensacola, Eglin Air Force Base, and other military installations in Northwest Florida will join these veterans upon completion of their service and sacrifice to our great nation.

My 110, 000 veterans are primarily serviced by two outpatient clinics. Both of these clinics are unable to adequately service the large number of veterans seeking care. I am constantly hearing stories from my constituents that they are required to wait 5 or 6

months for appointments at the clinics. Additionally, we do not have a single in-patient bed in the Panhandle, and most veterans are forced to go to the medical center in Biloxi, Mississippi, over 3 ½ hours away, passing two military facilities with available beds on the way. This is not only unacceptable, but it is a poor allocation of our resources. While I have been encouraged by our network's efforts on a wide variety of sharing ventures with government agencies as well as private-sector health care entities, we can and we need to do more.

For these reasons, I have made the accessibility, quality and timeliness of health care to the veterans of Florida's First District my top priority.

This Administration has prided itself on running like a business, and I believe this situation begs the question, "What would a business do?" At the most basic level, DoD and VA boast two excellent healthcare systems in the business of providing healthcare to our nation's active duty military and military retirees and veterans. Especially in light of finite resources, it is vital that we constantly reexamine how we are conducting this business to ensure that we are not only providing the highest quality care in a timely manner, but that we are also doing so in the most efficient manner possible. I welcome the fine panelists here today, and look forward to your testimony, especially regarding resource cosharing endeavors between DoD and VA.

In this time of global conflict and impending defense of our freedoms and democratic ideals, we *must* send the right message to our active duty personnel, reservists, veterans, and future recruits

alike. In Northwest Florida a promise made is a promise kept. I will continue to fight for what our government has promised our nation's finest. As our veterans have fulfilled their duty, now is the time for us to do our duty to those who have fought for freedom and democracy. Thank you, Mr. Chairman.

Statement of Congressman Stearns
Veterans Affairs Committee Hearing 1/29/03 Health
VA Health, Focus on Capacity to Meet Capacity

Mr. Chairman,

Thank you for starting off the 108th Congress with this full committee hearing on the status of the VA health care system. Unfortunately, I worry that the status is that it is bursting at the seams. The waiting list is around 200,000, and veterans on this list are waiting months, even a year for an appointment.

I look forward to Dr. Roswell's suggestions, particularly on the supposed new partnership with CMS, called VA + Choice.

I think that what our veterans have to say about their desperate need to access VA health care system is perfectly expressed in this cartoon by Pulitzer Prize-winning World War II cartoonist and veteran Bill Mauldin. Sgt. Mauldin, who unfortunately passed away a week ago today, drew this for *Stars and Stripes* in 1944. It shows one of his archetypical tired,

unshaven and loyal to the end GI's approaching a medic, saying…

"Just give me the aspirin. I already got a Purple Heart."

Bill Mauldin, *Stars and Stripes*, 1944

Statement of
The Honorable Robert H. Roswell, M.D.
Under Secretary for Health
Department of Veterans Affairs
before the
Committee on Veterans' Affairs
U.S. House of Representatives
on the
State of VA Health Care

January 29, 2003

Mr. Chairman and members of the Committee, I am pleased to be here today to discuss the challenges facing VA in meeting the current demand for VA health care services. As you know, the Secretary and I will be testifying before you on the President's FY 2004 budget request in less than 2 weeks. I will not be able to discuss the details of the budget request today.

Today's VA health care system is one of the most effective and successful health care systems in the Nation. VA's performance now surpasses many government targets for health care quality as well as measured private sector performance. For 16 of 18 clinical performance indicators, critical to the care of veterans, and directly comparable externally, VA is now the benchmark. This includes use of beta-blockers after a heart attack, breast and cervical cancer screening, cholesterol screening, immunizations, tobacco screening and counseling, and multiple aspects of diabetes care. These improvements don't just look good on paper; they save lives, reduce hospitalizations, preserve function, lower costs, and satisfy patients. By the way, VA is essentially identical to the best private sector health care performance on the last two indicators.

Our performance measurement program creates a framework for accountability, specifying the improvement we will achieve, not simply recording where we have been. The recent Institute of Medicine study entitled "Leadership By Example," lauded VA's approach to translating the best scientific evidence of research into increasingly effective patient care. Quoting from the study, "VA's integrated health care information system, including its framework for using performance measures to improve quality, is considered one of the best in the nation."

VA's research program is specifically directed toward ensuring that the best science reliably informs our patient care, and that our research portfolio increasingly focuses on the clinical and health services research that specifically addresses the needs of Veterans. VA is widely recognized as a leader in such research areas as aging, women's health, AIDS, post-traumatic stress disorder, and other mental health issues. Our partnership with 107 medical schools and 1,500 other health professional training programs ensures that we bring state-of-

the-art thinking to patient care. Conversely, as VA improves technologies such as computerization, advances accountability through measurement, and develops delivery models that better address patient needs, we improve health care for the country, as sixty percent of all health professionals, and 70 percent of physicians, experience some portion of their training in VA.

VA now has nearly 1,300 sites of care and provides health care services at locations much closer to where our patients live. Eighty-seven percent of VA's patient population now lives within 30 minutes of a VA medical facility. VA is providing care to nearly 48 percent more veterans than it did in 1997. At the same time, we have reduced the cost of care per veteran by 26 percent, not by cutting corners, but by delivering care more efficiently and more effectively.

Towards this end, VA is implementing management initiatives that will produce an unprecedented offset to the overall cost of the projected growth in workload and utilization. We have undertaken a rigorous competitive sourcing plan to determine whether commercial activities should be performed in-house using government facilities and personnel, or with private procurement processes. In addition, we continue to implement aggressive strategies to leverage our purchasing power, standardize equipment and supplies, ensure that any provider working part-time for VA provides services for every hour paid by VA, and maintain other management costs at or below 2003 levels. VA will also achieve efficiencies at the local level.

While transforming VA health care to a more efficient, effective, and accessible system, VA has become an industry leader in customer satisfaction, as is shown by its consistent benchmark-level scores on the American Customer Satisfaction Index, an econometric measure of government and private sector customer satisfaction. It is also noteworthy that VA medical facilities' average accreditation scores exceed those of private sector facilities.

VA continues to place a strong emphasis on comprehensive specialty care for which it has long been highly respected within the medical community, but we now also emphasize coordination of care through the universal assignment of primary care providers. With this transformation to a primary care delivery model, and by employing new models of care coordination and delivery, veterans have gained access to an integrated health care system, focused on addressing their health care needs before hospitalization becomes necessary.

In the past year, top leadership in DoD and VA created a Joint Executive Council that developed an overarching shared vision for the future and began to implement changes. The Departments have made unprecedented progress in sharing/coordinating medical care resources. Two President's priorities are jointly underway which will greatly enhance the seamless delivery of services to veterans – the information technology efforts on enrollment systems and

electronic patient records. Many impressive collaborations have been made in other areas such as shared facilities and equipment, coordinated human resources, procurement, and other common business practices and training. We have shown significant progress and expect continued results as we coordinate the delivery systems beyond that experienced in the past.

The changes in the VA health care system have been profound, and the benefits have been recognized both inside and outside the Department. We provide better care to our nation's veterans, closer to their homes, and using the latest technology. However, we also face significant challenges, which we must meet to assure that our nation maintains a comprehensive, integrated health care system for all veterans who choose to come to VA for their care.

Resources and Demand

Because of the successes we have had in transforming VA health care and because of problems of coverage and availability of some services in the private sector, VA is experiencing an unprecedented demand for health care services. In FY 2002, VA enrolled approximately 800,000 additional veterans bringing the enrollment in the veterans health care system to nearly 6.5 million veterans. In FY 1996, VA provided care to 2.7 million veterans. In FY 2002, the number of veterans who received VA care increased to nearly 4.3 million. For FY 2003, we currently project that we will provide care to approximately 4.6 million veteran patients.

It is clear that continued workload growth of the magnitude we have seen in recent years is unsustainable. VA has been unable to provide all enrolled veterans with timely access to health care services because of the tremendous growth in the number of veterans seeking VA health care. During the past year, the Secretary took steps to assure that VA would afford priority access to veterans with service-connected disabilities. He has recently announced additional steps that are necessary for the system to adequately serve all its patients and, in particular, to ensure that VA has capacity to care for veterans for whom our Nation has the greatest obligation: those with service-connected disabilities, lower-income veterans, and those needing specialized care.

Fully recognizing the extraordinary service that veterans have rendered to their fellow Americans, the Administration's budget for fiscal year 2004 will, we understand, seek a significant increase in VA medical care funding. As the demand for services from the Department continues to grow at a substantial pace, the Department must, of course, allocate its limited resources according to the priorities set by law. Accordingly, on January 17, 2003, the Secretary announced that, while it will continue to enroll veterans in the top seven priority groups that it serves, the Department must take steps to limit enrollment of new

patients in Priority Category 8. Specifically, the Secretary has stated that the VA will enroll all priority groups of veterans, except those veterans in Priority 8 who were not in an enrolled status on January 17, 2003, or who request disenrollment on or after that date.

To understand the wisdom of the decision to limit enrollment of certain persons in Priority Group 8, it is important to understand the Priority Group system established by law for the Department. Our priorities are as follows:

Priority Group 1

- Veterans with service connected disabilities rated 50% or more disabling.

Priority Group 2

- Veterans with service connected disabilities rated 30% - 40% disabling.

Priority Group 3

- Veterans who are former POWs.
- Veterans awarded the Purple Heart.
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty.
- Veterans with service-connected disabilities rated 10% or 20% disabling.
- Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation".

Priority Group 4

- Veterans who are receiving aid and attendance or housebound benefits.
- Veterans who have been determined by VA clinicians to be catastrophically disabled.

Priority Group 5

- Nonservice-connected veterans and noncompensable service-connected veterans rated 0% disabled whose annual income and net worth are below the established VA Means Test thresholds.
- Veterans receiving VA pension benefits.
- Veterans eligible for Medicaid benefits.

Priority Group 6

All other eligible veterans who are not required to make co-payments for their care, including:

- World War I veterans;
- Mexican Border War veterans
- Veterans solely seeking care for disorders associated with:
  - exposure to herbicides while serving in Vietnam; or

   - exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or
   - for disorders associated with service in the Gulf War or for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.
- Compensable 0% service-connected veterans.

Priority Group 7

- Veterans who agree to pay specified copayments with income and/or net worth above the VA Means Test threshold and income below the VA's Geographic Means Test.

Priority Group 8

- Veterans who agree to pay specified copayments with income and/or net worth above the VA Means Test threshold and the VA Geographic Means Test threshold.

Thus, it is clear that the decision regarding limitation of enrollment of certain persons in Priority Group 8 reflects a sound application of limited resources to priorities.

Let me emphasize that those in Priority Group 8 who were enrolled prior to January 17 are not affected by the limited enrollment decision and may continue to receive health care from VA.

We believe that the difficult decision to limit enrollment of certain persons in Priority Group 8 had to be made in order to maintain the quality of the health care we provide to currently enrolled patients and those higher-priority veterans who have yet to enroll. It will allow the VA to refocus the mission of the healthcare system and rebuild the capacity of the system to provide for the tertiary care and special needs of the service-connected, low income, and special needs veterans, as well as future veterans who may suffer significant disability resulting from combat service.

On a related point, the Secretary has announced that work is underway with the Department of Health and Human Services (HHS) to determine how to give Medicare eligible Priority Group 8 veterans who cannot enroll in VA's health care system access to a "VA+Choice" Medicare plan. To accomplish this, VA could contract with a Medicare+Choice organization, and eligible veterans would be able to use their Medicare benefits to obtain care from VA. Additional details will be forthcoming as we work out the details of this approach. We are hopeful that the "VA+Choice Medicare" plan will become effective later this year.

Waiting Lists

During much of the past year, we had over 300,000 patients on waiting lists to receive medical care. Currently, about 201,000 veterans are on waiting lists. It should be noted that these numbers are not static. New enrollees join the list, even as enrollees come off of the waiting list to become new patients in the system. While the enrollment decision will serve to reduce the number of veterans who will be allowed to enroll in the VA health care system, we must continue our efforts to reduce and eliminate excessive waits. VA has made a concerted effort to reduce waiting times and is fostering multiple efforts including:

- Developing the Advanced Clinic Access (ACA) initiative in collaboration with the Institute for Healthcare Improvement: The core of ACA is a training program that provides strategies and change concepts to assist clinic staff make their processes more efficient to reduce wait times, improve access, and decrease costs.
- Developing a national Waiting Times Web Site and computerized wait list and scheduling package: This effort enhances measurement of wait times for every patient seeking access to VA services and improves scheduling, efficiency and effectiveness, and
- Developing monitors to identify the percent of active patients assigned to primary care providers and the percent of primary care provider capacity that is utilized by active patients.

Despite all of these efforts, we now must recruit additional primary care and specialty provider staff in order to keep pace with the current demand for care and assure our ability to meet the comprehensive needs of the veterans we serve.

Improved Health Management

Although our efforts to reduce waiting times have been highly successful, we must continue to find better ways to deliver health care. Historically, health care in this nation has been managed from the perspective and needs of the provider. As a hospital system, we waited until veterans required hospital care. Even now, we schedule appointments based on the provider's best guess of when the patient will need to be seen and when an appointment might be available, not based on when the patient actually requires care. We're not alone; this is the approach taken by most health care systems today. However, we believe that better health care management strategies are now possible.

We must find new ways to partner with patients to more effectively manage health and disease processes continuously, 24 hours a day, 365 days a year. We need to be able to see the patient "just in time" when a complication or need starts to develop. This shift constitutes a fundamental change in how we

view health care and this approach will have a groundbreaking impact on both primary care and long-term care. While the impact on primary care and the management of many chronic conditions will be substantial, the impact on long-term care will be even more profound, especially as we are a system that will experience a 200 percent increase in veterans over 85 years of age by decade's end.

Institutional long-term care is very costly and may impair a long-term spousal relationship and reduce overall quality of life. Long-term care should focus on the patient and his or her needs, not on an institution. The technology and skills exist to meet a substantial portion of long-term care needs in non-institutional settings.

In those situations where long term care in the veteran's home is not practical, assisted living facilities may meet the needs of veterans and their spouses. The VA recognizes that assisted living facilities are used in the private sector as a lower cost alternative to institutionalization, and more importantly, as an option which keeps the pair bond between the husband and wife intact, providing a higher quality of life. VA currently is operating an assisted living pilot project and will evaluate the significant impact of the pilot in terms of quality of care, veteran satisfaction, and cost.

VA must leverage its leadership in computerization and advanced technologies to better provide patient-centric care. Technology is increasingly available to provide the limited health care that is needed to support long-term care for many veterans in their homes or in assisted living facilities. Technology can be used to monitor how patients feel and whether they are taking their medications properly. Technology can also be used to monitor various health status indicators in the patient's home, such as blood pressure, blood glucose levels for diabetics, and weight for patients with heart failure. With tele-health support, many of our nation's veterans will be able to stay in their homes or in assisted living facilities with their spouses in the towns where they have a support network. Nursing home care should always be the option of last resort, where it is medically infeasible or inadvisable for a veteran to receive care at home or in an assisted living facility.

To oversee many of the initiatives needed to implement a patient-centered model for primary and long-term care, I have instructed creation of a Care Coordination Office. Although the final responsibilities of this office are still under consideration, it will have in its charge such things as the use of technology in care coordination and the development and implementation of policy and initiatives in chronic disease management and long term care.

But while there is much that VA can do on its own, there are also legislative impediments that need to be addressed. First, we must revisit the

long-term care capacity provisions implemented by the Veterans Millennium Health Care and Benefits Act (Millennium Act). Currently, only VA-operated and VA-staffed extended care programs may be considered for purposes of meeting the capacity requirement for institutional and non-institutional extended care. For more than 30 years, however, VA has developed a continuum of institutional and non-institutional services to meet the extended care needs of veterans, including VA-provided, contracted, and State home-provided services. In FY 2002, for example, approximately 70 percent of VA's institutional nursing home care occurred in contract community and State home nursing homes. Also in FY 2002, approximately 37 percent of VA's total extended care patient population was served in non-institutional settings. The availability of these programs has improved access and created choices for veterans who have family and social support systems far from VA nursing home facilities. As a result, the quality of remaining life in this group of veterans has increased significantly. I believe that the capacity requirement should better reflect VA's current direction in the provision of long-term care.

Recruitment and Retention

To work down the waiting lists, and to continue to provide the quality and safety our veterans deserve, and to provide care with the efficiency that the budgetary environment demands, we need to be able recruit and retain appropriate health care professionals. National nursing leaders and health care organizations are projecting a shortage of registered nurses that will be unlike any experienced in the past. The current and future numbers of professional, registered nurses may be insufficient to meet our national health care needs. At the same time, changes in health care delivery will require larger numbers of well-educated nurses who perform increasingly complex functions in hospitals and the community. VA expects to face increasing challenges in maintaining its nursing workforce and we must remain competitive in pay and workforce innovations.

VA is also facing a critical situation in which its compensation system for physicians and dentists is unresponsive to the demands of the current market. The effect of noncompetitive pay and benefits is seen in dramatic increases in VA's scarce-specialty, fee-basis, and contractual expenditures. In addition, the short supply of some clinical subspecialties in the medical community is causing rapid increases in salaries, benefits, and perquisites. VA's special pay authorities have not been revised since 1991. VA's current pay authorities are stretched to the maximum, and the Department can no longer offer competitive salaries for these medical sub-specialists. More importantly, the current statutory

compensation structure does not offer a way for VA to link physician and dentist compensation to quantitative and qualitative outcomes.

We are currently developing a comprehensive workforce improvement proposal that would improve our ability to recruit and retain physicians, nurses, and other health care occupations. The Administration expects to submit this proposal by late spring of this year. This proposal will be vital to our ability to recruit the additional providers needed to increase our capacity, eliminate waiting lists, and refocus on our core mission of comprehensive care for service connected, low income, and special needs veterans.

Mr. Chairman, the current state of VA health care is excellent, but we still have much to do to maintain that excellence and build upon it in order to provide the right services, at the right time, and in the right place to the veterans of the 21st century. My vision of the future of VA health care is positive, but to realize that vision, we must address head-on the challenges I have outlined and do so deliberately, or we risk a different future.

This concludes my statement. While I cannot answer any specific questions regarding the content of the FY 2004 President's Budget that will be released next week, I will now be happy to answer any other questions that you and other members of the Committee might have.

STATEMENT OF

DENNIS CULLINAN, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVE

WITH RESPECT TO

THE VA HEALTH CARE SYSTEM'S CAPACITY TO
MEET THE CURRENT DEMAND FOR HEALTH CARE

WASHINGTON, DC JANUARY 29, 2003

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the 2.7 million members of the Veterans of Foreign Wars of the United States (VFW) and our Ladies Auxiliary, I would like to thank you for conducting and including us in this hearing of vital importance to America's veterans.

The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) is the nation's largest direct provider of health care services with over 160 hospitals and 800 community-based outpatient clinics. Amid the climate of rising health insurance premiums and costly prescription drugs, open enrollment, under the Health Care Eligibility Reform Act of 1996, and a shift from primarily inpatient care to outpatient care flooded VHA's facilities with millions of new users. The growth produced by these reforms quickly outpaced existing facilities and clinics capacity to provide access to quality, timely care.

Why should this matter? Open enrollment was supposed to pay for itself in third-party collections and co-payments for non-service-connected care. Despite the best efforts of the Department of Veterans Affairs this has never fructified. Meanwhile, successive years of improper budgeting and inadequate appropriations coupled with the impact of the aforementioned reforms have forced VHA to ration care, turning a once national treasure into a national tragedy. The most obvious manifestation of health care rationing has been the lengthening of appointment waiting times.

With your permission, Mr. Chairman, I would like to ask the Committee, "How long do each of you have to wait to see your doctor?" I know that in most cases I can see mine within **24 hours** while VHA maintains a self-imposed goal for veterans seeking access to VA health care

of **30 days** for an initial appointment - 30 days for a specialty appointment - 20 minutes to see a doctor at a scheduled appointment, which is a full 29 days after you and I have been seen. Even these conservative goals have not been met. According to a VHA survey conducted on December 16, 2002, there is currently a backlog of over 200,000 veterans waiting **six months** or more for a non-emergency clinic visit. Of course, it is impossible to truly know how many veterans are being denied care because VA's databases are severely deficient. We do know that be it six months or 29 days, it is too long for America's veterans to wait for medical care.

In response to this bleak situation, created by too many users and not enough dollars, VA proposed a $1,500 enrollment fee for then Category 7 veterans this past spring; and last fall, VHA issued a memorandum that directed network directors and their staffs to discontinue any outreach campaigns to enroll veterans despite the fact that the more veterans enrolled in a network the more funding a network could expect to receive under the Veterans Equitable Resource Allocation (VERA) system. Furthermore, the Secretary recently issued regulations ensuring the most severely disabled service-connected veterans priority access to health care.

Clearly, these past efforts to meet the demand for services have failed to produce the desired results leading to the recent concession by the Secretary of Veterans Affairs to suspend enrollment of Category 8 veterans in order to focus resources on "those with service-connected disabilities, the indigent and those with special health care needs" while at the same time announcing the "largest requested increase [in discretionary funding] in VA history" for fiscal year (FY) 2004.

Does it really matter that it is the largest requested increase if it is still inadequate to provide timely access to quality health care for all eligible veterans authorized access to VA health care under the Eligibility Reform Act? My point is that no veteran should ever be left behind. The enrollment announcement should have been unnecessary if the budget request were truly adequate, not just historic. As one VFW member accurately stated, "We need a White House budget that adequately reflects the demand for veterans' health care, Congressional budgets that mirror the Administration's adequate budget requests, and final appropriations that meet or exceed these amounts – NOW."

We are not alone when we say that the traditional budget/appropriations process has failed to provide adequate resources to meet the demand for VA health care. The President's

Task Force To Improve Health Care Delivery For Our Nation's Veterans' Interim Report acknowledged as much. Further, the VA was compelled to request $417 million in supplemental funding for FY 2002 because demand out stripped capacity. On top of all this, the budget/appropriations process broke down and Congress failed to pass 11 appropriations bills for FY2003 leaving VA to make due with FY2002 appropriation levels, going on 4 months now, while at the same time health care inflationary costs have soared consuming an astounding 14.1 percent of the Gross Domestic Product.

Where do we go next? If we are to have a system that could potentially allow VA to meet actual demand for services versus tailoring services to meet the budget then we must consider alternative funding formulas. This is why we have joined forces with the American Legion and Disabled American Veterans, along with numerous other veterans and military organizations, to secure passage of legislation that would guarantee mandatory funding for all enrolled users of the VA health care system.

We thank the Chairman and the Ranking Member for introducing legislation that would've accomplished this goal last Congress and we are hopeful that such legislation will be reintroduced in this Congress, where it will once again enjoy our full support. The need for a public debate on the future of VA health care is now.

Along with the alternative source of mandatory funding, we have long supported the enactment of Medicare Reimbursement. We applaud the VA Secretary and the Secretary of Health and Human Services for their groundbreaking initiative to establish a new program that will allow Category 8 veterans who are Medicare eligible to join a "VA Plus Choice Medicare" plan. We view this as a step in the right direction and are anxious for the expansion of this program to include all priority categories of Medicare-eligible veterans. Interestingly enough, Medicare Reimbursement was supposed to be instituted at the same time as eligibility reform.

With or without adequate appropriations, VHA should continue to incorporate best medical practices across *all* Veterans Integrated Service Networks, thus ensuring uniform implementation, something the current management structure does not promote. There are many programs and initiatives that merit consideration. They range from VA-DOD sharing to

expanded roles for VA clinical pharmacy specialists (Pharm. D's) in the monitoring, overseeing and prescribing of drugs. We would also advocate the adoption of Chronic Disease Management. Coordinating this type of aggressive medical outreach in tandem with preventative care will ultimately afford the delivery of excellence in health care to our nation's veterans as well as enhance their health and longevity.

To conclude, current funding formulas have been proven inadequate to provide the capacity that is needed to meet current demand for VA health care. The manifest health care needs of millions of veterans depend upon the Nation's courage to adopt and stick to the policies that will produce the optimal results over the long run. Unequivocally, the Veterans of Foreign Wars possesses a long held conviction and aspiration that no veteran should be denied medical treatment he or she is eligible for because of lack of funding.

Mr. Chairman, once again, I thank you for the opportunity to present our views and I will be happy to answer any questions you or the members of the committee may have.

STATEMENT OF
PETER S. GAYTAN, PRINCIPAL DEPUTY DIRECTOR
VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE DEPARTMENT OF VETERANS AFFAIRS
HEALTH CARE SYSTEM'S
CAPACITY TO MEET CURRENT DEMAND

JANUARY 29, 2003

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to express The American Legion's views on the Department of Veterans Affairs' (VA) health care system's capacity to meet the growing demand for health care. This hearing could not have been scheduled at a better time as veterans are being forced to wait in excess of a year to obtain an appointment to receive care within the VA health care system and the VA Secretary has been forced to terminate enrollment of new Priority Group 8 veterans. As it stands now the backlog is estimated to be between 236,000 – 300,000 veterans.

VA HEALTH CARE

The American Legion recognizes the Veterans Health Administration (VHA) as a national resource. Over the years, Congress has invested a great deal of time and effort to establish an integrated health care delivery network to care for America's veterans. VHA's primary missions are to serve the health care needs of the nation's veterans; medical research, medical education, and contingency backup to the Department of Defense's (DoD) medical service and the National Disaster Medical System. Today, there are nearly 24.5 million veterans. As more choose to use VA as their primary health care provider (over 7 million veterans enrolled or waiting to enroll), the strain on the system continues to grow.

The American Legion fully supported the enactment of Public Law (P.L.) 104-262 that authorized eligibility reform and opened enrollment in the VA health care system within existing appropriations. Until enactment of this law, many veterans were unable to receive VA health care. Veterans recognize that VHA provides affordable, quality health care.

Several other reasons influencing veterans to seek health care from VA:

- its holistic approach to health care;
- its full continuum of care, to include specialized services;
- its medical and prosthetics research;
- its affiliation with over 100 medical schools;

- its renown patient safety record;
- its pharmacy program;
- its numerous health care facilities; and
- its camaraderie atmosphere.

FY 2002 saw the astronomical growth of Priority Group 7 veterans seeking health care at their local VA medical facility and the creation of a new Priority Group 8. This unparalleled increase in enrollees into the VA health care system has resulted in 236,000 - 300,000 veterans currently waiting for medical appointments, half of which are waiting 6 months or more for an appointment.

Timely access to quality health care is a continuing struggle for veterans seeking care throughout VHA. Continued budgetary shortfalls, combined with rising medical care costs, limited number of health care professionals, and increased demand for care have resulted in unprecedented waiting times. VA estimates that there will be 4.9 million unique patients in FY 2003, versus the 3.7 million veterans projected only one year ago for FY 2002--a 31.5% increase overall. Of significance is VA's projection that while its patient population is projected to decrease, VA's number of enrollees and unique patients are projected to exceed 8 million and nearly 6 million, respectively, by 2012. Those numbers alone indicate that not only is the current system not equipped to handle the recent increase in workload, but also the health care system of the future must be shaped to adequately meet the anticipated increase of demands that will most certainly be placed upon it.

Concomitant to the real and projected growth of patient demand for health care is the continuing critical shortage of health care professionals available to treat veterans. At the top of this list are specialty doctors, psychologists, nurses and nursing personnel. The crisis of the nursing shortage is so critical that the National Commission on VA Nursing was recently chartered to address the ongoing recruitment and retention issues. The American Legion supports active recruitment of health care professionals, especially nurses, into the VA health care system.

In order for more veterans to access VA health care, additional revenue streams must be generated to supplement (not offset) annual discretionary appropriations. Annual discretionary appropriations for medical care are primarily designed to provide funding for the care of veterans assigned to Priority Groups 1-6, medical and support personnel, research, medical affiliations, its infrastructure and capital assets. The annual discretionary appropriations are distributed to Veterans Integrated Service Networks (VISN) via the Veterans Equitable Resource Allocation (VERA) formula which takes into account numerous factors; however, ***neither*** the number of enrolled Priority Group 7-8 veterans ***nor*** Medicare-eligible veterans is considered in that formula. There is no established VERA-like formula for the distribution of discretionary within the VISN to each VA medical facility.

Currently, VA is authorized to bill and collect copayments, deductibles, and third-party reimbursements, except from the nation's largest public insurance program -- Medicare. While this provides VA with much needed additional resources; these funds are unjustly scored as an offset to annual discretionary appropriations. This offset is detrimental to the overall VHA

budget because the amounts actually collected consistently fall well-short of budgetary projections. When VA does not meet its projected collection goals, the health care system experiences a budgetary shortfall, which results in limited health care services and timeliness of access for veterans seeking care. Third-party reimbursements for the treatment of nonservice-connected medical conditions of enrolled veterans primarily come from private health insurance providers. VA's collection rate of copayments far exceeds its collection rate of third-party reimbursement, especially since Medicare – the health insurance provider of most enrolled veterans – is billed, but does not have to pay for the treatment of nonservice-connected medical conditions.

PROBLEMS FACED BY VETERANS SEEKING HEALTH CARE

Backlog and Waiting Times - During the congressional hearing last September, The American Legion's National Commander,. Ron Conley promised you and your colleagues he would be visiting VA medical facilities across the country. Over the last four months, National Commander Conley has visited over 25 facilities in 17 different states. So far, in the aggregate, he has found that veterans are waiting anywhere from 4 months to well over a year in some places for medical appointments. Additionally, it is very evident, from the data in surveys each facility was asked to complete, the wait times and backlog numbers are not getting any better, but rather worse. The American Legion is outraged by the unacceptable number of veterans waiting months to be treated at a VA medical facility. Clearly, VA is not meeting its own acceptable access standards.

As a result of the growing number of complaints about lengthy waits for initial doctor visits at VA medical facilities across the nation, The American Legion has launched a national program to gather personal stories about these complaints. The American Legion has launched the ***I am Not a Number*** national campaign in an effort to help lawmakers understand that behind the statistics are real veterans who need help. National Commander Conley plans to make a full report of his findings and the results of this unique, community-based campaign in the near future.

The brave men and women who are currently deployed to far off regions of the world in support of the war on terrorism must be assured that the VA health care system is capable of serving their needs when they turn to VA for care. The willingness to commit American service members to war must be tempered with a willingness to treat the wounds that result from their service.

Suspension of Category 8 Veteran Enrollment – VA Secretary Principi recently announced his decision to suspend enrollment of new Category 8 veterans. This was done in an effort to decrease the backlog of veterans waiting for health care and to ensure VA has the capacity to care for veterans in Priority Groups 1-6. Category 8 veterans are those veterans whose incomes exceed $24,644 in 2003 for a single veteran and $29,576 for a veteran with a single dependent and that also exceed a geographically based income threshold set by the Department of Housing and Urban Development (HUD) for public housing benefits. The American Legion disagrees with the recent decision. We believe denying veterans access to VA health care, particularly while young men and women fight the war on terrorism and prepare to do battle in Iraq, is unacceptable. By denying health care to Priority Group 8 veterans, VA is sending the message that these veterans are not welcomed, even if they have private health

insurance coverage that VA can bill for the cost of their medical treatment. This decision will exclude enrollment of new service-connected disabled veterans in Priority Group 8. These service-connected disabled veterans can receive treatment of their service-connected medical condition, but cannot receive treatment of any nonservice-connected medical condition. They will also be barred from using VA's pharmacy, except for medications for their service-connected medical condition.

While The American Legion agrees that budgetary shortfalls have led to the extreme backlog of veterans awaiting care from VA, we believe that rationing health care to America's veterans is not the best approach. Instead of squeezing the VA health care system to meet the budget, The American Legion believes the budget should be adjusted to meet the rising medical demand of ***ALL*** enrolled veterans. If the budget can be adjusted to meet this nation's war-fighting capabilities, it can surely be increased to meet the health care needs of its warriors – past, present, and future. The American Legion believes the true cost of freedom is best reflected in the cost of caring for America's freedom fighters.

Capital Asset Realignment for Enhanced Services (CARES) - The CARES program was developed in response to a March 1999 General Accounting Office (GAO) report that concluded VA could significantly save money by conducting an efficient utilization analysis of every building within VHA's infrastructure. VA initiated CARES with the goal of enhancing current and future health care services to veterans by realigning its capital assets.

The initial pilot study conducted in VISN 12 raised many concerns. The American Legion questioned the planning assumptions and the lack of involvement of veterans' service organizations. Because of disgruntled stakeholders' outcry over the pilot study and the way it was conducted, VA has undergone a restructuring of the process. Even with the restructuring of the process, The American Legion remains concerned that CARES may result in the reduction of VA expenditures under the pretext of cost-savings without regard to the needs of the patient population. Once VA capital assets are disposed of, it is nearly impossible to recoup similar assets.

Currently, Step 4 of Phase II is underway and the Market Plans are being developed by each of the remaining 20 VISNs. But inaccurate projections for enrollment and utilization in the areas of outpatient mental health, as well as future long-term and domiciliary care have resulted in those critical issues being excluded from the market plan development process. Outpatient mental health projections are currently being recalculated and will be added to the process by early February; however, VISNs are already developing their individual Market Plans. VA cannot possibly properly plan for the future needs of veterans without thoroughly considering and including such critical information. At this stage of the process excluding long-term care and domiciliary needs altogether is inefficient and only reinforces the concern that the ***Enhanced Services*** of the patient population are not truly the top priority of CARES.

The American Legion believes that many of the current underutilized or unused spaces in VHA facilities are the result of decisions that were budget-driven rather than demand-driven. Due to limited funding and a focused effort to achieve maximum efficiencies, VHA facilities

have concentrated on reducing their expenditures to meet their budget constraints rather than the growing demand for services by:

- Reducing the number of inpatient beds to include acute hospital care, subacute care, rehabilitative care, psychiatric care, nursing home care, and residential care;
- Allowing the waiting period for appointments to exceed universally acceptable access standards rather than hiring additional health care personnel;
- Contracting out services without regard to quality of care;
- Consolidating of services in regions regardless of distance patients and their families must travel for care; and
- Changing treatment philosophy, such as inpatient versus outpatient care of psychiatric patients.

While these reductions have created a lot of empty buildings previously used to meet the health care needs of its patient population, The American Legion believes there are many effective approaches to handling unused or underutilized facilities:

- P. L. 106-117, the Veterans Millennium Health Care and Benefits Act, mandates VHA to provide long-term care to service-connected veterans rated 70 percent and higher and those veterans with service-connected conditions that require long-term care. VHA has yet to fulfill the requirements of this law. As previously mentioned, long-term and domiciliary care are currently not included in CARES.
- DoD and VA could use these facilities in an effort to integrate their health care services through additional sharing agreements and joint venture opportunities. There are Reserve and National Guard medical units across the country that could use these facilities to meet their training requirements and storage of medical equipment and supplies.
- VA's medical education programs provide excellent training opportunities for health care professionals, many are full-time students living on fixed incomes and in need of affordable housing. Serious consideration should be given to renovations of unused or underutilized facilities to provide on-campus lodging for health care professional students or academic training facilities, such as, labs, classrooms, or research centers.
- Homeland Security requirements will begin at the grassroots level and many VHA capital assets may serve local, state and national needs in its role as a contingency back-up to DoD medical services and the National Disaster Medical System (NDMS) during national emergencies. However, it has been clearly stated by key personnel in the CARES process that the current Market Plan development process makes no allowance for VA's contingency role.

The American Legion is very concerned that CARES will result in the further limiting of veterans' services. We believe that any CARES recommendations should be considered in the context of a fully utilized VA health care delivery system that takes into consideration VA/DoD sharing, the Veterans Millennium Health Care and Benefit Act, VA's medical education program, and Homeland Security.

THE AMERICAN LEGION RECOMMENDATIONS

Mandatory Spending - Funding for VA health care currently falls under discretionary spending within the Federal budget. Under the rules of discretionary spending the VA health

care budget competes with other agencies and programs for limited Federal dollars each year. Unlike Medicare beneficiaries or Social Security recipients, the funding requirements of health care for service-connected disabled veterans are not guaranteed under discretionary spending. VA's ability to treat veterans with service-connected injuries is solely dependent upon congressional approved discretionary funding each year.

Under mandatory spending, however, VA health care will be provided funding by law for all enrollees who meet the eligibility requirements. Making funding for veterans health care mandatory and not discretionary would guarantee yearly appropriations for the earned health care entitlement of enrolled veterans, especially those with severely disabled, service-connected veterans.

Last Congress, Mr. Chairman, you and many of your colleagues supported H.R. 5250, the *Veterans Health Care Funding Guarantee Act* in an attempt to improve funding for VA health care. In the other body, Senator Johnson (SD) introduced a companion bill. This legislation would change VA health care from discretionary spending to mandatory spending by establishing a base funding year and calculating the average cost of a veteran using the VA health care system. Funding would then be provided based on the total number of veterans who participate in the VA health care system. That number would be indexed annually for inflation.

The American Legion believes it is disingenuous for the government to promise timely access to quality health care to veterans and then make it unattainable because of inadequate funding. Rationed health care is no way to honor America's obligation to the brave men and women who have, and continue to unselfishly put the nation's priorities in above of their own needs. Mandatory funding for VA health care will help ensure timely access to quality health care for America's veterans.

GI Bill of Health (GIBOH)- The American Legion introduced the GIBOH as a blue print for the future of VA health care. For over a decade, The American Legion has advocated for the underlying concept of the GIBOH which is to provide access to VHA for all eligible veterans either through government-funded care or through a combination of other funding streams to include, public and private health insurance. While many changes have occurred over the past several years, two major components of the GIBOH, Medicare reimbursement and premium-based health benefits packages remain. We believe enactment of these components would strengthen VA's fiscal stability and ultimately benefit the veterans' community.

Medicare Reimbursement – Under current law, VA is prohibited by Federal statute from billing the country's largest Federally mandated, pre-paid health insurance provider – Medicare. Over half of the enrolled veterans seeking health care services in VA list Medicare as their primary health insurance provider. Others list health maintenance organizations (HMO) that traditionally refuse to reimburse VA for treatment of their health care beneficiaries. Others list preferred providers organizations (PPO); however, VA is not listed as a preferred provider – therefore, cannot be reimbursed for care. Finally, many veterans list no private health care coverage at all.

The American Legion urges Congress to authorize VA to bill, collect, and retain third-party reimbursements from the Centers for Medicare and Medicaid Services (CMS) for treatment of Medicare-allowable, nonservice-connected medical conditions of Medicare-eligible veterans. Since Medicare is a Federally mandated, pre-paid health insurance program, The American Legion believes Medicare-eligible veterans should be allowed to choose their health care provider. If VA is an enrolled, Medicare-eligible veteran's health care provider of choice, then VA should be reimbursed for providing quality health care services.

Secretary Principi recently announced a plan to implement a Medicare reimbursement program based on the Medicare+Choice model, called VA+Choice. Under this model, Medicare-eligible veterans could purchase Part B coverage and choose to only seek health care within VHA. In return, CMS would reimburse VA provided Medicare access standards were met for its beneficiaries. Needless to say, The American Legion is waiting for further information on the details of this agreement between CMS and VA. The American Legion is deeply concerned since Medicare+Choice's reputation in both the public and private section is not very flattering. Many private health care plans that initially participated in Medicare+Choice now refuse to participate because on unacceptable reimbursement rates. DoD's TRICARE Senior Prime program was also based on the Medicare+Choice model and proved to be a fiscal disaster for DoD after TRICARE for Life was enacted. The American Legion believes VA+Choice could be successful provided the reimbursement rate is acceptable and there is no maintenance of effort (or level of effort) that plagued TRICARE Senior Prime. VA health care is not based on age, but rather solely on military service.

Premium-Based Health Care Plan – Ten years ago, the rules governing the type of health care services a veteran would expect to receive were very complex and confusing. The GIBOH recommended VA offer a Basic Health Benefits Package, a Complex Health Benefits Package, and Specialized Services Health Benefits Package. Each Health Benefits Package would be premium-based. Veterans rated 50 percent service-connected disabled or higher would receive the Complex Health Benefits Package and the Specialized Services Health Benefits Package at no cost to the veteran. CHAMPVA eligible dependents would receive the Basic Health Benefits Package and any Specialized Services need to meet service-connected disability needs at no cost to the dependent. Veterans rated less than 50 percent service-connected disabled would receive the Basic Health Benefits Package, but could purchase the Complex Health Benefits Package or Specialized Services Health Benefits Package on a discounted premium-basis based on the degree of disability. Economically indigent veterans would receive the Basic Health Benefits Package and Specialized Services Health Benefits Package at no cost to the veteran.

All other enrolled veterans would use their private health insurance coverage or select and purchase the VA health benefits package that would meet their individual health care needs. This coverage would have complete portability and would not change based on employer or medical condition. The cost of the coverage would probably increase, based on inflation, but would be comparable with private health insurance premiums.

CONCLUSION

Since its founding in 1919, The American Legion embraces former President Lincoln's closing remarks in his Second Inaugural Address: ***With malice toward none, with charity for all, with firmness in the right as God gives us to see the right, let us strive on to finish the work we are in, to bind up the nation's wounds, to care for him who shall have borne the battle and for his widow and his orphan – to do all which may achieve and cherish a just and lasting peace among ourselves and with all nations.***

Mr. Chairman, achieving ***a just and lasting peace*** is the real cost of freedom. That cost includes maintaining a strong national defense, but it also includes maintaining veterans' cemeteries; veterans' compensation, retirement, and pension benefits; and timely access to quality health care for those veterans in need. The old adage – *actions speak louder than words* – is as true today as it was in 1776. The actions of the members of the Armed Forces of the United States have repeatedly spoken louder than words. That service was required personal sacrifice by a select group of Americans that accepted more than the basic obligations of citizenship to protect and defend freedom – at home and abroad.

The American Legion once again thanks the Committee for the opportunity to present its assessments and solutions concerning VA's health care system's capacity to meet the current demand for health care. We look forward to working with the Committee this year on this very important issue.

Mr. Chairman and Members of the Committee, that concludes my testimony. Thank you.

STATEMENT OF
JOSEPH A. VIOLANTE
NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
JANUARY 29, 2003

Mr. Chairman and Members of the Committee:

We appreciate the opportunity to testify today about the Department of Veterans Affairs (VA) health care system's capacity to meet the current demand for health care. Timely access to VA health care is, of course, a matter of paramount importance to the nearly 1.3 million members of the Disabled American Veterans (DAV) and its Auxiliary. As an organization made up of wartime service-connected disabled veterans, the DAV is especially concerned about maintaining a stable and viable health care system to meet the unique medical needs of our nation's veterans now and in the future. The effectiveness of all veterans' programs, including VA health care, is dependent upon sufficient funding for the available benefits and services, and resources adequate to allow for their timely delivery.

Many of our nation's 2.3 million disabled veterans need and rely on the VA health care system for treatment of their service-connected conditions. However, today we are not meeting our promises to our veterans. As a result of perennially inadequate health care budgets, VA is no longer able to provide timely access to quality health care. Pressures on the VA health care system have escalated to a critical point that can no longer be ignored.

We have often stated that through their extraordinary sacrifices and contributions, veterans have *earned* the right to free health care as a continuing cost of national defense. However, veterans' health care remains a discretionary program, and each year funding levels must be determined through an annual appropriations bill. Year after year, DAV, along with the other *Independent Budget* organizations and veterans service organizations, has fought for sufficient funding for VA health care and a budget that is reflective of the rising cost of health care and increasing need for medical services. Unfortunately, despite our continued efforts, the cumulative effects of insufficient health care funding have now resulted in the severe rationing of medical care. We adamantly believe America's citizens, as beneficiaries of veterans' service and sacrifice, want the government to fully honor its moral obligation to provide quality and timely health care services to wartime service-connected disabled veterans.

The Veterans Health Administration (VHA) is the largest health care delivery system in the United States, providing care to more than 4 million veterans at more than 1,300 sites. Following enactment of Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996, a standardized Medical Benefits Package became available to all enrolled veterans. Since that time, VA has transformed itself into a world-class health care system and proven it is a treasure worth preserving. VHA serves as the primary back-up to the Department of Defense

and National Medical Systems in times of national emergency and is a leader in research and health professions education. Nearly one-half of the physicians in the United States have received all or part of their training through VA.

Most importantly, the veterans' health care system acts as a safety net for service-connected disabled and low income veterans and is a provider of a wide range of specialized services not readily available in the private sector, tailored to meet the unique needs of veterans, including: spinal cord injury medicine; blind rehabilitation; prosthetics; treatment for post traumatic stress disorder and traumatic brain injury; and extended mental health and long-term care programs. VA also provides comprehensive programs for the chronically mentally ill, the homeless, and veterans with AIDS-related disorders and hepatitis C. VA has set standards for safety, quality, and efficiency and is also the nation's leader in geriatric research, education and training. Major medical breakthroughs pioneered by VA have benefited millions of Americans.

Studies have shown that VA provides more cost-effective care than in comparable private sector health care. Without VA millions of veterans would be forced to rely on Medicare and Medicaid at substantially greater federal and state expense. Additionally, private sector health care organizations would not likely want to enroll veteran patients who are typically older, poorer, more severely disabled, or chronically sicker than the average U.S. citizen. VA health care for veterans is a win-win situation. Veterans get excellent comprehensive health care services tailored to their needs, while society gets highly trained doctors and nurses, and the taxpayer pays a fraction of the market value for the expertise the academic affiliates bring to VA.

VA's success has led to unprecedented growth in the system. According to VA, the number of veterans using VA's health care system has risen dramatically in recent years, increasing from 2.9 million in 1995 to 4.5 million in 2002. An additional 600,000 veterans are projected to enroll in VA health care in 2003. However, VA reports resources do not meet the increased demand for services and that the system is unable to absorb this significant increase. With nearly 236,000 veterans currently on a waiting list, waiting at least six months or more for care, VA has now reached capacity at many health care facilities and closed enrollment to new patients at many hospitals and clinics. Additionally, VA has placed a moratorium on all marketing and outreach activities to veterans and determined there is a need to give the most severely service-connected disabled veterans a priority for care. Most recently, the Secretary announced his decision to cut off enrollment to veterans whose income exceeds geographically determined thresholds and are not already enrolled in the veterans' health care system. This plan will deny health care access to 164,000 veterans this year alone and is just one more example of the effects of chronic underfunding of the veterans' health care system.

Unfortunately, discretionary funding for VA health care has failed to keep pace with medical inflation and increased demand for medical care. As a result, VA has been forced to ration care, deny services to eligible veterans, and delay necessary modernization of facilities and purchasing of state-of-the-art medical equipment. According to the *Independent Budget*, in 1995, VA treated 2.9 million veterans with a workforce of 205,000. In 2002, 183,700 employees provided care for 4.5 million patients. Additionally, although significant increases in annual appropriations have been realized over the past several years, the VA buying power of those appropriated dollars is 9 percent less in 2002 than in 1984. The number of veterans served

continues to increase while the appropriated dollars per veteran are steadily decreasing and the buying power of each of those dollars plummets. To stop this trend and the rationing of care, Congress must make VA health care non-discretionary. Currently eligible veterans must be guaranteed provision of promised services.

This situation has also affected some of our nation's most severely disabled veterans. Over the last year, we have received a record number of calls from DAV members reporting they are unable to get the health care they need from VA in a timely manner. One member, a 100 percent service-connected disabled veteran, reported he was told by VA that he would remain on a waiting list for ten months before he would receive needed surgery for his service-connected back condition. In the meantime, the veteran indicated he was experiencing severe balance problems and incontinence. Unfortunately, these are the truths that face many of our nation's 2.3 million disabled veterans today.

Since the current crisis in the VA health care system has significantly hampered access to care for many totally disabled DAV members, we greatly appreciate the action taken by VA Secretary Principi to give our most severely disabled service-connected veterans priority for care. Although DAV fully supports priority access to care for service-connected disabled veterans, we see this as a short-term solution to a more complex funding problem. DAV strongly believes that VA must receive an adequate appropriation for health care so that all veterans eligible for care, including service-connected disabled veterans, will receive health care in a timely manner. Guaranteed VA health care funding is a more comprehensive solution to address the overall funding problem the VA health care system is facing and will end the long waiting times and backlog for care.

Mr. Chairman, on behalf of all DAV members, I want to thank you and Ranking Democrat Lane Evans, for your bold step in introducing the Veterans Health Care Funding Guarantee Act of 2002 last year, and for your exceptional leadership and advocacy on this issue. This legislation was strongly supported by all the major veterans service organizations, and also by the State Directors of Veterans Affairs. Additionally, many of the Commissioners on the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans have expressed strong support for guaranteed funding for VA health care, and the issue has been openly discussed as a possible Task Force recommendation.

We also thank all Committee members who cosponsored this important measure and fully support guaranteed funding for VA health care. We are pleased that the Veterans Health Care Funding Guarantee Act of 2003 (S. 50) was reintroduced in the Senate and are hopeful that similar legislation will be reintroduced in the House this session by the bipartisan leadership of this Committee.

Providing quality, timely health care services for veterans disabled as a result of military service should be a top priority for this Congress, this Administration, and the American people. In a time when more veterans are turning to VA for care, it is unconscionable that VA must reduce services, close enrollment and ration care due to insufficient funding. But the discretionary appropriations process continues to unfairly subject disabled and sick veterans to

the annual funding competition for limited discretionary resources. We urge Congress to do the right thing and change the current funding mechanism for VA health care.

Guaranteed veterans' health care funding would eliminate the year-to-year uncertainty about funding levels that have prevented the VA from being able to adequately plan for and meet the constantly growing number of veterans seeking treatment. We believe it is disingenuous for our government to promise health care to veterans, especially service-connected disabled veterans, and then to make it unattainable because of inadequate funding. Rationed health care is no way to honor America's obligation to the brave men and women who have so honorably served our nation and continue to carry the physical and mental scars of that service.

The Health Care Eligibility Reform Act of 1996 authorized eligible veterans access to VA health care and brought us closer to meeting our moral obligation as a nation to care for veterans and generously provide them the benefits and health care they rightfully deserve. With current pressures on the veterans' health care system, exacerbated by the failure to pass a fiscal year 2003 appropriations bill, some members of Congress and some veterans have begun to question the VA's ability to treat certain nonservice-connected veterans and the full impact of eligibility reform on the system. Before eligibility reform legislation, nonservice-connected veterans were treated in VA facilities. However, the prior eligibility criteria were poorly suited to sound medicine. A service-connected veteran could be denied less costly outpatient treatment for nonservice-connected high blood pressure, for example, but could be given more costly inpatient care for a stroke ensuing because the hypertension went untreated. This situation made no sense from either a medical or economic standpoint. In addition, if VA medical care was limited to treatment of service-connected veterans, the patient load would not justify a nationwide system of VA medical facilities dedicated solely to the care of veterans. Expanding the eligibility was designed to correct the inefficiencies of the system, treat more veterans, and preserve the system, primarily for service-connected veterans, low income veterans and veterans with special needs. That goal was, and still is, a sound one. The problem is not with eligibility reform, but with inadequate funding through the discretionary appropriations process. That is why DAV is seeking guaranteed funding for veterans' medical care, and why we were part of a Partnership of ten veterans organizations who called for guaranteed funding in the mid-90s, when we asked Congress to reform eligibility requirements and "reinvent" VA health care.

The law requires that the VA Secretary "shall" furnish hospital care and medical services, but only to the extent Congress has provided money to cover the costs of the care. Thus, the funding under the Federal budget for this program is "discretionary" meaning that it is within the discretion of Congress to determine how much money it will allocate each year for veterans' medical care. Because the level of funding to cover the costs of treating veterans is not guaranteed, VA is forced to ration medical care based on inadequate resources.

The shift to guaranteed funding would not create an individual entitlement to health care, nor would it change the VA's current mission. Only the way the funds are provided for VA health care would change under a guaranteed funding source as introduced by you, Mr. Chairman, in the last Congress, and currently reintroduced in the Senate this Congress, as S. 50. This measure is designed to ensure that the veterans' health care system has adequate resources to meet existing statutory obligations. Having a sufficient number of veterans in the health care

system is also critical to maintaining the viability of the veterans' health care system and sustaining it into the future. By including all veterans currently eligible and enrolled for care in the mandatory health care funding measure, we ensure a sufficient capacity level to sustain tertiary care expertise and an appropriate patient mix to support specialized programs. Ultimately, we protect the system formally dedicated to improving the health and well-being of our nation's service-connected disabled veterans, and ensure that it is there in the future for veterans currently fighting terrorism around the world.

A guaranteed funding program for veterans' health care would require a provision of benefits to all who meet the eligibility requirements of the law. The authorizing law for such a program mandates funding sufficient to cover the expenses of the program, and funding is not subject to varying discretionary levels in the budget each year. If veterans' health care were guaranteed, sufficient funding to treat all veterans who fell under its provisions would be required for so long as the authorizing law remained in effect. Veterans would not have to fight for sufficient funding in the budget process every year as they now do. It would also ensure that VA receives its new funding level on October 1, the first day of the new fiscal year, instead of being forced to operate under last year's spending level until Congress can pass an appropriations bill. Currently, VA is funded at last year's level until this Congress passes an appropriations bill in January or February of 2003. There is also a strong possibility that a 2.9 percent across-the-board cut will be enacted, creating a devastating reduction—about $700 million—in fiscal year 2003 funding levels for veterans' health care. Therefore, to avoid the uncertainties of the annual appropriations process, we are pressing for funding for veterans' health care to be guaranteed in permanent law.

We have only a few concerns regarding last year's legislation and the current Senate guaranteed VA health care funding measure. Initially, we want to ensure that the baseline formula in the measure, an amount equal to 120 percent of the amount obligated by the Department during fiscal year 2002, is not too low. It is imperative this baseline calculation is adequate since all subsequent calculations will be based on this initial figure. Therefore, it may be necessary to increase it to 130 percent or 135 percent to fully fund unmet demand for services. We also want to ensure that the provision in the bill authorizing an annual adjustment for medical inflation, based on the medical Consumer Price Index (CPI), is the best method for predicting annual inflationary health care costs to VA. Whatever method is used to determine projected inflationary medical care costs should cover increased cost of medical supplies, equipment, pharmaceuticals, mandated wage increases, and any other medical inflationary costs VA deems appropriate. Finally, we want to ensure that veterans seeking VA health care have reasonable waiting times for primary and specialty care appointments. Therefore, we suggest an added provision that requires that if funding under this Act proves insufficient to provide timely medical services to all eligible veterans during any fiscal year, the Department shall report to Congress any shortfall in funding and the reasons therefore. For the purposes of the added subsection, "timely care" means: 1) access to urgent care 24 hours a day; 2) scheduled appointment with primary care provider within 7 days for established patients; 3) scheduled appointment with primary care provider for new patients within 30 days; 4) appointment with a specialist within 30 days of referral; and 5) being seen within 30 minutes of a scheduled appointment.

It is hard to believe that our government "cannot afford" the funds required to rectify the problems we see today in the VA health care system. What could be more important than ensuring that those who have been disabled in service to this nation have timely access to medical treatment for their life-long disabilities?

It is only fair that Congress support America's veterans, especially at a time when we are asking new generations of men and women serving in our Armed Forces to protect the United States interests at home and abroad, maintain our security and freedoms, and fight the global war on terrorism. These men and women risk their lives daily and are clearly dedicated to fulfilling their commitment to this nation; likewise, Congress must demonstrate its full support and commitment to them. Think of this: A young American wounded in Central Asia today will still need the VA health care system in the year 2060. He or she will still need VA disability compensation and medical benefits. Although disability compensation payments are guaranteed under a mandatory program, access to needed VA health care services are not guaranteed. We have an obligation to ensure that these veterans have access to a stable, thriving health care system, dedicated to their needs, now and in the future.

Equally important is Congress' support for those who have previously served this nation. So many veterans sacrificed their health, their limbs, and mental well-being on our nation's behalf. We believe most Americans would agree they deserve a health care system dedicated to their needs. A comprehensive, world-class health care system that delivers quality, timely medical care services free of charge. None of us should forget the sacrifices made by these generations of veterans. That is why something must be done now to ensure VA is guaranteed sufficient resources so that it can deliver the specialized high quality health care to those who need it most.

But these days it is increasingly difficult to focus the attention of elected officials on the needs of our nation's veterans. And as the years go by, there will be far fewer veterans in our population to keep the memory of wartime sacrifice alive. Year after year, the DAV and our other veterans' service organizations have gone before Congress, asking the same question: "When will our nation remember its heroes with respect, dignity, and gratitude?"

Today, we are not meeting our promises to our veterans. VA has consistently received inadequate resources to meet the rising costs for health care and increased demand for health care services. As leaders on veterans' issues, we hope this Committee will remember the needs of America's veterans and take swift action to remedy this serious problem. This Committee knows best the enormous fiscal distress that VA is under. We hope that Congress is willing to make VA health care funding guaranteed and break the budget cycle that has decimated the veterans' health care system. Your action on this issue will determine what level of health care is available for veterans tomorrow. Our nation's sick and disabled veterans cannot wait any longer to receive the health care services they need and deserve.

Veterans feel they have been let down by their government and see the rationing of medical care as a broken promise at a time when they need VA health care more than ever before. Instead of a request for an adequate appropriation, there are continued recommendations to put more of the burden on veterans with increased copayments for medicine and medical care

and proposals to reduce veterans demand for services. Congressman Evans was right on point when in response to the Secretary's decision to limit enrollment for certain veterans he stated, "The problem isn't that veterans are seeking health care from their health care system—it's that the federal government is not making the resources available to address their needs." Sadly, these are symptoms of a society that, in some respects, has lost its way and many of its values. Are Congress and the Administration going to continue to ignore the health care needs of the millions of men and women who have so selflessly fought for this country and our democratic ideals—or are we going to keep our promises to veterans and make the necessary changes to remedy the intolerable situation veterans face?

Although veterans have felt let down by their government, the hopes of the entire veterans' community for a brighter future were rekindled when you, Mr. Chairman, and Mr. Evans took the bold step of introducing legislation to ensure better access to VA health care through a guaranteed funding source. We will forever be thankful to both of you for your advocacy on behalf of sick and disabled veterans.

In closing, we encourage you, Mr. Chairman, and Ranking Member Evans to reintroduce the Veterans Health Care Funding Guarantee Act. We ask for your continued leadership and unwavering support of this important issue. Once again we need strong leadership from the Committee to address the current workload and resource imbalance that exists in the veterans' health care system and to guide the department out of its existing crisis. There must be a bipartisan effort to fix veterans' health care funding this Congress. Guaranteed funding provides the most comprehensive solution to the current VA medical care funding problem. It would ensure the viability of the veterans' health care system and meet the needs of current and future service-connected disabled veterans. Therefore, it is imperative that funding for the veterans' health care system is guaranteed so that all service-connected disabled veterans, and all other enrolled veterans, have access to high quality health services in a timely manner.

This concludes my testimony on the state of VA health care. I appreciate the opportunity to present DAV's views, and I thank this Committee for its continuing support for this nation's service-connected disabled veterans.

STATEMENT FOR THE RECORD

PRESENTED BY

JOHN C. BOLLINGER

DEPUTY EXECUTIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

JANUARY 29, 2003

Mr. Chairman and members of the Committee, Paralyzed Veterans of America (PVA) appreciates this opportunity to present our views on VA's efforts to meet current health care demand and access challenges. PVA is the only national veterans service organization, chartered by Congress and recognized by the Department of Veterans Affairs, to represent and advocate on behalf of our members and all veterans. All of PVA's members, in each of the fifty states and Puerto Rico, are veterans with spinal cord injury or dysfunction. Because of the unique nature of these disabilities, and the highly specialized care provided through VA's network of spinal cord injury centers, up to 80 percent of PVA's members use VA for all or part of their care. This is a higher utilization rate than any other veterans service organization can claim. According to a recent study, VA spinal cord injury programs provide more acute, rehabilitative and sustaining services, with higher quality and lower cost than any comparable system in the world.

The VA health care system is praised by veterans and the medical community alike for making vast improvements in the quality, quantity, and efficiency of the services it provides. Because of this fact, and the rising cost and declining value of other federal and private health-care providers and insurers, VA has become a magnet, attracting record number of veterans enrolling in the system and presenting themselves for care.

In 1995, VA treated 2.7 million veterans with a workforce of 205,000. In 2002, 183,700 employees provided care for 4.5 million patients. Over six and one-half million veterans are enrolled in the VA health care system. That VA has been able to absorb this workload with wholly inadequate resources is a testament to the flexibility of management and the quality of VA's health-care providers. Clearly, however, the system is under great strain.

Over 230,000 enrolled veterans are currently waiting six months or longer for initial appointments. Many overburdened Veterans Integrated Service Networks (VISNs) have stopped enrolling veterans in certain categories altogether. Secretary Principi announced plans to curtail enrolment of Category 8 veterans affecting 160,000 potential enrollees this year alone. Surely these actions address the symptoms of the ongoing utilization crisis facing VA. But apart from the severe inconvenience these actions impose on thousands of veterans, they are certainly not reasonable solutions to the crisis in themselves. The problem is far greater than that. Simply curtailing access to the system will never solve the underlying and long-standing condition of chronic under-funding. The Congress or the Administration could stop all new enrollments in every category and those veterans who remain in the system would still be faced with a health care system that is constantly starved for resources.

PVA was saddened by the decision to curtail enrollment for new Category 8s. Still, that decision would have, at first glance, little impact on most PVA members. Under current enrollment regulations veterans who are classified as "catastrophically disabled" are eligible to enroll as Category 4, a currently protected classification. Certain PVA members, those with milder or early on-set spinal cord dysfunction, not meeting the definition of "catastrophic," could be affected by the decision. We hope to work with the Secretary to see that those who have a need for the specialized services only provided by VA could gain

entry into the system. On a second look, however, PVA members have not found a "safe haven" in the VA enrollment system seeking services. Those who gain entry into the system are at equal risk of losing access to services as those who are seeking care for the first time. Budget strains are affecting every aspect of health care the VA now provides.

This Committee and the Congress, over the years, have certainly recognized the threat to VA's expensive inpatient specialized services programs such as those provided in VA spinal cord injury centers. Rising costs, increasing demand and the shifting of resources from inpatient to outpatient programs had seriously eroded the ability to fund beds and staff in these centers. We greatly appreciate the efforts of this Committee in drafting statutory direction requiring VA to maintain the capacity of this core VA program. We have worked diligently with the Department of Veterans Affairs to help shape a directive that has gone out to the field setting specific capacity levels for beds and staff. We monitor and report on the capacity levels every month for each of VA's 21 acute and sustaining spinal cord injury centers and 4 spinal cord injury extended care facilities.

Statutory capacity language notwithstanding, VA has never met the capacity requirements defined in its own directive. The continuing budget shortfalls threaten the services provided in the centers for Category 1 enrolled veterans as they would for a Category 4 or Category 7. According to our more recent survey and report, as of December 31, 2002:

The directive calls for a "staff bed requirement" of 824 acute and sustaining beds in the system.

In December 2002 VA only had 747 staffed acute and sustaining beds.

As for staffing, the December report shows a deficit of 117 registered nurses below the capacity requirement. (A full copy of the "December 31, 2002 Survey of Spinal Cord Injury Center Beds is attached to this testimony.)

Under-funding is not a new threat to the system. It is a challenge this Committee, the Congress, the VA and the veterans service organizations struggle with every year. Because of the arcane and convoluted budget process for domestic discretionary accounts, funding issues preoccupy our attention twelve months out of every year. Preparing for this testimony I took a look back to see if there was ever a time when a "funding crisis" or "budget shortfall" for VA health care wasn't a cause for concern.

The Independent Budget (IB), annual budget and policy analysis, published annually by AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars is now in its seventeenth year. The Administration and the Congress have never met the IB recommendations that are determined on need-based formulas and annual projections for the costs of health care services. The VA "funding shortfall" has been, and still is, a major cause of concern for all of these years. In fact, 24 year ago, in 1979, the House and Senate Committees on Veterans' Affairs, held what was then called an "unprecedented" joint hearing to decry the seriously under-funded VA health care system and the impact this was having on the veteran population. I am certain the problem, whether it was under-funding or inconsistent funding, goes farther back than most of us can remember.

Fiscal Year 2002 is a classical example of the state we are in. The Congress approved FY 2002 funding levels that were higher than the Administration's proposal, but still inadequate to meet the projected demands on the system. The Secretary proposed and the Congress approved a $400 million supplemental appropriation last summer, but the Administration only allowed $140 million of

that to be applied. The Congress adjourned last Fall without approving a FY 2003 VA appropriation. The health care system has been limping along for the past 5 months at inadequate FY 2002 funding levels. The Senate, last week, voted for a version of the FY 2003 appropriation that, after across-the-board reductions, cut $700 million from the health care line item. If this proposal is allowed to stand in conference, that reduction equates to a loss of health care options for 240,000 currently enrolled veterans.

In 1993, when the Administration and the Congress were debating the future of a national health-care system, ten major veterans organizations, including PVA joined together to form "The Partnership for Veterans Health Care Reform." Our object was to make certain that if national reforms were to take place, the VA and veterans health care would be part of that solution. Among a list of recommendations we made at that time was to guarantee VA health care funding on an annual basis. Citing "chronic under-funding" The "Partnership" proposed the following solution.

"Guaranteed Funding: Funding must be guaranteed for the provision of a comprehensive benefit package to all eligible veterans who choose VA. Rationing must stop. Congress must make VA health care accounts non-discretionary, set at risk adjusted capitated rates that reimburse VA adequately for care provided. Unlike today's situation, currently eligible veterans must be guaranteed provision of promised services."

Mr. Chairman, those words were true ten years ago - they are even more so today.

Thank you for this opportunity to represent Paralyzed Veterans of America before the Committee. I will be happy to answer any questions you may have.

SCI Center Beds and Staff SURVEY

December 31, 2002

	Acute & Sustaining Care Facilities	BEDS Available Reqmt	BEDS Staffed Reqmt	BEDS Staffed Actual	NURSES Reqmt	NURSES Actual	MDs Reqmt	MDs Actual	SOCIAL WORKERS Reqmt	SOCIAL WORKERS Actual	PSYCHOL-OGISTS Reqmt	PSYCHOL-OGISTS Actual	THERAPISTS Reqmt	THERAPISTS Actual
1	Albuquerque	30	26	16.5	36.9	23.4	3.1	2.8	1.5	1.0	1.5	1.5	6	6.0
2	Augusta	60	55	50.6	78.1	71.9	6	6.0	3	3.5	3	3	12	12.6
3	West Rox	40	34	23.5	48.3	33.4	3.9	4.0	2	2.0	2	2	8	8.0
4	Bronx	62	53	51.8	75.3	73.6	5.8	5.6	3.1	3.0	3.1	3.1	12.4	7.5
5	Cleveland	38	32	22.7	45.4	32.3	3.7	4.5	1.9	2.2	1.9	1.9	7.6	6.0
6	Dallas	30	26	29.2	36.9	41.5	3.1	4.0	1.5	2.0	1.5	1.5	6	6.5
7	East Orange	14	12	13.0	17	18.5	1.7	2.0	0.7	0.9	0.7	0.5	2.8	2.5
8	Hines	68	58	57.9	82.4	82.2	6.3	6.3	3.4	3.6	3.4	3.4	13.6	13.0
9	Houston	40	34	27.8	48.3	39.4	3.9	4.0	2	2.0	2	2	8	7.0
10	Long Beach	85	72	59.1	102.2	83.9	7.7	7.0	4.3	4.3	4.3	3.8	17	14.0
11	Memphis	70	60	58.8	85.2	83.5	6.5	6.5	3.5	3.5	3.5	3.5	14	13.0
12	Miami	36	31	25.6	44	36.3	3.6	3.7	1.8	2.0	1.8	2	7.2	7.0
13	Milwaukee	38	32	32.4	45.4	46.0	3.7	3.7	1.9	2.0	1.9	2	7.6	7.6
14	Palo Alto	43	43	41.8	61.1	59.4	4.8	4.8	2.2	2.8	2.2	1	8.6	7.5
15	Richmond*	100	68	58.8	96.6	83.5	7.3	7.0	5	4.0	5	3.1	20	15.5
16	San Antonio	30	26	23.6	36.9	33.5	3.1	3.1	1.5	1.5	1.5	1.5	6	7.0
17	San Diego	30	26	18.1	36.9	25.7	3.1	1.5	1.5	1.5	1.5	1.38	6	9.0
18	San Juan	20	17	19.0	24.1	27.0	2.2	2.0	1	1.0	1	1	4	4.0
19	Seattle	38	32	27.3	45.4	38.8	3.7	4.2	1.9	2.0	1.9	2	7.6	10.3
20	St. Louis	32	27	26.5	38.3	37.7	3.2	3.2	1.6	1.6	1.6	1.6	6.4	6.4
21	Tampa	70	60	63.3	85.2	89.9	6.5	5.5	3	3.0	3	3	12	12.0
	SUBTOTAL	974	824	747.4	1169.9	1061.3	92.9	91.2	48.3	49.4	48.3	44.78	192.8	182.4

	Extended Care Facilities	BEDS Available Reqmt	BEDS Staffed Reqmt	BEDS Staffed Actual	NURSES Reqmt	NURSES Actual	MDs Reqmt	MDs Actual	SOCIAL WORKERS Reqmt	SOCIAL WORKERS Actual	PSYCHOL-OGISTS Reqmt	PSYCHOL-OGISTS Actual	THERAPISTS Reqmt	THERAPISTS Actual
1	Brockton	40	30	25.1	42.6	35.6	1.7	1.0	1	1.0	1	1	2.9	2.9
2	Castle Point	20	15	15.2	21.3	21.6	2	2.0	1	0.3	1	1	4	4.0
3	Hampton	64	50	50.6	71	71.9	2.5	2.5	1.6	1.5	1.6	1.5	4.6	6.0
4	Hines RCF	30	30	28.2	42.6	40.1	1.7	0.7	0.8	0.8	0.8	0.8	2.1	2.5
	SUBTOTAL	154	125	119.1	177.5	169.1	7.9	6.2	4.4	3.6	4.4	4.3	13.6	15.4
	TOTAL	1128	949	866.5	1347.4	1230.4	100.8	97.4	52.7	52.9	52.7	49.08	206.4	197.8

SYSTEM TOTALS	BEDS Available Reqmt	BEDS Staffed Reqmt	BEDS Staffed Actual	NURSES Reqmt	NURSES Actual	MDs Reqmt	MDs Actual	SOCIAL WORKERS Reqmt	SOCIAL WORKERS Actual	PSYCHOL-OGISTS Reqmt	PSYCHOL-OGISTS Actual	THERAPISTS Reqmt	THERAPISTS Actual
Acu/Sus Care	974	824	747.4	1169.9	1061.3	92.9	91.2	48.3	49.4	48.3	44.78	192.8	182.4
Extended Care	154	125	119.1	177.5	169.1	7.9	6.2	4.4	3.6	4.4	4.3	13.6	15.4
To be Identified	180	180											
Cleveland	10	10											
Memphis	20	20											
Menlo Park	10	10											
Miami NH	10	10											
Tampa	30	30											
TOTAL	1388	1209	866.5	1347.4	1230.4	100.8	97.4	52.7	52.9	52.7	49.08	206.4	197.8

DEFICITS	Staffed Bed *Deficit*	Nurse *Deficit*	MD *Deficit*	Social Worker *Deficit*	Psych-ologist *Deficit*	Ther-apist *Deficit*
Acu/Sus Care	76.6	108.6	1.7	-1.1	3.5	10.4
Extended Care	5.9	8.4	1.7	0.9	0.1	-1.8
Total	82.5	117.0	3.4	-0.2	3.62	8.6

**Includes 20 hoptel beds*

SCI Center Beds and Staff SURVEY

December 31, 2002

Acute & Sustaining Care Facilities	# of LIGHT DUTY NURSES	% of LIGHT DUTY NURSES	Inpatient CENSUS	(Inpatients/ Staffed Beds) LOAD FACTOR	RNs	% of RNs
1 Albuquerque	0	0%	16	97%	10.4	44%
2 Augusta	3	4%	45	89%	31.5	44%
3 West Rox	2	6%	20	85%	14.8	44%
4 Bronx	1	1%	52	100%	18	24%
5 Cleveland	2	6%	17	75%	10.7	33%
6 Dallas	0	0%	17	58%	10.4	25%
7 East Orange	0	0%	9	69%	7	38%
8 Hines	0	0%	41	71%	39.4	48%
9 Houston	0	0%	21	76%	18	46%
10 Long Beach	7	8%	45	76%	25	30%
11 Memphis	2	2%	58	99%	27	32%
12 Miami	0	0%	28	110%	14	39%
13 Milwaukee	2	4%	19	59%	16.1	35%
14 Palo Alto	7.8	13%	30	72%	25.6	43%
15 Richmond*	5	6%	42	71%	20.4	24%
16 San Antonio	5	15%	19	81%	13	39%
17 San Diego	1	4%	16	88%	14	54%
18 San Juan	1	4%	15	79%	11	41%
19 Seattle	0	0%	26	95%	19.2	49%
20 St. Louis	1	3%	25	94%	12.7	34%
21 Tampa	6	7%	38	60%	43.6	48%
SUBTOTAL	45.8	4%	599	80%	401.78	38%

Extended Care Facilities	# of LIGHT DUTY NURSES	% of LIGHT DUTY NURSES	Inpatient CENSUS	(Inpatients/ Staffed Beds) LOAD FACTOR	RNs	% of RNs
1 Brockton	1	3%	21	84%	10	28%
2 Castle Point	0	0%	12	79%	6.6	31%
3 Hampton	1	1%	56	111%	21	29%
4 Hines RCF	0	0%	28	99%	9	22%
SUBTOTAL	2	1%	117	98%	46.6	28%
TOTAL	47.8	4%	716	83%	448.38	36%

Can you
ignore
27 million Americans?
Recommendations of
The Partnership for Veterans Health Care Reform

27 million American Veterans didn't ignore you!

How To Reinvent Veterans Health Care:

Reform Eligibility:
Provide access to a full continuum of care and improve the efficiency of services for all currently eligible veterans.

Guarantee Funding:
Guarantee funding for the provision of health care services.

Retain Alternative Funding Sources:
Allow local facilities to retain third party reimbursements and Medicare payments.

Streamline VA Bureaucracy:
Decentralize VA management operations to improve efficiency, empower local managers and increase responsiveness to veterans' health needs. Deregulate contracting, resource sharing and personnel management functions.

Protect VA's Specialized Services:
Protect VA's specialized health programs which include spinal cord injury medicine, blind rehabilitation, advanced rehabilitation, prosthetics, amputee programs, post-traumatic stress disorder treatment, extended mental health and long-term care programs.

Advance VA's Unique Missions:
Preserve VA's role as a back-up to the Department of Defense in time of emergency; advance VA's leadership roles in award-winning research and health professions education.

THE PARTNERSHIP FOR VETERANS HEALTH CARE REFORM

The American Legion, AMVETS (American Veterans of WWII, Korea and Vietnam), Blinded Veterans Association, Disabled American Veterans, Jewish War Veterans of the USA, Military Order of the Purple Heart of the U.S.A., Inc., Non Commissioned Officers Association of the USA, Paralyzed Veterans of America, Veterans of Foreign Wars of the United States, Vietnam Veterans of America, Inc.

Why VA Health Care Facilities Are Important To You

HEALTH CARE PROVIDER:

The Department of Veterans Affairs (VA) is the nation's largest federal health care provider, encompassing 171 hospitals, scores of outpatient clinics, nursing homes, outreach centers and domiciliaries.

JOBS:

VA employs nearly 200,000 health care professionals and support staff in cities and communities across the United States.

HEALTH CARE SAFETY NET:

During the past six years, 4.8 million veterans (mostly service-connected disabled and low-income non-service-connected disabled) relied on VA for all or part of their health care.

SPECIALIZED CARE:

VA provides a wide range of specialized services not available in the private sector, tailored to meet the unique needs of veterans: spinal cord injury medicine, blind rehabilitation, amputee programs, advanced rehabilitation, prosthetics, post traumatic stress disorder treatment, extended mental health and long-term care programs.

COST-EFFECTIVE CARE:

Studies show that VA medical centers provide more cost-effective care than comparable private sector health care facilities.

SAVINGS FOR OTHER FEDERAL AND STATE PROGRAMS:

The acute and long-term care services VA provides subsidize Medicare and Medicaid programs at great savings to the Medicare Trust Fund and the state taxpayer.

SPECIAL MISSIONS:

VA supplies one-third of all care provided in the United States for the chronically mentally ill. VA is the largest source of health care for AIDS-related disorders. One-third of the nation's homeless are veterans, and VA has developed broad-reaching programs to address their psycho-social needs.

WHY VA HEALTH CARE FACILITIES ARE IMPORTANT TO YOU

LONG-TERM CARE:

VA is the nation's leader in geriatric research, education and training, providing long-term care for more than 100,000 veterans annually.

MEDICAL EDUCATION:

VA has affiliations with 126 medical schools. Nearly one-half of the physicians in the United States have received all or part of their training through VA. VA helps train over 100,000 health care professionals each year.

RESEARCH:

VA medical, prosthetic and health-services researchers have received two Nobel Prizes. Major breakthroughs pioneered by VA include the cardiac pacemaker, the CAT scan and the development of radio-immune assay techniques.

NATIONAL EMERGENCY BACKUP:

VA's health care facilities are a strategically located national resource. By statute, VA serves as a back-up to the Department of Defense and National Disaster Medical Systems in times of national emergency.

What's Wrong With The VA Health Care System?

PROBLEM:

Byzantine Eligibility Rules: Convoluted eligibility criteria create haphazard access to care. Some veterans receive care through expensive inpatient services but are denied more efficient outpatient and preventive care. A VA study has indicated that over 40 percent of inpatient treatment is "non-acute" and could be more efficiently and cost-effectively provided in alternative settings.

SOLUTION:

Basic Benefit Package: VA needs to offer a basic benefit package providing a full continuum of care to veterans who are currently eligible: service-connected disabled, low-income non-service-connected disabled, and special category veterans. Higher income, otherwise ineligible veterans should be permitted to choose VA by utilizing their own insurance, including Medicare.

PROBLEM:

Chronic Underfunding: Discretionary funding for VA health care has failed to keep pace with medical inflation and the changing needs of the veteran population. As a result, VA has been forced to ration care, deny services to eligible veterans, curtail needed medical treatment and forego the modernization of facilities and the purchase of necessary state-of-the-art medical equipment.

SOLUTION:

Guaranteed Funding: Funding must be guaranteed for the provision of a comprehensive benefit package to all eligible veterans who choose VA. Rationing must stop. Congress must make VA health care accounts non-discretionary, set at risk-adjusted capitated rates that reimburse VA adequately for care provided. Unlike today's situation, currently eligible veterans must be guaranteed provision of promised services.

PROBLEM:

VA Cannot Retain Third-Party Reimbursements: Unlike other health care providers, VA cannot retain funds recovered from third-party payers. Almost all payments VA receives from private health insurers must be remitted to the Department of the Treasury.

SOLUTION:

Retain Third-Party Reimbursements: VA must be allowed to retain third-party collections to increase its funding base and reduce its exclusive reliance upon federal appropriations. Appropriations must not be offset by amounts retained. VA must also be allowed to collect and retain premiums, copayments, deductibles and Medicare payments from high-income veterans and dependents. Dependent care would be provided only after all veteran demand had been met.

WHAT'S WRONG WITH THE VA HEALTH CARE SYSTEM?

PROBLEM:

Bureaucratic Inertia: The VA health care system is stymied under an inflexible, highly regulated, centrally controlled management system. By statute and regulation, individual VA medical centers cannot easily respond to procurement, hiring, contracting and marketing demands. They cannot streamline by adapting to local market pressures. The result is higher than necessary cost and diminished service.

SOLUTION:

Management Reform and System Reorganization: All health care is local. VA must allow its local directors to tailor their programs to meet state benefit packages and private sector management practices.

VA Health Care Myths and Realities

MYTH:

All 27 million veterans are eligible for free services at VA health care facilities.

REALITY:

VA care is severely restricted by convoluted eligibility criteria based on veteran status, income and degree of disability. Only veterans with service-connected disabilities, low-income veterans with non-service-connected conditions and others (World War I veterans, former prisoners of war, and veterans exposed to Agent Orange, ionizing radiation and toxic substances during the Gulf War) can receive care—and then only at certain levels based on eligibility status.

MYTH:

Veterans don't want VA to change.

REALITY:

Ten national veterans' service organizations representing 9 million veterans want comprehensive VA reform now. VA cannot survive and meet its congressionally mandated responsibilities to veterans if it cannot keep pace with today's health care revolution.

MYTH:

Veterans could get comparable service in the private sector if VA hospitals were closed.

REALITY:

The private sector would not want to enroll the typical VA patient who is often older, indigent, disabled or chronically ill. VA is the only practical option for most veterans who currently use the system. VA also provides services unmatched and largely unavailable in the private sector that meet the special needs of veterans: spinal cord injury medicine, blind rehabilitation, advanced rehabilitation, prosthetics, post traumatic stress disorder treatment, extended mental health and long-term care programs.

MYTH:

Veterans could be cared for at lower cost elsewhere.

REALITY:

Studies have shown VA medical centers provide more cost-effective care than comparable private sector health care facilities. Without VA, millions of veterans would be forced to rely on Medicare and Medicaid at substantially greater federal and state expense.

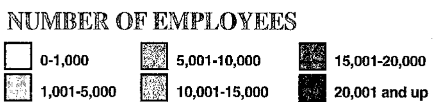
MYTH:

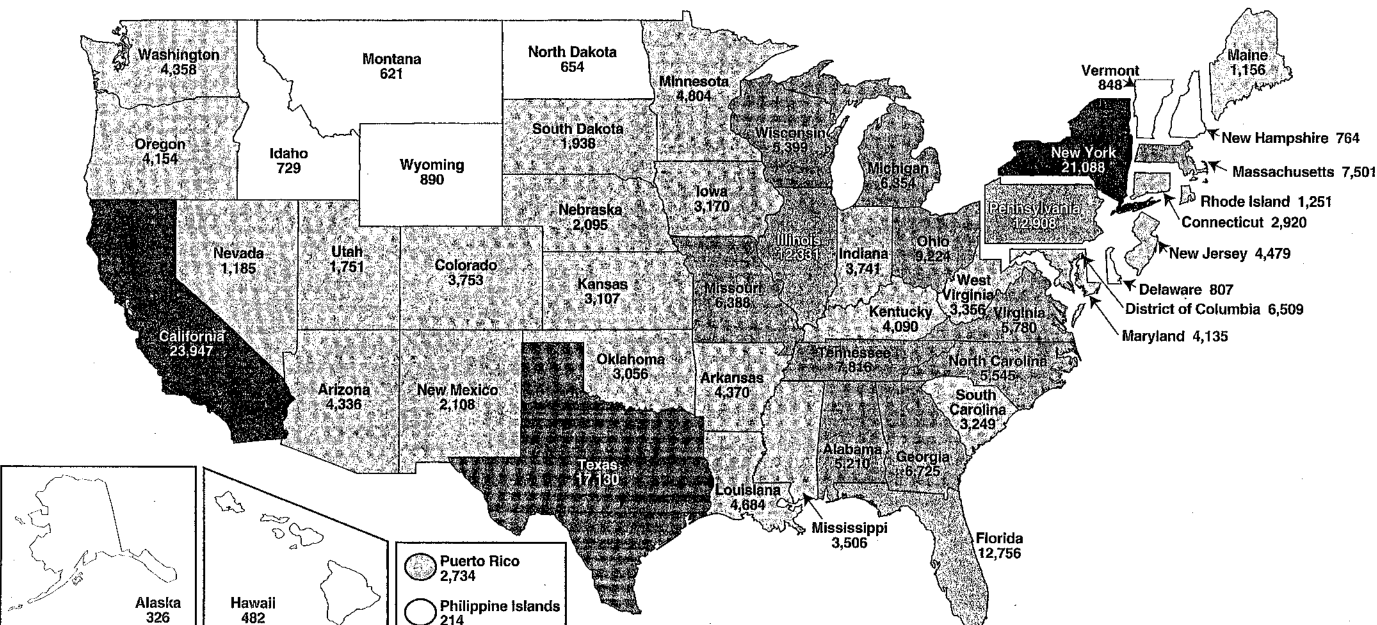
VA medical facilities provide poor quality care.

REALITY:

VA hospitals exceed the Joint Commission on Accreditation of Health Care Organizations' quality standards—the same standards that apply to private health care facilities. VA medical centers are affiliated with 126 medical schools and have access to the finest clinicians and researchers in the nation.

VA Employment by State (as of 9/30/94)





Geographic Distribution of VA Expenditures for Fiscal Year 1993
Summary of Expenditures by State

STATE	VETERANS POPULATION	TOTAL EXPENDITURES	COMPENSATION AND PENSION	READJUSTMENT BENEFITS AND VOCATIONAL REHABILITATION	INSURANCE AND INDEMNITIES	CONSTRUCTION AND RELATED COSTS	MEDICAL SERVICES AND ADMINISTRATION
Alabama	432,430	736,102,386	395,438,554	14,464,741	34,604,124	13,355,660	278,239,307
Alaska	65,901	107,805,714	39,910,000	2,598,000	2,686,909	2,122,502	60,488,303
Arizona	461,753	599,891,499	310,290,942	12,377,529	33,853,607	6,411,735	236,957,686
Arkansas	262,278	558,147,076	306,442,826	7,273,457	13,297,685	5,038,747	226,094,361
California	2,886,304	3,094,236,513	1,329,781,945	40,126,623	178,701,789	37,151,798	1,508,474,358
Colorado	394,280	478,437,833	253,008,138	13,844,648	26,955,927	3,921,558	180,707,562
Connecticut	352,598	358,013,289	137,161,403	4,774,041	29,827,315	3,597,029	182,653,501
Delaware	79,884	100,596,494	39,792,844	1,929,317	3,787,571	2,891,487	52,195,275
Dist. of Columbia	52,887	1,078,329,922	52,653,883	1,582,592	2,706,284	14,397,370	1,006,989,793
Florida	1,719,022	2,148,026,677	1,257,603,603	26,370,643	123,544,000	43,911,053	696,597,378
Georgia	689,354	913,923,938	536,747,518	15,606,142	5,061,054	32,075,213	324,434,011
Hawaii	117,033	130,574,495	65,790,61 6	3,294,435	10,540,972	1,886,262	49,062,210
Idaho	114,194	125,852,451	68,987,812	3,559,596	4,809,188	463,145	48,032,710
Illinois	1,108,893	1,281,595,803	409,526,818	15,014,394	77,405,483	17,432,689	762,216,419
Indiana	605,587	565,823,605	271,640,621	10,163,420	24,646,664	36,572,365	222,800,535
Iowa	299,808	379,893,609	150,128,200	7,022,468	26,279,055	2,726,404	193,737,482
Kansas	270,033	373,990,237	164,859,129	6,265,044	18,566,040	3,354,008	180,946,016
Kentucky	373,785	548,375,269	311,189,573	8,960,548	19,329,272	1,869,618	207,026,258
Louisiana	389,692	628,333,352	329,795,788	11,504,110	18,787,31 6	10,832,145	257,413,993
Maine	156,058	229,379,857	137,269,505	4,708,078	10,802,281	2,821,319	73,778,674
Maryland	541,819	578,548,583	271,542,173	9,631,077	42,335,461	7,265,016	247,774,856
Massachusetts	617,643	1,015,801,765	459,010,489	13,358,482	54,480,662	11,429,660	477,522,472
Michigan	972,707	951,928,795	432,229,343	11,797,464	54,997,877	81,842,910	371,061,201
Minnesota	473,674	567,339,896	247,520,079	11,153,232	34,539,673	2,729,293	271,397,619
Mississippi	236,691	496,594,904	265,676,842	6,414,031	16,710,427	2,773,694	205,019,910
Missouri	598,242	449,171,785	358,146,116	12,456,174	37,997,476	2,583,750	37,988,269
Montana	98,175	123,876,563	67,793,632	2,805,326	8,667,205	353,284	44,257,116
Nebraska	172,087	249,754,527	113,146,134	4,982,727	9,813,826	30,687	121,781,153
Nevada	184,820	189,771,067	99,156,323	4,290,789	8,590,243	2,083,146	75,650,566
New Hampshire	137,832	151,131,281	87,722,521	3,535,752	12,334,147	544,448	46,994,413
New Jersey	770,579	721,996,309	353,627,323	8,384,629	83,442,387	8,430,239	268,111,731
New Mexico	174,325	297,211,483	154,355,957	4,681,151	7,512,617	1,533,529	129,128,229
New York	1,602,073	2,300,709,513	894,291,699	18,703,719	142,959,353	30,004,371	1,214,750,371
North Carolina	716,599	947,935,547	559,408,558	17,454,808	33,918,330	7,603,152	329,550,699
North Dakota	61,399	86,698,196	38,519,865	2,866,231	4,115,065	803,417	40,393,618
Ohio	1,218,776	1,226,119,728	612,236,793	19,473,797	71,443,828	8,308,114	514,657,196
Oklahoma	359,981	623,553,042	401,498,942	13,602,350	18,528,896	13,625,489	176,297,365
Oregon	376,616	499,746,821	226,369,350	9,396,892	20,666,059	5,399,561	237,914,959
Pennsylvania	1,402,348	1,552,916,448	710,232,786	17,467,652	95,212,590	21,493,136	708,510,284
Rhode Island	112,924	160,019,272	79,032,737	2,261,352	8,466,591	2,180,843	68,077,749
South Carolina	381,794	490,336,752	282,948,440	10,610,218	21,650,541	2,401,427	172,726,126
South Dakota	75,588	178,295,655	61,908,077	3,797,492	3,789,156	957,327	107,843,603
Tennessee	524,060	887,814,901	412,175,549	10,856,058	25,776,305	10,933,470	428,073,519
Texas	1,676,292	2,440,286,707	1,331,620,179	38,225,320	101,590,169	30,177,135	938,673,904
Utah	142,287	222,317,259	81,639,547	6,079,213	10,700,498	9,920,242	113,977,759
Vermont	63,290	102,585,481	40,902,231	1,523,593	3,412,850	204,777	56,542,030
Virginia	715,309	921,222,561	515,573,945	18,955,632	53,441,747	6,386,558	326,864,679
Washington	640,160	724,419,498	390,053,545	17,197,688	40,452,366	9,247,297	267,468,602
West Virginia	204,798	424,031,479	182,244,435	4,436,687	12,774,105	13,246,094	211,330,158
Wisconsin	519,760	604,100,258	276,578,473	10,323,806	31,371,350	5,629,672	280,196,957
Wyoming	50,255	92,565,723	29,762,589	1,528,744	3,526,150	5,135,242	52,612,998
UNITED STATES TOTAL	**26,654,677**	**34,716,131,818**	**16,604,944,390**	**529,691,912**	**1,741,410,486**	**548,089,087**	**15,291,995,943**

GEOGRAPHIC DISTRIBUTION OF VA EXPENDITURES FOR FISCAL YEAR 1993

Categories of VA Expenditures

COMPENSATION AND PENSION

- veteran compensation for service-connected disability
- dependency and indemnity compensation for service-connected death
- non-service-connected disability pensions for surviving spouses and children
- burial expense allowances for veterans

READJUSTMENT AND VOCATIONAL REHABILITATION

- vocational rehabilitation for disabled veterans
- specially adapted housing for disabled veterans
- automobile and adaptive equipment for certain disabled veterans
- G.I. Bill and other educational assistance programs for certain veterans, dependents and survivors

INSURANCE AND INDEMNITIES

- death claims
- matured endowments
- dividends
- cash surrender payments
- total disability income provisions payments
- total and permanent disability benefits payments

CONSTRUCTION AND RELATED COSTS

- major and minor construction projects for all VA facilities utilized for health and benefit delivery systems

MEDICAL SERVICES AND ADMINISTRATIVE COSTS

- operational resources for the VA health care system, which include: medical care, medical administration, medical and prosthetic research and general operating expenses

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

Abraham Lincoln

The Partnership for Veterans Health Care Reform

Representing 9 Million American Veterans

The American Legion
1608 K Street, N.W.
Washington, DC 20006
(202) 861-2700

AMVETS (American Veterans of WWII, Korea and Vietnam)
4647 Forbes Blvd.
Lanham, MD 20706
(301) 459-9600

Blinded Veterans Association
477 H Street, N.W.
Washington, DC 20001
(202) 371-8880

Disabled American Veterans
807 Maine Avenue, S.W.
Washington, DC 20024
(202) 554-3506

Jewish War Veterans of the USA
1811 R Street, N.W.
Washington, DC 20009
(202) 265-6280

Military Order of the Purple Heart of the U.S.A., Inc.
5413-B Backlick Road
Springfield, VA 22151
(703) 642-5360

Non Commissioned Officers Association of the USA
225 N. Washington Street
Alexandria, VA 22314
(703) 549-0311

Paralyzed Veterans of America
801 Eighteenth Street, N.W.
Washington, DC 20006
(202) 872-1300

Veterans of Foreign Wars of the United States
200 Maryland Avenue, N.E.
Washington, DC 20002
(202) 543-2239

Vietnam Veterans of America, Inc.
1224 M Street, N.W.
Washington, DC 20005
(202) 628-2700

TESTIMONY

of

RICHARD JONES

AMVETS NATIONAL LEGISLATIVE DIRECTOR

before the

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

on

THE VA HEALTHCARE SYSTEM'S CAPACITY

TO MEET CURRENT DEMAND

Wednesday, January 29, 2003

10:00 A.M.

Room 334

Cannon House Office Building

MR. CHAIRMAN, RANKING MEMBER EVANS, AND MEMBERS OF THE COMMITTEE:

It is an honor to appear before you and the distinguished members of the Committee on Veterans' Affairs to examine the VA health care system's capacity to meet the current demand for health care. For the record, AMVETS has not received any federal grants or contracts during the current fiscal year or during the previous two years in relation to any of the subjects discussed today.

Mr. Chairman, at an earlier time in our history, one of our most revered leaders said, "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive the veterans of earlier wars were treated and appreciated by their nation."

Notwithstanding the observation of our First President, George Washington, for the past several years, vital VA healthcare programs keyed to assisting veterans have, in the main, received benign neglect. These trends deeply trouble AMVETS because we believe, like you, that a sacred commitment to those—both past and present—who wear this nation's uniform falls short of the honor our forebears intended.

The VA healthcare system is a unique and irreplaceable national investment, critical to the nation and its veterans. Access to high quality health care remains essential to veterans. In fact, many veterans consider health care to be one of the most important benefits they receive.

If we are to honor our obligation to the brave and dedicated men and women who have worn this nation's uniform, we should clearly understand their legacy – which is freedom. And, in this understanding, we must come to grips with the fact that freedom is not free. Its costs are measured in terms of lives lost and citizen soldiers who, together with their families, bear the scars and infirmities of their service throughout the remainder of their adult lives.

Mr. Chairman, the VA healthcare system's capacity to meet demand is in critical condition. AMVETS has reported over the years about chronic funding shortfalls that have resulted in denial, delay and rationing of veterans healthcare. Most would agree that this is not what our Nation intended as its "grateful" response to the millions of men and women who have defended, and continue to defend, freedom throughout the world.

Indeed, we do not believe these circumstances represent what you and your full committee have collectively fought for on behalf of veterans. AMVETS truly appreciates the support you have provided in your attempt to fund the Department of Veterans Affairs at the necessary levels to allow it to deliver the world-class services of which it is capable.

Last year, your Committee's bipartisan leadership led to a solid recommendation for funding the VA Medical Care system. Unfortunately overall appropriations for VA and nearly all discretionary funding programs fell fate to the turmoil of the last Congress and no appropriation was approved. As a result, there remain serious funding shortfalls in the system, which we hope can be responsibly addressed this year.

Few would suggest that VA's healthcare system is in good shape. As VA ended fiscal year 2002, over a quarter million veterans seeking healthcare were waiting more than six months for an appointment. The Secretary of VA forewarned of this situation when he said in November 2001 that the system required supplemental funding of over $400 million to meet demand and get through the year. Unfortunately, the Congress and Administration provided a little more than a third of that amount.

Today, as we discuss the condition of the VA healthcare system, funding for the current fiscal year remains stagnant. The VA has waited four months, funded at the already inadequate FY2002 level, for Congress to act on this year's funding. Yet, it is not in

place. Unless better things happen, the picture remains troubled. Last week, the Senate voted a devastating reduction in proposed VA funding for the current year. They recommended a 2.9 percent across-the-board cut in veterans health care. If allowed to go forward, it is estimated that a total of 400,000 veterans would be denied health care over the next nine months.

To further underscore the critical challenge facing VA's healthcare system, the administration dropped a bombshell on January 17 by announcing a policy to ban future access to the system for so-called "category eight" veterans who had not previously enrolled for care. Under the plan, the VA would change Abraham Lincoln's compassion "to care for him who shall have borne the battle," by adding the phrase, "at least for those enrolled in the system prior to January 17, 2003."

Veterans are told through a VA press release that the Department has no other alternative under consideration other than amputating future enrollment. VA indicates that every effort has been undertaken to implement management efficiencies that might partially offset increasing demand against resources. Further, according to VA, the option "to continue placing veterans on waiting lists" is unacceptable "as it negatively affects quality and timely patient care."

Earlier this year, VA implemented a policy aimed to ensure that severely disabled veterans receive prompt care. AMVETS gave its support. With nearly 265,000 veterans waiting for an appointment, granting priority in scheduling healthcare appointments for severely disabled veterans is the right thing to do. AMVETS continues, as always, to support the core mission of VA healthcare. But we are deeply troubled by the decision to ban access.

AMVETS fully supports the enactment of Public Law 104-262 that provided eligibility reform. Eligibility reform championed values that reflect our Nation's obligation to those who served in the Armed Forces.

Blocking access for a certain segment of veterans is not the answer. Recent demand for care is exceeding capacity, because VA is not addressing inadequate funding. Instead of discouraging veterans from seeking health care, AMVETS would like to see VA present a budget sufficient to cover its true costs.

Instead of directing VA healthcare workers to refer veterans in need of healthcare services who are not enrolled with VA to community Social Work for assistance, we'd rather see a grateful Nation treat them with the dignity they have earned. (VHA Directive 2003-003, January 17, 2003, 4(d))

VA is on the wrong road. Chronic under funding is the issue. Shortfalls in funding have made the system like a rubber band, stretched about as much as it can and ready to pop.

Some suggest that a partial solution, beyond adequate appropriations, would be to allow VA to accept Medicare payments for those veterans who are eligible and who wish to be treated in VA facilities. Frankly, a large majority of those seeking treatment for non-service-connected disabilities are Medicare eligible.

Another suggestion, supported by AMVETS, is to provide mandatory funding. This funding approach would give some certainty to healthcare services. VA facilities would not have to deal with discretionary funding, which has proven fickle and inconsistent.

In the last Congress, legislation to make funding for VA health care mandatory attracted substantial enthusiasm among members of Congress with 129 cosponsors, despite introduction of the bill at the end of the year.

AMVETS trusts identical legislation will be approved in this Congress. We believe mandatory funding of VA health care provides a comprehensive solution to the current funding problem. Once healthcare funding matches the actual average cost of care for the veterans enrolled in the system, with annual indexing for inflation, the VA can fulfill its mission.

Mr. Chairman, as we continue to move forward together in this new millennium, the sustained availability of quality health care is central to VA's mission. AMVETS calls on the Administration and Congress to provide the resources needed to care for America's veterans. We believe that adequate funding will remain central to VA's ability to sustain the timely delivery of quality health care to the men and women who have sacrificed and served in the military.

This concludes my testimony. Thank you for extending the opportunity to appear before you today and thank you for your support of veterans. We believe the price is not too great for the value received.

STATEMENT

of

Vietnam Veterans of America

Presented by

Dr. Linda Spoonster Schwartz
Chair, VVA Health Care Committee

Before the
House Committee on Veterans' Affairs

Regarding

The Department of Veterans Affairs health care system capacity to meet the current demand for health care

January 29, 2003

Vietnam Veterans of America **House Committee on Veterans Affairs**
January 29, 2003

Good morning, Mr. Chairman and other distinguished Members of this panel. I am Dr. Linda Spoonster Schwartz, chair of the National Health Care Committee of Vietnam Veterans of America (VVA). I also serve as a Research Scientist at the Yale School of Nursing. I am a disabled veteran and regularly use VA health care services.

I want to thank you, Mr. Chairman, for convening this very timely hearing on the issue of the U.S. Department of Veterans Affairs' capacity to provide quality consistent, and timely health care for America's veterans. This topic is of grave concern to VVA members and their families, and indeed all veterans who look to the VA as a source of health care. We believe the capacity to provide quality and appropriate health care is predicated upon adequate funding for this system. Therefore, it is not surprising that VVA's **number one Legislative Priority is adequate funding for veterans enrolled in the VA Health Care system. Of equal importance to VVA is the lack of accountability in the VA system.** There is overwhelming evidence that there has not been adequate funding for VA services and programs for quite some time. There is also ample evidence that the VA does not have adequate financial tracking systems, modern management information systems, or the means or track record of holding senior managers accountable for poor performance.

Background

Former VA Undersecretary for Veterans Health Kenneth Kizers' 1996 promise to overhaul VA healthcare set out in his "Prescription for Change" has not materialized. It is true that important changes in clinical care and the introduction of technology called for in the plan have improved and modernized the system. However, the massive savings that were envisioned then have come at the expense of America's veterans. It is important that members of this Committee who were not here when these plans to restructure were adopted know that veterans who lived through the experience feel as if this new crisis is a timewarp deja vu.

The original rush to enroll every veteran in the country was touted as a means of assuring better funding for VA Health Care. In 1995, veteran service organizations were sold a bill of goods. We were encouraged to spread the word to our members and every veteran we met to ENROLL! ENROLL! ENROLL! Push up the numbers. Demonstrate the depth of the market, the need for product lines and impress Congress with a projection of the demand for funding. This has become a numbers game in which each year the Secretary is required to determine if enough resources exist to serve all priority categories of veterans. Because funding allocated for VA Health Care is not based on the total number of veterans enrolled in the system, gross underestimation of health needs and patient requirements resulted. Misconceptions and misinformation about the realities of this process amounted to a cruel hoax.

Since 1996, VA reports that over 20,000 health care positions have been cut from VHA. At the same time, the number of eligible veterans using the system has increased by 1.4 million. Lack

of a consistent, reliable budget has obstructed VA's capacity to respond to the changing needs of the health care system, to efficiently grow, acquire competent personnel and maintain a viable service infrastructure for VHA. VVA enthusiastically joins other veteran service organizations and advocates in endorsing the need to upgrade VA Health Care from the discretionary funding category to the more binding commitment of the Mandatory Funding classification. This action is necessary to abate the annual funding frenzy that VHA faces as it attempts to balance its mission to protect and safeguard veterans in its care and keeping.

VVA also believes that whether funding is funded on the discretionary side of the ledger or on the mandatory side of the ledger, there must be adequate funding. That would mean a minimum of at least $28 billion (exclusive of co-payments and third-party collections) for veterans health care operations in FY 2004.

It is incumbent on the President, with troops in the field, to ask for these funds in the request that will be sent to Congress soon, as well as for at least $23.9 Billion that Congress had seemingly already all but approved some time ago for FY 2003. If Congress does not pass appropriations for FY 2003 soon, then it is incumbent on the President to ask for the difference between the continuing resolution currently in place and the $23.9 billion as an emergency appropriation that is needed virtually immediately.

Adequate Funding

Most Americans believe that health care for veterans is a government obligation to those men and women who stepped forward to defend freedom and this nation. At a time when our President is asking a new generation of Americans our sons and daughters to bear the burden of defending this country, we must keep faith with their dedication by making the commitment to assure that the funds to care for their injuries and disabilities is not relegated to a discretionary duty of the nation they have sworn to defend. Budgets are a reflection of the values and priorities of the administrators who design them and the legislators who approve them. What does discretionary funding for the care of men and women who defend this country say about America?

In addition to a change to the mandatory-funding category, VVA strongly recommendations that policies for increased accountability of the VA Senior Executive Staff (SES) be set in place. It is imperative that the traditional cycle of promoting, reinventing and retreading members of the SES leadership, who fail in their service or who pose a danger to veterans, not be retained in the system. This is a tradition within the bureaucracy of VA which paralyzes the ability of the system to respond to the needs of veterans and provide safe, quality, and timely health care.

Secretary Principi has instituted impressive programs to increase the efficiency of the system to offset demand. He inherited substantial problems of claims backlogs that were years in the making; insufficient Third Party Reimbursement cost recovery, and incredible waiting times for clinic appointments and unacceptable standards of care. He has been brave enough to

acknowledge that under the present conditions VA cannot be all things to all veterans. He has emphasized on improved access for high-priority core constituencies: veterans with service-connected disabilities, low income and special health care needs. Measures to increase quality and decrease waiting times are worthy goals that require tough management decisions.

Rising costs of pharmaceuticals has compelled Americans to seek out sources of relief from the crushing burden of maintaining their health through medication. By extending the opportunity of low co-pays for medications, VA set into motion a process that is sucking the system dry. While insurance and health care plans have decreased their coverage for medications, veterans have flocked to VA to avail themselves of a very attractive and low-cost access to prescriptive drugs. The requirement that a VA provider must see these new enrollees has drained the system and increased the backlogs of patients waiting to be seen. The effectiveness of the care of seriously disabled veterans has been compromised.

We welcome VA's recent efforts to refine the Veterans Equitable Resource Allocations (VERA) to ensure that eligible veterans receive the same level of care and access to specialized services regardless of where they live. Such actions as the revision of the complexity of care funding allocation, increased funding to networks for severely ill patients, and efforts to manage and contain workloads and growth are important improvements. However, we believe it is too little too late.

This system has been in decline since the beginning of the Vietnam War over 40 years ago. It has never recovered. Buildings in decay, cuts in services at medical centers, projected increases in Community Based Outpatient Clinics (CBOCS) while waiting times for appointments in Medical Centers become ridiculously long. Waiting times of 365 days for an appointment in any health care system is unacceptable and indefensible.

VA has said that they are unable to provide all enrolled veterans with timely access to appropriate health care services because of the tremendous growth in the number of veterans seeking help. In the fiscal year alone, when budgetary constraints were already an issue, VA reported an influx of 830,000 new veterans.

Vietnam Veterans of America supports the efforts of Secretary Principi to stabilize VHA by suspending enrollment of Category 8 veterans until such time as there are resources adequate to take care of service-disabled veterans and combat veterans, plus indigent veterans. Once VA can take care of the core mission, only then should the Secretary provide care to others. The action to limit enrollment at this time was responsible given the dire situation. Congress has added significant money to the inadequate requests from two successive administrations for the Veterans Health Administration. We hope this trend will continue, but the President should ask for truly adequate resources in the initial request.

Capital Assets Realignment for Enhanced Services (CARES)

The original concept for an assessment of real estate holdings and plans for disposition of excess VA property has evolved into a clinical management tool. From the onset, the plan to embark on a disposition of excess buildings at the same time VA was engaged in a massive transformation of the agency health care delivery systems cast doubt on the plan.

There was no question that many VA sites had unused buildings. However, as VHA moved from a disease-oriented hospital-based system to a patient centered outpatient modality, the state of need was in flux. Decisions made within the context of CARES has effectively closed beds, cut staffing, compromised services and damaged VA's ability to respond to emerging needs of veterans. For example, this Committee and veteran advocates have spent considerable time in the last 20 years focusing on the unmet needs of women veterans. From that time until now, Congress has crafted a remarkable program to ensure that America's 1.2 million women veterans receive the privacy and specialized health services they need. Because the number of women in military service has increased from 2% in 1970 to 17.5% of the Active Force there is evidence to suggest that these efforts have been an investment in the future. However, we have seen signs that in the CARES process there are plans to dismantle these services and dissolve the hard won improvements to service to women veterans by mainstreaming their care. These plans are being discussed without identifiable representation in the VISNs or at Central Office by women veteran advocates. This is not an isolated incident. Members of VVA are active in the VISN's and on the Management Advisory Committees and at VA Medical Centers. They report their frustrations that veteran stakeholders are not being taken seriously in this process. Input about the needs of veterans are not appearing in reports or visible in the decision-making process.

Summary

In the discussion of capacity to provide health care to America's veterans, this boils down to a question of honor. For in essence this Committee and both Houses of Congress are the Board of Trustees of the largest health care system in the world. It does not matter what this body authorizes for insurance, organ transplants, or any other health care legislation. Congress does not bear the responsibility for those issues as directly, as specifically, as absolutely as health care for the men and women who defend this nation. The question of honor is not their honor but how Congress honors them. This concludes my testimony. I am available to answer any questions.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

Questions for the
Honorable Robert H. Roswell, M.D.
Under Secretary for Health
from the Honorable Lane Evans
Ranking Democratic Member
House Committee on Veterans Affairs
in regard to the
January 29, 2003, Hearing on the
Status of VA Health Care

1. Dr. Roswell, more and more of the VA health system's funding increase is contingent upon receipt of third-party and co-payment collections. Did VA meet its target for fiscal year 2002? How well is VA doing meeting its targets for medical care collections in fiscal year 2003?

Response: In FY 2002, VA collected $1.176 billion, which represented 112 percent of the target collection goal of $1.050 billion. For the first quarter of FY 2003, VA has collected $348 million, which represents 98 percent of the FY 2003 target of $356 million through December.

2. What are VA's views on H.R. 5250, the Veterans Health Care Funding Guarantee Act of 2002, introduced in the last Congress?

Response: VA's views were not sought on this 107th Congress proposal and no formal position was developed. VA has developed views on S. 50, a similar bill introduced in the 108th Congress, at the request of Senator Tim Johnson. A copy of the Secretary's letter to Senator Johnson is attached.

3. What has been the impact of having a continuing resolution funding VA health care for the first third of this fiscal year?

Response: The Continuing Resolution had a limited impact on FY 2003 operations. This is due to the late supplemental appropriation received at the end of FY 2002 and the ability to carryover multi-year funds for patient care that would not have otherwise been available. This carryover, along with favorable Continuing Resolution levels approved by the OMB, has enabled VHA to maintain a relatively stable operation to this point. However, VA was not able to fully address the patient wait list and waiting times during this period. Purchases of necessary equipment and maintenance projects were also deferred.

4. In its Interim Final rule RIN 2900-AL51, "Enrollment – Provision of Hospital and Outpatient Care to Veterans Subpriorities of Priority Categories 7 and 8 and Annual Enrollment Level Decision," VA has noted it would expect to have $21.549 billion available for the medical benefits package in fiscal year 2003, while the costs of delivering the benefits will be $23.455 billion. This figure is estimated based on receipt of the full appropriation of $23.982 billion, which may be reduced to $23.202 billion if a widely reported 2.9% reduction is affected across all yet to be funded discretionary programs. In anticipation of at least $1.9 billion shortfall from serving all enrollees for

Fiscal Year 2003, has VA requested supplemental funds in the package that is expected to come to the Hill shortly?

Response: No supplemental request is being made. As you know, the final VA FY 2003 appropriation excluded Medical Care from across the board cuts.

5. VA outlined savings of $316 million in management efficiencies in its FY 2003 budget. Given the current funding situation, have you been able to implement any of these savings? If so, are you identifying savings from any particular initiatives? Which ones and how much?

Response: The Committee is correct that for FY 2003, VA proposed management savings of $316 million to partially offset the overall cost of health care demand. Since the beginning of FY 2003, specific actions include improved standardization policies that are facilitating best-value product pricing through volume purchasing. Resource savings are also expected from adherence to national criteria promoting operational efficiencies in community-based outpatient clinics and from improved guidance and control of centrally managed programs. In addition, VISNS have been assigned the responsibility to implement specific operational and management initiatives to achieve local goals. While VA cannot provide a specific list of savings achieved to date, all Networks must operate within their budgets, which have already taken into account the amount of management savings identified in the President's budget.

6. Has VA identified Priority 8 veterans who attempted to enroll prior to January 17, 2003, but were turned away? Is there a systematic way the VA has identified through internal policy for dealing with such veterans?

Response: Prior to the enrollment decision, VA policy had been to accept applications for enrollment from all veterans. All applications received were to be entered in the local Vista systems with subsequent transmittal to the Health Eligibility Center for eligibility verification and centralized enrollment processing. To assure accurate processing of applications received prior to January 17, 2003, VA issued guidance to field facilities to date stamp all applications received January 16, 2003, or before to assure proper processing. Sites were instructed to accept mail-in applications if the postmark was prior to January 17, 2003, and to file the mail envelope as verification of the application date. Similar instructions were provided for applications initiated online. These manual processes have helped to insure that no eligible veteran is inappropriately denied access to the VA health care system.

Field facilities with waiting lists have followed the guidelines noted above. As a result, even patients waiting for appointments were processed for enrollment. Sites with backlogs in application processing implemented these procedures to assure that veterans were granted access when appropriate. It is possible that there are individual situations where an error occurred. However, VA is prepared to review any such cases to determine if an application for enrollment has been inappropriately denied.

7. Phase II of the Capital Assets Realignment for Enhanced Services is now taking place. I understand that VA is reconsidering its estimates of need for outpatient mental health services and for long-term care. Realistically, without solid estimates for these

high-demand programs, how far can VA go with its planning initiatives now due this April?

Response: Because of the uncertainty about some of the mental health outpatient projections in the CARES demand model, demand projections for outpatient mental health where they showed declines were held constant for this cycle. VISNs were instructed only to plan for increases in mental health services. Meanwhile, the CARES office and mental health program officials are engaged in a study of the forecasting models for mental health. Alternative forecasting methods will be developed for the next cycle of CARES or within a strategic planning process integrated with CARES. The approach taken allows VA to plan for increased demand while preventing any unintended adverse effects on mental health outpatient programs.

The long-term care (LTC) projection models were reviewed and updated using the Census 2000 veteran population numbers and the policy changes affecting Priority 8 enrollees. However, because of the need to determine the impact of factors such as future improvements in the functional status of the elderly and the potential for alternatives to institutional care, LTC projections will not be included in the current cycle of CARES in sufficient time to meet the April 15 deadline for the submission of market plans. The revisions are expected to be available for use in the next cycle of CARES or within an integrated strategic planning process.

8. Will you please update the Committee on implementation of section 204 Program of Provision of Chiropractic Care and Services to Veterans of P.L. 107-135? NOTE: This response previously furnished under separate cover to Committee Staff on February 24, 2003.

Response: Section 204 of Public Law 107-135 requires VA to do the following:

- Establish a chiropractic advisory committee to provide advice and assistance to the Secretary in the development and implementation of the chiropractic health program. The Committee is to provide recommendations to the Secretary on scope of practice, services to be provided and protocols governing referrals to and direct access to chiropractors.
- Provide chiropractic care on at least one site in each geographic service area of the Veterans Health Administration.
- Provide "a variety of chiropractic care and services for neuro-musculoskeletal conditions, including subluxation complex".
- Provide training and materials relating to chiropractic care and services to VA health care providers assigned to primary care teams.

The Chiropractic Advisory Committee was appointed in August 2002 and has held three meetings. At the first meeting, in September 2002, the Committee received briefings on VA organization and operations and discussed how to address the Committee charges contained in Public Law 107-135. At the second meeting in December 2002, the Committee made a site visit to the chiropractic clinic at the National Naval Medical Center in Bethesda and discussed scope of practice issues, services to be provided, and access and referral issues.

A third meeting was held on March 25-26, 2003, at which the Committee discussed scope of practice and services to be provided. The Committee also plans to continue discussions on protocols governing direct access and referrals to chiropractors.

When the Committee completes the recommendations on the specific items listed in Public Law 107-135, they plan to discuss implementation issues, including the design and content of educational materials and programs.

VA anticipates selecting sites at which chiropractic care will be provided later this year in order to have sufficient time to prepare adequate clinic space if renovations are needed. The law requires at least one site per VISN and that the selected sites should be in both urban and rural areas. In making selections, we will look at current usage data, availability of needed support services, space availability, and patient demographics. VA will also consider sharing agreements with DoD facilities that have chiropractic clinics and will continue to offer chiropractic care through fee basis for eligible veterans who are not close to a VA site that has a chiropractor.

We currently anticipate offering chiropractic services under these new policies at some point in FY 2004. This assumes that the Advisory Committee completes its required functions and the required occupational study and qualification standards for hiring chiropractors are completed. *

*VA currently has authority to appoint chiropractors under 38 U.S.C.§ 7405, which authorizes temporary full-time and part-time appointments. However, since at the present time, no Federal agency hires chiropractors, no federal qualification standard or compensation schedule exists. VA must conduct an occupational study (job analysis and cross-occupation comparison) to collect the information necessary to develop these. At their first meeting, the Chiropractic Advisory Committee recommended to the Secretary that the occupational study be initiated as soon as feasible. The Secretary concurred with the recommendation. The occupational study will be contracted and the work of preparing a solicitation is underway. The projected time frame for the study is for the contract to be awarded by early summer 2003, with the study to be completed in 6-7 months. VA Office of Human Resource Management will then finalize the qualification standard, revise policies, and complete other administrative matters.

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

April 4, 2003

The Honorable Tim Johnson
United States Senate
324 Hart Senate Office Building
Washington, DC 20510-4104

Dear Senator Johnson:

I am pleased to present the Department's views on S.50, the "Veterans Health Care Funding Guarantee Act of 2003." The legislation would establish, by formula, the annual level of funding for all programs, activities, and functions (except for grants to states for the construction or acquisition of state homes for veterans) of the Veterans Health Administration (VHA). More specifically, funding for FY 2005 (the first fiscal year covered by the bill) would be automatically established at 120 percent of the amounts obligated by VHA (for all its activities, programs, and functions) for FY 2003. Thereafter, VHA funding would be automatically determined by a fixed formula, which is based on the number of enrollees each year multiplied by a fixed per capita amount. The per capita amount would be adjusted annually in accordance with increases in the Consumer Price Index.

VA does not support the concept of using a fixed formula to determine VHA funding. Although VA recognizes the appeal of such an approach, we believe the approach taken in this and other similar bills would prove to be unworkable and is inappropriate for funding a dynamic health care system, like VA's.

The provision of care evolves continually to reflect advances in state of the art technologies (including pharmaceuticals) and medical practices. It is very difficult to estimate both the costs and savings that may result from such changes. Moreover, patients' health status, demographics, and usage rates are each subject to distinct trends that are difficult to predict. The proposed formula in S. 50 would not take into account any changes in these and other important trends. As such, there is no certainty that the amount of funding dictated by the proposed formula would be adequate to meet the demands that will be placed on VA's health care system in the upcoming years.

Perhaps more importantly, use of an automatic funding mechanism would also diminish the valuable opportunity that members of the Congress and the Executive Branch now have to carry out their responsibility to identify and directly address the health care needs of veterans through the funding process. It might

2.

The Honorable Tim Johnson

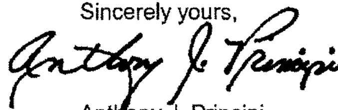
also tend to depress the Department's incentive to improve its operations and be more efficient.

Finally, VA does not believe this proposal would ensure open enrollment. The Department would still be required to make an annual enrollment decision, and that decision would directly affect the number of enrolled veterans and thus the amount of funding calculated under the formula. Indeed, references to "guaranteed funding" may give the public the false impression that this bill would give VA full funding to enroll all veterans and to furnish care for all their needs, which would not be the case.

We share the desire by many in Congress to ensure stable funding for the Department's health care system, and we look forward to working closely with the Congress to achieve that goal. However, for the many important reasons discussed, the approach taken in S. 50 is not the answer.

The Office of Management and Budget advises that there is no objection to the submission of this report from the standpoint of the Administration's programs.

Sincerely yours,



Anthony J. Principi

Congressman Evans to The American Legion

House Committee on Veterans Affairs
Full Committee Hearing
On
The Department of Veterans Affairs' Health Care System
January 29, 2003

Follow-up Answers of Peter S. Gaytan, Principal Deputy Director Veterans Affairs and Rehabilitation Division, The American Legion

1. **The American Legion has long supported Medicare subvention. Yet The American Legion expresses concern about a Medicare program based on the Medicare+Choice model. Would you oppose such a program? If so, what form of Medicare subvention would your organization support?**

   The American Legion does indeed support Medicare subvention for the Department of Veterans Affairs (VA). The American Legion Resolution 203 urges Congress to amend title XVIII of the Social Security Act to allow Medicare reimbursement for VA on a fee-for-service basis for the treatment of nonservice-connected veterans. Additionally, this resolution supports authorizing enrolled, Medicare-eligible veterans to participate in the Medicare+Choice option by choosing VA as their primary health care provider.

   The American Legion does have concerns about VA's proposed VA+Choice Medicare plan as it has been outlined by VA leadership. The VA+Choice Medicare plan would allow Medicare eligible Category 8 veterans to receive health care through VA. A Category 8 veterans who is Medicare eligible **and** purchases Medicare Part B, **and** has an income and/or net worth above the VA Means Test threshold and the HUD geographic index **and** chooses VA as their primary care provider can be treated at a VA Medical Facility and utilize their Medicare benefits.

   Under the proposed VA+Choice Medicare plan, VA would be held to the same access standards as any private health care provider operating under the Medicare+Choice plan. Any veteran seeking care from VA under the VA+Choice Medicare plan is guaranteed care within the Medicare+Choice access standard of 30 days. So, under the VA+Choice Medicare plan, VA is guaranteeing Category 8 veterans care within 30 days but, VA makes no guarantee of access to any other Category of veteran. This we feel is unfair. With a current backlog of 260,000 veterans waiting to receive care, it will be difficult for VA to guarantee care to Medicare eligible Category 8 veterans under the Medicare Access standards.

   Additionally, the VA+Choice Medicare plan would mandate VA reimburse Medicare for any services not provided within the 30 day access standard. It was explained by VA that in order to ensure VA meets the 30 day access standard for care a "third-party handler" would track patient waiting times and if it becomes apparent that VA cannot meet the 30 day requirement the care would be contracted through a private facility. The American Legion has some concerns over the combined cost of the "third party handler" and contracting out care.

   While The American Legion does not oppose an effective and comprehensive VA+Choice Medicare program for Medicare eligible veterans, it is important that any form of Medicare Subvention for VA reflect a fair system of access for all eligible veterans receiving care through VA. The access standards for any Medicare Reimbursement plan is a reality and VA must ensure that compliance to the access standards does not negatively effect the existing priority system within VA.

The American Legion believes the simplest and fairest solution is for the Centers for Medicare and Medicaid Services (CMS) to recognize VA just like any other health care provider. VA should be authorized to seek reimbursement from CMS for the treatment of allowable, nonservice-connected conditions of Medicare eligible enrolled veterans treated in VA health care facilities.

Additionally, any reimbursements made to VA from CMS must be added to existing appropriations and not treated as an offset to the budget.

2. **Some have stated that eligibility reform has caused the problems with the waiting times that are now prevalent at VA Medical Centers. As you know, eligibility reform allowed VA to provide certain services to all enrolled veterans. Most VSOs who long supported eligibility reform claimed that this would actually increase VA's efficiency by allowing VA to provide the most appropriate and cost effective services to veterans. The law also required VA to decide how many veterans it could enroll each year.**
    a. **Is it really appropriate to blame eligibility reform on the current surge in demand?**
    b. **Given the new style of medical practice focused on outpatient and community based care would it even be possible to "turn back the clock" and revert to the old eligibility rules?**

a. The American Legion does not seek to assign blame for the current crisis in VA, we do however support Medicare reimbursement and Mandatory Spending as initiatives for improving VA's ability to provide timely access to quality health care for all veterans.

For whatever reason, the surge in demand for VA health care is a reality. That reality has caused Secretary Principi to suspend enrollment of Category 8 veterans. VA claims this decision to deny formerly eligible veterans from receiving health care will enable VA to improve health care access for its higher-priority core constituency –those veterans with service connected disabilities, with low incomes and with special care needs. VA also explains that the large number of higher-income, non-disabled veterans expected to seek VA care would prevent VA from focusing on this core constituency.

Public Law 104-262 allowed for all eligible veterans – including those now considered Category 8 veterans to enroll in the VA health care system. Secretary Principi's recent decision to suspend enrollment prevents eligible veterans access to care that they were once granted. The American Legion supports allowing access to care through VA for all veterans, including those now classified ineligible as Category 8 veterans.

The American Legion believes that instead of squeezing the system to meet a limited budget, the budget should reflect the rising demand for health care. That is why The American Legion is urging Congress and the Administration to support legislation designating funding for VA Medical Care as a Mandatory Spending item under the Federal Budget. Years of inadequate funding under the current discretionary system have proven inadequate. Mandatory Funding for VA Medical Care will provide a formula that will ensure VA receives adequate funding to meet the health care needs of all eligible veterans – including Category 8 veterans.

b. The American Legion does not support any efforts to "turn back the clock" on VA health care delivery.

RESPONSE TO FOLLOW-UP QUESTIONS FOR
JOSEPH A. VIOLANTE
NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
FROM THE HONORABLE LANE EVANS
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS
JANUARY 29, 2003 HEARING

Question One: The added timeliness standards DAV would have added to the mandatory funding bill introduced by the Chairman in the last Congress are inconsistent with Medicare+Choice practice standards that VA will have to adopt for treating Priority 8 veterans who chose this option. Does that infer that there may be two different standards for VA users depending on who is paying for their care? Is that acceptable? If not, which standard is appropriate?

Answer:

As I stated in my testimony, the Disabled American Veterans (DAV) proposed that timeliness standards be included in any guaranteed funding bill for Department of Veterans Affairs (VA) health care. We described timely care as:

1. access to urgent care 24 hours a day;
2. scheduled appointment with primary care provider within 7 days for established patients;
3. scheduled appointment with primary care provider for new patients within 30 days;
4. appointment with a specialist within 30 days of referral; and
5. being seen within 30 minutes of a scheduled appointment.

In the fiscal year 2004 budget, VA proposed a VA plus Choice program for Medicare-eligible veterans unable to enroll for VA health care (new Priority Group 8 veterans). Under this plan, VA would contract with an existing plus Choice plan through a third party administrator, with the stipulation of VA-defined benefits and that VA serve as a provider. Under such a plan, VA would have to meet Medicare plus Choice practice standards.

Dr. Roswell indicated there would not be a double standard for enrolled veterans receiving VA care and Medicare-eligible veterans under a VA plus Choice program. He stated that before any Veterans Integrated Service Network (VISN) could participate in the VA plus Choice program, it would have to be able to meet Medicare's practice standards for all veterans it is serving prior to initiating the VA plus Choice program in that VISN.

DAV would strongly oppose two different access standards for VA users based on who is paying for their care. All enrolled veterans should have equal access to timely VA health care. The timeliness standards we proposed in our testimony are maximum waiting times for what we consider to be reasonable or timely access to care. It is preferred that veterans are seen as soon as possible or when deemed medically necessary.

Question Two: Some have stated that eligibility reform has caused the problems with the waiting times that are now prevalent at VA medical centers. As you know, eligibility reform allowed VA to provide certain services to all enrolled veterans. Most VSOs who long supported eligibility reform claimed that this would actually increase VA's efficiency by allowing VA to provide the most appropriate and cost-effective services to veterans. The law also required VA to decide how many veterans it could enroll each year.

a. Is it really appropriate to blame eligibility reform for the current surge in demand?
b. Given the new style of medical practice focused on outpatient and community based care would it even be possible to "turn back the clock? and revert to the old eligibility rules?

Answer:

Initially, DAV does not believe eligibility reform is solely to blame for the current surge in demand for VA health care, the wait list, and excessive waiting times for care. Many factors have contributed to increased demand for VA health care, including: development of a standardized health care benefits package, increased access to VA care through development of Community-Based Outpatient Clinics (CBOCs), aggressive outreach to veterans to enroll into the VA health care system, improvements in quality of care provided at VA health care facilities, and low co-payments for pharmaceuticals.

High costs for health care insurance, the lack of a prescription drug benefit for Medicare eligible seniors, and the current health care crisis facing our nation today are also likely factors in the unprecedented growth in demand for VA health care. Unfortunately, funding for veterans' health care has not kept pace with increased demand for care, medical inflation, and mandated changes in the benefits package. The long wait lists nationwide, rationing of care, and excessive waiting times for primary care and specialty care appointments are a result of insufficient funding. For these reasons, DAV has urged Congress to enact legislation to provide a guaranteed level of funding for veterans health care.

Prior to eligibility reform, the provisions of law governing eligibility for VA health care were complex, confusing, and in some ways inconsistent with sound medical practice.

In 1995, draft eligibility reform legislation proposed changes to include an eligibility system that:

- could be fully understood by veterans seeking care and those providing care;
- would ensure VA was able to provide patients the most appropriate care and treatment medically necessary in both a cost-effective manner and in the most appropriate setting;
- would not reduce any veteran's eligibility for health care benefits that were afforded prior to eligibility reform; and
- would allow VA management the flexibility it needed to effectively manage the VA health care system

The main goal of eligibility reform was to substitute a single uniform eligibility standard for the complex array of standards governing access to VA hospital and outpatient care. Most importantly, it established a requirement of clinical need for care and medical judgment over legal criteria as a guideline for providing needed medical services to veterans.

The idea of "turning back the clock" and reverting to old eligibility rules is unthinkable. Enactment of Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996, removed the statutory barriers that prevented VA from providing medically appropriate comprehensive health care to meet veterans' unique health care needs. The transition allowed VA to provide an equitable continuum of care to include preventative, primary, and long-term care based on veterans' health care needs. The law also paved the way for the creation of a Uniform Benefits Package and simplified the process by which veterans can receive VA services.

The transition was instrumental in VA transforming itself into a world-class leader in the health care industry. VA is not only well known in the areas of specialized care, but in many other areas such as patient safety, research, and quality. VA has made dramatic improvements in its health care system and the result is better health care services for our nation's veterans. We supported health care eligibility reform at the onset and support it still today.

Eligibility reform helped us to fulfill our obligation to providing quality health care services to our nation's sick and disabled veterans. It was the right decision then, and we have a continued obligation now to ensure this exceptional system is well maintained and adequately funded so that future generations of veterans know they too will have the best medical care available to them for their service-connected injuries. Eligibility reform raised the expectations of all veterans to receive comprehensive quality health care services. It also raised the bar to provide those services to veterans who come to the VA and need such services. We believe it is a small price to pay for the sacrifices made by veterans and the freedoms we as a nation enjoy today.

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