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HEARINGS ON THE REPORT OF THE PRESIDENT'S TASK FORCE TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATION'S VETERANS

HEARINGS

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHT CONGRESS

FIRST SESSION

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HEARINGS ON THE REPORT OF THE PRESIDENT'S TASK FORCE TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATION'S VETERANS

TUESDAY, JUNE 3, 2003

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

The committee met, pursuant to notice, at 10:03 a.m., in room 345, Cannon House Office Building, Hon. Chris Smith (chairman of the committee) presiding.

Present: Representatives Smith, Simmons, Boozman, Bilirakis, Evans, Gutierrez, Snyder, Rodriguez, Michaud, Strickland, Bradley, Beauprez, Brown-Waite, Renzi, Murphy, Ryan, Davis, and Udall.

OPENING STATEMENT OF CHAIRMAN SMITH

The CHAIRMAN. Good morning. I want to welcome all of you to the hearing. It is a pleasure to have Dr. Gail Wilensky, a noted health economist, former Administrator for the Health Care Financing Administration, and the co-chair of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans, here today to present the findings from the Task Force's Final Report.

When President Bush announced early in his presidency that he was creating a task force to study the health care being provided to our Nation's veterans, he served notice to two very large organizations—the Departments of Veterans Affairs and Defense—that it would no longer be "business as usual."

By virtue of his decision, both VA and DOD have already begun paying much closer attention to the concerns and needs of veterans and each other. And based upon recent reports, including this one, I am pleased to see that a greater commitment to sharing has made some progress, although there is still much to be done. I congratulate the President and the two secretaries for having recognized that the Nation expects more cooperation between their departments than occurred in the past.

But, as the PTF report states, "in spite of extensive research and efforts to increase VA/DOD sharing and collaboration, and thereby improve veterans' access to care, the results until very recently have been at best marginal, or at worst, superficial."

While there is an obvious area of commonality between these two departments, and particularly in the populations served by their

respective health care systems, both of these departments have distinct missions and challenges that frequently eclipse the need for collaboration between them.

In this regard, the President's Task Force has reached a similar conclusion to what this committee has found repeatedly in the years I have been a Member of Congress. For a variety of reasons, the two departments have often acted toward each other as if they were agencies of different nations, and sometimes not particularly friendly nations at that.

I first noticed this attitude at military installations in my own congressional district in New Jersey. Over the past 23 years, I have represented all or parts of Fort Dix Army Base, McGuire Air Force Base, and Lakehurst Naval Air Engineering Station, which are located adjacent to one another in central New Jersey. I can recall trying to travel from one base to the other. It seemed as if I had to have a passport to go from one border to the other.

Today, there is much better cooperation among these bases, but my experience taught me how difficult it can be to achieve collaboration among organizations with separate and distinct missions.

I would note that Congress has acted on numerous occasions over two decades to improve VA-DOD cooperation and resource sharing, including legislation enacted last year in the DOD authorization bill, and most recently, new legislation sponsored by Congressman Boozman of this committee that was approved by the House last month.

Yet if you look at the Task Force report and web site—and I commend the web site to all of you for its breadth and depth of data—you'll note that the amount of actual collaboration between the two departments' health systems is surprisingly low. Despite over 700,000 military retirees receiving some or all of their health care from VA, very little resource sharing actually takes place.

While the two departments have continued to negotiate on meaningful improvements to reduce the perceived gulf between an individual being on active duty and then becoming a veteran, too often these efforts occur in isolation from one another and seem to ignore reality, and thus, to deny real needs.

The Task Force has identified a number of common-sense management improvements that would promote greater efficiency, particularly concerning the need for committed leadership, providing a seamless transition to veteran status, and removing barriers to collaboration. This committee will work with the administration and veterans' advocates to help implement these ideas.

Perhaps the most important recommendations will come as a surprise to some, but not to most. In the course of their work, the Task Force reached a unanimous conclusion; it found that the key factor interfering with improved collaboration between the two departments is the current mismatch between demand for VA health care and available funding.

The Task Force concluded that this mismatch could "threaten the quality of VA health care" and that it "impedes efforts to improve collaboration between VA and DOD." In other words, until VA has a properly-funded health care system, it will be unable to take full advantage of the collaboration or resource sharing within the Department of Defense.

In order to achieve the maximum efficiency from both health care systems, we need to fund both of them fairly and adequately. As long as the funding problems remain, it is hard to imagine how other recommendations made by the Task Force can overcome this basic dilemma.

Although there will be many questions about how to reform VA's health care funding system, it is clear that fixing the funding system is essential to assuring better use of taxpayer funds, and, most importantly, to improve the delivery of benefits and services for military veterans.

With that, let me introduce our witnesses. But before that, I would like to yield to my good friend and colleague, Mr. Evans, for any opening comments that he might have.

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

Mr. EVANS. Thank you, Mr. Chairman. Doctor, let me welcome you for coming forward today. I commend you and the other members of the President's Task Force on your report. It recognizes that there is a significant gap between veterans' health care needs and the funding that is provided to meet those needs. Your report also cites mandatory funding as a viable way to address this serious flaw. We view it as not only viable; it is essential.

I would be remiss if I did not point out that distinguished alumni of this committee were members of the Task Force, and contributed significantly to its progress and conclusions. Our good friends John Paul Hammerschmidt and the late Gerry Solomon, both of whom were ranking minority members of the committee, served as co-chairmen of the Task Force. You would be hard-pressed to find more loyal, outspoken champions of veterans and their causes.

Doctor, we appreciate for the most part the report as submitted, but we do have some concerns. I'm particularly interested in why the Task Force stopped short of recommending a guarantee of funding for health care for Priority 8 veterans. It would be interesting to hear a characterization of the deliberations of the President's Task Force in this regard.

I note that a dissenting opinion was filed with the report that broaches this subject. I want to thank our Chairman for giving the authors of this opinion, as well as the veterans' service organizations and the Department of Veterans Affairs, an opportunity to testify at a second hearing on June 17.

Again, I do appreciate the Task Force's work, and generally accept its findings in regard to the considerable mismatch between demands on the VA health care system and its funding, and the call for increased VA-DOD sharing. Mr. Chairman, thank you, and I yield back the balance of my time.

The CHAIRMAN. Let me—Vice Chairman Bilirakis? Would any other members like, before we go to—let me go over here to Mr. Boozman.

OPENING STATEMENT OF HON. JOHN BOOZMAN

Mr. BOOZMAN. I'd just like to comment, one of the co-chairs, Congressman Hammerschmidt, held this seat that I hold now 10 years ago. And I know firsthand, in visiting with him and things, how

hard that you all worked, and how seriously this was taken, and that this really was a major effort. And again, I really do want to compliment him and the rest of the Task Force for working so hard and bringing us this information.

The CHAIRMAN. Mr. Rodriguez.

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you very much, Mr. Chairman, and Ranking Member Evans, and Dr. Wilensky. It's a pleasure to be here, and also listen to the Final Report of the Task Force. And I want to commend you and fellow committee members for the hard work and the good work that you've done, and particularly for your willingness to address what you termed the growing mismatch between the funding and the demand, which there's no doubt that we have, you know. And I want to thank you for that.

I also want to commend our Ranking Member Lane Evans for announcing his intentions to introduce the Assured Funding for Veterans Health Care Act for 2003. I will be also original co-sponsor of that particular legislation, and I strongly believe that the best interest of our Nation's veterans is to find the solution for that inadequate budget request that we have before us.

And especially as we look at the demographics out there, there's really a demand right now for us to come up to the plate because of the number of our veterans that are reaching that age where they need us the most. So I just want to encourage the members to kind of look at that now before they pass away and we fail to respond to some of their needs.

I also want to just mention that based on the report—you know, maybe you can comment on it—I was surprised to find that 1.1 billion shortfall in this year's budget request that was supposed to be filled, the so-called management inefficiencies. And maybe you can, you know, mention that a little bit more. But thank you very much for your hard work that you've done in that. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Let me now introduce our very distinguished panelist and witness, Dr. Gail R. Wilensky, who was appointed by President Bush in 2001 to serve with our good friend and former colleague for many years, the late Gerry Solomon, as co-chairs of the President's Task Force to Improve Health Care Delivery to Our Nation's Veterans.

Tragically, as we all know, Gerry Solomon died in 2001, the effects of a chronic heart disorder. And the report of the Task Force has been commissioned in his memory, a fitting tribute to this great Marine and great man and wonderful Member of Congress.

John Paul Hammerschmidt, the former ranking member of this committee for many years, was designated to co-chair the Task Force thereafter. Although John Paul could not join us today, I would like to commend him for his job well done as well. But we are extremely fortunate to have Dr. Wilensky, who co-chaired the Task Force with him, who also serves as the John M. Olin Senior Fellow at Project HOPE.

Dr. Wilensky is a previous chair of the Medicare Payment Advisory Commission, which advises Congress on payment and other

issues related to Medicare. And she also chaired the Physician Payment Review Commission.

Dr. Wilensky served as deputy assistant to President George H.W. Bush for Policy Development, and prior to that was administrator for then what was called the Health Care Financing Administration, or HCFA, overseeing Medicare and Medicaid programs.

Dr. Wilensky is an elected member of the Institute of Medicine, serves as a trustee of the Combined Benefits Fund of the United Mineworkers of America, and of the Research Triangle Institute, and is an advisor to the Robert Wood Johnson Foundation and the Commonwealth Fund. Dr. Wilensky received several collegiate degrees at the University of Michigan.

The committee welcomes you, and we look forward to your testimony, Doctor.

STATEMENT OF GAIL R. WILENSKY, Ph.D., CO-CHAIR, PRESIDENT'S TASK FORCE TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATION'S VETERANS

Ms. WILENSKY. Thank you. Mr. Chairman and members of the committee, I'm pleased to be here today to discuss the Final Report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans.

As you have already acknowledged, I was joined in this initially by former Congressman Gerry Solomon, and later by your former colleague John Paul Hammerschmidt. And it has been a labor of almost 2 years now that it has taken to produce this report.

It is a joint effort. It is not the single effort of either a co-chair or the two co-chairs. And obviously, you need to regard it as the result of a committee effort. We are very pleased with it, and we think the report basically speaks for itself.

Our work was carried out in very open manner. All of our meetings were held open to the public. Any of your staff could, and on occasion did, attend these meetings. All of the briefing slides were posted on a web site. And within a very short time after each of our public meetings, a verbatim transcript of the Task Force was also on the web site. The Final Report has been mailed to each of you, both its full version and its short version, but it is also available on the web site for you to use or distribute to any people that you think would be appropriate.

I mention that, because I think it is important—although I'm very glad to answer questions—on how we came to recommend what we recommended. If you want to have a better sense about what happened during the committee deliberations, you actually can thumb through voluminous pages and get the flavor of what happened at the meeting for yourselves.

As you indicated, we were established in May of 2001, almost exactly 2 years ago, at an event at the White House on Memorial Day. The President then asked former Congressman Solomon and myself to serve as co-chairs. Later in the summer, 13 other members were appointed.

We are a very diverse group, and we believed it was important that we are a diverse group of individuals who came, who donated our time over a 2-year period, and came out with a series of recommendations, all of which, but for one—which, of course, I'll be

glad to address if you want—was supported by the full Task Force, 23 numbered recommendations, some 35 specific recommendations. All but one of them had the full support of all members. One had some alternative versions that were preferred by some of the Task Force members.

When we were established, we were given basically three charges. First, to identify ways to improve benefits and services for VA and DOD beneficiaries through better coordination of the two departments. Second, to review barriers and challenges that impeded that cooperation, and to find ways for opportunities to improve that. And third, to identify opportunities for improved resource allocation so that VA and DOD could make the best use possible of their resources.

We carried out this focused work on collaboration. But as we went along, we realized that there were other issues that were not part of our direct charge that we could not avoid. And you have already made mention of the biggest one of those. That is, the mismatch between the demand and the available funding in the VA. And that if we were to reasonably address issues of collaboration and sharing and better resource allocation and removing barriers, we needed to deal with this issue of a mismatch between the demand for services and the available funding.

We hope that our recommendations, all of them, will aid the Congress in finding ways to improve collaboration, but more importantly, to improve the health care that is provided to our Nation's veterans.

Our goal early on was to not add one more report to your shelves, or to kill a lot of trees—although we probably did that during our time—but rather, to find a series of recommendations that could be implemented. And that was a constant focus.

We have gained from the participation of people who have spent many years on the Hill, either as your former colleagues or as former staff. And as I've indicated, we believe that in general, the report speaks for itself, but I would like to review some of the specific recommendations with you, and also, obviously, to answer any questions.

As you know better than I—because many of you have been at this particular issue longer than I have—this issue of VA-DOD collaboration is not a new one. It has now more than a 20-year history, and it has been characterized as one of fits and starts. There is occasionally flurries of activities, usually because of what goes on at the local level, but it has rarely been a sustained activity.

We identify very early on that the single most important issue for having sustained collaboration efforts between the VA and DOD is senior leadership commitment. It has not been, in our view, present during this whole 20-year history of the congressional interest. It seemed to increase in the mid-1990s. It then waned to some extent, and in the last couple of years, has increased substantially.

We believe, at least in part, we are seeing the reflection of a President's interest in an issue, and there is nothing like a presidential issue to bring an issue to the perspective of two secretaries.

We believe that the current leadership focus within the departments is very effective. We are very impressed with the activity of

the Joint Executive Committee, which is chaired by VA Deputy Secretary Mackay, and also DOD Under Secretary David Chu, and we are also impressed with the Health Executive Committee. And we would like to see that continue. We were pleased with congressional action to put in statutory language these important elements, and we think that their institutionalization is very important.

It has been a theme in our report and in our deliberations that we are very impressed with activities we see from time to time. And we have struggled with how to institutionalize them, so that when the particular individuals who are involved with that collaboration move on to other areas, they do not go away. And in this effort, we would like to encourage you to be vigilant in following that the now present joint collaboration at these very senior levels of the VA and the Department of Defense continue on into the future.

We also think it's important that field managers understand the commitment of their top leadership, too, for their collaboration. That also works very well to continue in engagement, if people who are actually at the operational level believe that they are following something that is reflecting the commitment of their leadership.

We did try to make the point—and I would like to have an opportunity to stress this to you—we are not looking at collaboration for the sake of collaboration. We are looking at collaboration between the VA and the DOD, because we believe it is important as a way to get timely access to good quality health care for veterans and the current military retirees, and also to find a way to reduce the cost of health care in terms of the services that the VA and the DOD provide.

So collaboration is important, but we try to remind ourself periodically our focus was on making sure that veterans have access to good quality and timely health care.

We found that there are a number of process and institutional issues that need to be changed if we are to have improved collaboration. And we attempted through these 25—and in part, 35—major recommendations to come up with very specific ways that would work to improve this collaboration.

The idea that we are trying to accomplish is to make the transition from military service to veteran status seamless to the individual. That is fundamentally what our goal is, and it is important in order to have that happen that we remove some of the barriers.

We came to the conclusion that one of the most serious problems that needs to be addressed has to do with timely, high-quality, effective information sharing, that when you talk to the clinicians at these joint sites—and several of us made a number of field trips on our own so we could see both what was working and what was not working—was the inability of the VA and DOD's electronic medical record systems to readily share data was a sense of enormous frustration.

It was particularly frustrating for me to see what represents the most advanced electronic medical record systems in the country that is provided by the VA and the DOD individually have enormous difficulty in communicating with each other. And that was a

source of considerable discussion among us, and some of our recommendations.

It was frustrating enough to some of the local leadership that they would invest some of their scarce facility resources in order to try to improve on an ad hoc basis information sharing at the local level. And we have identified electronic medical record sharing as one of the focus areas.

The problem is not a technology problem, as best we can tell, as best we can tell from the advice of our technical experts, but rather, the will and the leadership to get around the silos that currently exist. We need to have electronic medical records that can share data in order to foster collaboration between these two systems, but also because it's the best way to reduce medical errors and the costs that are associated with medical records.

And so we have recommended the development and employment of interoperable bidirectional standard space electronic medical records, and we have recommended that this occur by the year 2005. We believe it is possible, although it will push the VA and the DOD to meet that target date. But it will help accomplish a number of objectives in terms of the seamlessness so that information that is related to what happens in employment, to occupational exposures, and other issues that reflect what happens during an individual service members's history will be readily available at a time when it is needed so that health care can be provided.

There have been a number of instances in the last few years where the inability to track where people have been and what they may have been exposed to have caused enormous frustration for the Congress and for the people providing services to the veterans.

The process for determining eligibility for veterans benefits and for reviewing their health status and for receiving timely access to VA health care needs to be accurate, and it needs to be seamless for the individual service member. We think that this should start with a single physical from discharge. We think when the individual separates, the DD214, which I had previously not been aware of, needs to be available in a timely way. It needs to be transmitted electronically so information goes from the DOD to the VA. It is our sense that it is the single most important barrier now for veterans to get timely access to the benefits they are entitled to when they are leaving the military, and that it is now frequently—although not always—slow, cumbersome, and bureaucratic in its process.

We need to make sure that the joint ventures that go on are viewed as more than pilots. There is a tremendous amount of activity. As I've indicated, we want to institutionalize it so that it is not just subject to the individuals who are there, and that we want to see these joint ventures as integral to the activities of the VA and the DOD. And we've made a number of recommendations as to how we think that should occur in terms of how the Joint Executive Committee should look at it, and that all proposed VA and DOD facility construction within a geographic area should be evaluated as potentially available for a joint venture until it is demonstrated or believed that that is not appropriate.

As I have indicated, and as you mentioned early on, although we focus primarily on the issues that were directly in our charge, we

did keep bumping up to the fact that there is a mismatch between the demand for services in the VA and the funding that is available to meet that demand. And that although there has been some historical gap in the funding that is present in the VA services, the current mismatch is far greater for a variety of reasons, and its impact, we believe, has been more detrimental than has occurred in the past, and that it really has interfered with the VA's ability to provide high-quality health care and support that the system needs to the veterans.

We are concerned about this not only because of how it impacts overall collaboration, which was our charge, but we were concerned because of its direct impact on the ability of the VA to provide quality health care. It is, as you know, and as is available for perusal in the records, an area where there was the greatest difference of opinion among members.

But I think that while it is appropriate to discuss why we believe there was some disagreement or difference of opinion with regard to the treatment of veterans in the Category 8, we do believe it is even more important that you understand and focus on the unanimity of our recommendation regarding the treatment of veterans in Categories 1 through 7, those veterans who have service-connected conditions, or with income below a specific income threshold geographically adjusted.

We believe that if our recommendations regarding the funding for those who have historically and traditionally received care through the VA would be provided, we would see a significant change in how the government fulfills its commitment to these veterans.

We believe that by providing full funding so that all enrolled veterans in Categories 1 through 7 had funding, they would be then able to receive in a timely way the comprehensive benefits within the VA's established access standards. We think it is sufficiently important that the access standards be met that we are recommending that if the VA in some areas cannot provide those services to meet their own standards, that care be offered outside of the VA service so that the standards can be met. This would allow for a timely receipt of care, and the elimination of the waiting lines for those who are in Categories 1 through 7.

We have had some legitimate disagreements about how Category 8 veterans should be treated. And they ranged from like 1 through 7's, to pay-as-you-go, to believing that we had neither the information nor the authority to make such decisions.

But we were unanimous on one issue with regard to 8's. And again, I want to encourage you to focus on this aspect, which is that the present situation is not acceptable, and that it needs to be resolved through decision-making by the Congress with the White House. And we believe that that is our most important contribution with regard to the treatment of Category 8's.

This concludes my statement, Mr. Chairman. I would be very happy to answer any questions that you or other members of the committee has with regard to the report. Again, I will encourage you at your leisure to read the full report, as well as the short version. And both the commissioners, speaking on behalf of them, and the staff members, some of whom will now be continuing their

work with the VA, would be happy to work with you in the future as you try to implement our recommendations. Thank you.

[The prepared statement of Dr. Wilensky appears on p. 118.]

The CHAIRMAN. Dr. Wilensky, thank you very much for the extraordinary job you have done heading up this commission. I have read the report very carefully. As a matter of fact, I yellow highlighted so much of it, it was almost like why don't I just put it all in yellow. There were so many good, solid recommendations made in this report. And I would pledge to you that our committee will seek to encourage the administration, the VA, DOD—but especially the VA, where we have more jurisdiction—to implement this faithfully.

As you point out in the report, going back to the Sharing Act—and I was a co-sponsor of the Sharing Act. Ron Model and Sonny Montgomery and John Paul Hammerschmidt produced a bill that looked like it was revolutionary in that it would finally get DOD and VA to collaborate. And unfortunately, 20 years later, 23 years later, there's next to nothing to show for it. Although as you indicated, there has been an up-tic recently.

But as you point out in your report, the 1991 report of the Commission on the future structure of veterans' health care went unimplemented, the transition Commission recommendations largely went unimplemented. The Eagle Group's 2001 recommendations, unimplemented. The GAO reports, one after the other after the other that would show where we could realize significant gains and cost avoidance, unimplemented, by and large.

So this, I think, you have provided us with a significant blueprint. You know, the President is talking about the road map in the Middle East. You've given us a road map for health care financing reform for the VA and the DOD that is truly a jewel. And we're going to work very hard on this committee in a bipartisan way to implement every aspect of it. And if there's a reason why not, we want to know, "Okay, what's better?" As you pointed out, the status quo is clearly unacceptable.

As you know, last year, I introduced—and I was joined by Mr. Evans and 129 other members—H.R. 5250, which would have provided a mandatory funding mechanism for the VA. And frankly, while it was a good start, all of us, I think, had questions about what is the proper formula. We started off with 120 percent of the 2002 number per enrollee, thinking that, you know, we could tweak it, go up or down based on what the real need might be. But still, it was a sense of we don't know what is the best way to predict, based on formula, a capitated plan how to go about it.

You make two recommendations, as you know, with regards to two alternative approaches in Recommendation 5.1. The first would be to impanel a board of experts—or actuaries, as you call them—to identify the funding requirement for veterans health care, and it must be included as the President's request. It would essentially bypass the Office of Management and Budget, so that Congress would get, in an unfettered, untarnished way, what the real need is based on an honest assessment without any other considerations about spending priorities worked into that equation.

The other would be to go with that original 5250 that we had introduced last year, which would be a capitated formula.

Now, in looking at this, if I could ask you, did the commissioners have a preference? When you looked at, for example, the second approach, which was our approach last year which we introduced, did you run up against the same potential problems what is the right formula? You know, how are we going to arrive at and define what the right number is? Or did you have any recommendations along those lines? And of the two, did you have a preference? Did you find that one might really be the way to go about this?

Ms. WILENSKY. We actually tried to be clear that we were listing these two strategies as what we regarding as examples among a larger potential set of strategies, not all of which we felt we were able to identify. The two we recommended were obvious examples of one because it existed in legislation, and the other because it approximated what DOD does for the under-65 population. So they were living examples.

But we thought there were many other examples that might be—or at least some other examples that might be relevant. We had the advice of individuals who both had experience on the Hill and experience in the executive branch. And our deep desire was to try to avoid some of the institutional in-fighting that might go with a specific mechanism to be used, and to indicate what we wanted to see the outcome, which is full funding, with the follow-on recommendation that if the VA can't meet its own access standards that it be forced to offer services purchased on the outside, that that was essentially how we wanted to go.

We did have some discussion as to whether mandatory funding, as defined, would necessarily eliminate waiting lines, and we did not—at least some of us did not believe that was necessarily the case for the reasons that you have, in fact, suggested.

There were some members of the committee who much more aggressively wanted to say how this should be done. But the majority of the committee believed that what we wanted to say was, "This is what we want to have happen—full funding. And if you can't meet your own access standards, go buy the services." And the Congress basically needs to come up with a strategy as to how that happens, obviously with the cooperation of the White House.

We do understand the concern about having budgetary reviews so that what goes or comes out of the administration might not be independently reflective of what went in, and that was why we used the first example.

The CHAIRMAN. I appreciate that. Your commentary basically reflects where my thoughts are with regards to a concern that at the end of the day, if we get the formula wrong, and then have to go through a very difficult process of enacting a new formula, we could end up disenfranchising veterans unwittingly, as opposed to—and there's no fool-proof method here, obviously—the first recommendation, which—and we've been working on some draft legislation to try to accommodate that recommendation—seems to possess the kind of flexibility, provided we don't have the red pen going through it as it goes through OMB.

And again, they have a very difficult position to—and very difficult task in trying to figure out how to formulate a budget. But it seems to me that if the cause and the goal is full funding for those who are eligible, the mismatch has to come to an end. And

I think this blueprint, more than anything I've seen as a member of this committee for 23 years, will be acted upon, and I think will lead to significant reform, especially in the way that we fund veterans' health care.

So I am deeply appreciative, and I know many of my colleagues are on both sides of the aisle, for the work you've done. It's exhaustive. You have taken the time to put together, you know, a mutually-reinforcing set of recommendations, that one builds upon the other, and the linchpin being the full funding and the access standards that are found in Chapter 5. Mr. Evans.

Mr. EVANS. Mr. Chairman, I don't have any comments or suggestions about the legislation right now. But I would like to speak out of order——

The CHAIRMAN. Oh, sure.

Mr. EVANS (continuing). To recognize a new staff director, Jim Holley, from the VA. He was up on the Hill for many years, and we're glad to have you back.

Mr. HOLLEY. Thank you very much.

[Applause.]

The CHAIRMAN. The vice chairman of the committee, Mr. Bilirakis.

OPENING STATEMENT OF HON. MICHAEL BILIRAKIS

Mr. BILIRAKIS. Thank you, Mr. Chairman. I'm losing my voice. I picked up a bug somewhere. And I, too, welcome Mr. Holley. It's good to see him again. I've been on this committee now—this is about my twenty-first year. And it's good to see you again, Jim.

Dr. Wilensky, what can I say? You and I worked on health care in all these many years where we'd gotten sick in trying to improve the health care system. That's kind of literal.

So no one could have selected a better person than you to have headed this committee, in my opinion, because of your longstanding background in this area and the credibility that you have in the health care field. And your suggestion on a full health exam at the time of discharge, now, I don't remember—I was discharged many, many years ago, and I don't think I had a full health exam. I do know when I was transferred from one base to another, they had some sort of an exam, because they found a bad tooth, and they had a hammer and a chisel trying to get at the—they broke the dang thing, and they had to—so anyhow, I knew that there was an exam at that time.

But that's a good idea. It's something that I've been trying to get in the Medicare bill, when a person goes on to Medicare, that they're—not required. It wouldn't be mandatory. But at least to have that available, or the funding available for a full medical exam, which I'm sure ultimately would save some money.

Let me ask you maybe a generic question. The letter—the report is dated May the 26th. At least that's the date of your letter on the report. This has been made available to the administration.

Ms. WILENSKY. Yes.

Mr. BILIRAKIS. Any comments from them yet?

Ms. WILENSKY. Let me share with you a process. Because it not only requires legislative action, congressional action, to implement some of our recommendations, but many of the recommendations

can be implemented administratively. And because we were a Presidential Task Force, we thought it important to keep the administration aware of where our deliberations were going. And approximately once a month, I would brief Under Secretary Chu, and either Secretary Principi or Deputy Secretary Mackay, and in addition, periodically meet with individuals from the White House to indicate where we were going, particularly before the interim report and before the Final Report.

My sense has been that at the two departments, we had very good cooperation from having detailees made available to us to—very responsive reactions to requests made at senior levels, and whenever the request was made at the White House to brief as well.

We have gotten very positive response in general ways. We have not—it has not been very long since the formal report has gone up. In fact, it was just a couple of days ago. So we have not had any formal reaction. But informally, the departments and the White House have seemed to be pleased with our recommendation in that we have both addressed a lot of issues with regard to leadership and seamlessness and transparency with some specific suggestions, and that our recommendation in terms of access has seemed to be in a reasonable and reasoned recommendation. So in a general way.

Mr. BILIRAKIS. Okay. And it's going to take an awful lot of cooperation. And you use the words "be vigilant." So we've got to be vigilant to make sure that the cooperation is taking place, and you're a Presidential Task Force, and you did receive courtesy, I guess, at the top and whatnot. But you and I know that it's the people down on the line who are more often not the problem.

On the point of the mismatch—and I know others are going to bring it up—was that made known to them prior to their actually receiving this report? And if it was, any comments from them?

Ms. WILENSKY. The answer is yes, at least in the sense of individuals who are part of the White House structure that I interacted with. That information was made available. Again, everything we do was open to the public, so it was as much courtesy as anything else, since our deliberations were already known what it was that we were going to be recommending.

It does appear, as best we can tell, that the fundamental recommendation that we have made with regard to the full funding of veterans 1 through 7 is or could be accommodated by the President's 2004 budget, so that we do believe, at least at the get-go, that what we have recommended within a general framework is at least consistent with the broad budgetary guidelines.

The question about how you assure full funding over time is a different issue, and it is one that we think is appropriately a congressional matter to be worked out. But we have had support, including the funding issue. Or at least we have not had any indication that what we have recommended is regarded as inappropriate.

Mr. BILIRAKIS. Just very quickly, Mr. Chairman. Is your recommendation, can that be interpreted as meaning mandatory funding for Categories 1 through 7?

Ms. WILENSKY. Well, we think it's very—the answer is we have been very careful not to use the term "mandatory funding." Be-

cause we think you get into fights that you don't need in order to resolve a problem which I believe all of you support, which is having full funding.

It was not an accident that we used the term "full funding" and indicated there were a variety of ways to meet that. Some of the commissioners would have been happy to stop at that level of saying, "We're recommending full funding so that certain things be accomplished, and there are a variety of ways to get there." Others felt more strongly they wanted some examples of what some of those are. Because we don't want to have an attachment to a particular strategy like mandatory funding get in the way of accomplishing what you want to see done.

And as a former HCFA administrator, I was very uneasy with terms of entitlement, as well as some of our other members who were very uneasy about what mandatory funding might mean in terms of disputes between appropriators and authorizers. So we thought it was much more important to focus on what we want to see done, and not specifically as to whether it ought to be a mandatory funding.

At a more technical level, my understanding in some discussions with some of our commissioners was the must-pay bill model that the DOD uses for the under-65 is now technically mandatory funding.

And so it was an issue where we thought it was important to say, "Here's what we want to see done." And we actually—and several of us actually felt rather strongly. We did not want to get locked into what we know are very controversial concepts, like the term "mandatory funding," which carries with it a term of art.

Mr. BILIRAKIS. The trouble is, we have to get locked into it.

Ms. WILENSKY. Yes.

Mr. BILIRAKIS. Yes. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Rodriguez.

Mr. RODRIGUEZ. Mr. Chairman, let me thank you. And also, Doctor, let me also thank you for your comment when you said the present situation is not acceptable. And I think we agree with you that it's not acceptable.

Let me ask you, I'm a little concerned with—you know, and I'm pleased that you, first of all, made the Priority 1 and 7, because I think that's important. But I'm a little concerned with what—you know, I want to get your explanation as to what the committee was thinking when they decided to exclude Priority 8 veterans from VA health services.

We just received a letter—you know, I got at least a comment from the American Legion. And it's my understanding, according to them, that it impacts about 164,000 Priority 8 members. And according to their letter, you know, you might have individuals such as Jessica Lynch and a couple of the others that might fall under that category. And I was wondering what the committee was thinking when they decided to indicate that Priority 8 veterans should not qualify for VA services.

Ms. WILENSKY. What we said is we think that we need to see full funding for those who have historically been treated by the VA. And those who have historically been treated by the VA are people with service-connected disabilities, which I suspect, actually, will

be where Jessica Lynch ends up. Although I don't know. She's a young woman and may have full recovery. Or those who are low-income, including, importantly, the new Category 7's, which are the geographically-adjusted definition of the low-income.

This is not happening. And we think this is, first and foremost, the function and obligation of the veterans hospitals. We are not telling the Congress or the White House what they ought to do about 8's. We are saying that for a variety of reasons, the traditional recipients of service are not being treated appropriately in the sense of being able to get access to timely services that meet the VA standards. And the 15 of us had no question that this needs to happen.

If you show the ability to get that done, and the Congress and the White House choose to do something for Category 8's, you should do whatever you think is appropriate. But put the money behind it, so that you don't end up backing out care for those who have historically been served by the VA. That is, those who have service-connected disabilities or who are low-income, which is what we believe has happened now.

So we're not telling the Congress, because we thought it would be presumptuous to do so, what you should do about 8's. We're saying the current situation means that the 1's through 7's are not getting the care that they traditionally have looked to the VA to receive.

Now, we understand that we've opened that door a little because of the 7's. But for someone like myself, as an analyst and researcher by background, I regarded the 7's as the corrected version of the 5's. That is, you can't use an income cutoff and not have a geographic adjustment, because cost of living is just too different around the country. We want to see that problem resolved for the 1's through 7's.

Mr. RODRIGUEZ. That was my concern, if you had made a decision on the 8's, whether a future task force might come before us and decide to cut off the 7's, and down the line, you know.

Ms. WILENSKY. Well, my view would be—and this may not make you happier with the statement—but the specific cutoff of what makes low-income that was chosen for the 5's was chosen at I don't know exactly when, and I don't know exactly who did it. Whatever the cutoff is for the 5's, that ought to be geographically adjusted.

So I'm not going to tell you that the current cutoff, which I think is about 24,000 for an individual, and 29,000 for two, is the right income cutoff. And by Medicare standards, that's very high. Or by Medicaid standards, that's very high.

But I'm going to tell you that whatever you use in 5, you ought to geographically adjust. Because the cost of living in Utah versus New Jersey or New York or Florida is not the same, and that the spirit of what you want to do requires a geographic adjustment.

So whether the particular income level that's in the 5 is right is a different matter that I don't have any particular——

Mr. RODRIGUEZ. And I agree with you from that perspective. Because there's no doubt that even from region to region, we've seen the disparity of the types of services that are provided. And if you're a veteran in a particular region, you might get a lot more

than if you're a veteran somewhere else. And so we see the disparities there.

Now, did you all talk about figures in terms of money that's needed and resources that are needed to fulfill that 1 to 7 priorities?

Ms. WILENSKY. We asked informally for some budget assessment. And we had an informal estimate by one of our staff who has a very long history of being a budget and finance expert, that we thought it was—I'm doing this from memory. I can give you this information more formally. But I think for the 2004 budget, we thought it was about $28 billion, or at least whatever—again, I'm doing this from memory—that the current request, the 2004 request from the administration, including the presumption of about a million dollars of administrative efficiencies, would accommodate that 1 through 7 delivery.

Mr. RODRIGUEZ. And it would accommodate the disparities from region the region?

Ms. WILENSKY. It would in the aggregate. This was what it would take in the aggregate to provide services for the 1's through 7's so that they could have their services provided with meeting the VA standards.

Now, again, what we acknowledge, one of the reasons that we have the recommendation 5.2, which is that if VA can't provide them, they ought to buy them, is that particularly in the short term, we think that even if the money in the aggregate is present, it may not be possible for the VA to meet its own access standards in the short term, because there will be spot mismatches in terms of supply and demand.

We're not suggesting that they ought to always go build. As you know, we're in a period where we're having expectations of increases in veterans and then decreases of veterans. And we think it's very important that a lot of thought go as to how short-term mismatches get taken care of if the funding is there. Funding there is a way to resolve the issue, and it's not necessarily to expand capacity in order to provide the services.

Now, that is a level of detail that we did not get into as to where that might occur. But in principle, the issue was one that we discussed.

Mr. RODRIGUEZ. Thank you.

The CHAIRMAN. Thank you. Mr. Beauprez.

Mr. BEAUPREZ. Thank you, Mr. Chairman. Doctor, good to see you. I want to follow some of that same logic, I guess, the money trail, if we can. Did your Task Force get into the issue of the DOD-VA collaboration? I've heard you speak about that. That intrigues me. Did you try to quantify the efficiencies that might be gained to any real degree?

Ms. WILENSKY. No. When the issue was raised, the issue was raised not only in terms of the collaboration, but the issue was raised as to what were the efficiencies possible of each of the two departments worked at their maximum efficiencies, which we think also impacts on funding requirements of the VA and the DOD. And we did not believe that we had the time or budgetary expertise to know how much more might be able to be done if each of the two departments operated at maximum efficiency. Periodically, as I

know you're aware, there are reports suggesting one or both departments have not resolved all of their efficiency issues.

What we were able to conclude, what we felt we were able to conclude—and it was more a sense than a calculation—was that the mismatch between demand and funding for the VA was so great that even as we observed that increased number of veterans being treated over time so that the resources for veterans was declining was such that it was not within the relevant range, and that therefore, there was a funding problem that went beyond, in our view, anything that was likely to occur in terms of relief because of collaboration.

So we did not want to deny what it was. We didn't particularly feel capable to try to estimate the financial impact of increased collaboration and sharing. We felt that what existed was sufficiently disparate from where we were that even if you had maximum efficiencies, both from collaboration and individual operations, it would not begin to accommodate the mismatch that we were observing.

So we did not want to downplay it. Several of our commissioners repeatedly reminded us that we need to acknowledge that while we are talking about increased funding, we need to put more pressure on increased efficiencies within each individual organization, as well as the potential for collaboration.

Mr. BEAUPREZ. And I suppose, from region to region and case by case, that opportunity for collaboration may provide different levels of financial efficiency——

Ms. WILENSKY. Absolutely. I mean, they are—right now, they were basically one-off experiences. The joint efforts and collaboration occur differently in different parts of the country. They were very much the result of leadership in the military in the veteran side, wanting to solve a problem and finding a way to do it, despite no particular encouragement that was present.

And it was that that we were trying to institutionalize and encourage, and recognize that leadership at the top, recognition, this is important, and the use of executive counsel, where you had an ability to think through and to do a lot of—there are a lot of things that if they were aligned better would make it easier.

For example, there are 21 VISNs for the VA. And those don't—and there are three big regions now from the DOD's TRICARE. Now, the fact that you have 21 and three might not be a real problem, except that there's so much decentralization in the 21 that if you're on the DOD side and you're working with three or four VISNs, you might have very different rules that apply, and you might not have a consistent fit in terms of the VISNs could map into a particular larger DOD region.

So those are the kinds of issues, if you're going to make it easier to have collaboration, if you're going to make it important, you're going to have leadership driving it, you've got to make sure that these barriers of different timing cycles and different geographic locations and different processes that occur across VISNs, that you take care of t. And we think you will be able to get some efficiencies out of it.

Mr. BEAUPREZ. This committee has heard me talk about the possibilities of moving our current VA hospital in Denver to the Fitz-

simmons campus. And in a recent visit, both DOD representatives as well as the VA representatives are very encouraged by the possibility of joint collaboration, and cited one very specific and current example, a challenge for the DOD.

During a period of deployment, as we're currently under, the challenge of providing adequate health care for active duty military, and especially dependents who are left behind, becomes extremely problematic, as you've got docs and staff deployed.

And in a final comment, if I might, Mr. Chairman, I am really pleased to hear of your recommendations about this seamless transition from active duty status to veteran status. It's at least my sense that we have done maybe a very poor job—"we," the government—in providing that reentry, that seamless reentry, back into private life for the sake of our veterans. And we've seen on this committee already far too much emphasis, needed emphasis—but sadly, the need for emphasis—on our homeless vets and other challenges that I think go back to that poor job of acclimating our active duty back into the private sector.

Ms. WILENSKY. And some of it does have financial consequences.

Mr. BEAUPREZ. Absolutely.

Ms. WILENSKY. Vice Chairman Bilirakis mentioned the fact that historically, there had been two physicals that would go on—one when you were leaving the military and another when you were trying to claim any benefit or be treated in a veterans' facility. And that is both wasteful and it is anything but seamless for the individual who's seeking care.

Now, we can't always get everything on the first round. Because if it turns out that there's some problem that either doesn't show up until a few years later, or that requires a lot of follow-on care, then, you know, you might need more than one physical. But the notion of having as the standard one physical at discharge and the information electronically going to the VA, and then if there's a need for follow-up, you know where you started, and you have a better chance of being able to do it once right.

So it's the reason for doing a lot of the one-stop shopping, that maybe you can keep some of the problems that have arisen later on for veterans, either homelessness or medical problems, you have a way of following what's happened to the veteran and seeing whether there appears to be some patterns.

We have a number of places where we recommend that there are annual reports that get made to the two secretaries and to the President, or that are made available to the public, so that there is a way to track whether that's something going on, and that it's not just one more event.

So I don't want to suggest we don't think there are efficiencies to be had. We do. We had trouble quantifying them, because the activities that go on appear to be unique or singular to the joint venture that is out there. But we also felt comfortable saying that the degree of mismatch is such that no reasonable assumption of efficiencies is going to solve the problem we stumbled on.

Mr. BEAUPREZ. A final comment, if I might, Mr. Chairman?

The CHAIRMAN. Very brief.

Mr. BEAUPREZ. In addition to financial concerns about later health care problems, I think we've got a humane concern, that we

may be discharging people, and then see families break up, and societal loss, and cultural loss, and the tragedy of the contribution that these veterans can make a positive one, as opposed to what we do to them and the folks around them. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Beauprez. Mr. Michaud.

OPENING STATEMENT OF HON. MICHAEL H. MICHAUD

Mr. MICHAUD. Thank you, Mr. Chairman. And thank you very much, Doctor, for coming here today. Really appreciate it.

Reading over the report, you made some very—in there, there are some strong statements that it's become clear that there is a significant mismatch in VA between demand and available funding. If unresolved, will delay veterans' access to care, and could threaten the quality of VA care. And further on, you talk about the problem of not being able to meet demand as already serious, but it will only get worse if not addressed soon.

I guess a couple of my questions. I appreciate the President taking a real interest in this and establishing the Task Force. But if full funding is not met, and all that you talk about in the report is nothing that we haven't heard about from the veterans' organizations from all around the country, what do you envision your role now as far as trying to push for full funding to take care of the veterans that we—the services that are currently out there?

Ms. WILENSKY. I think there's not in any way a formal role for any of us who are part of the Task Force. Our Task Force is effectively out of business. It was either last Wednesday or last Friday that the executive order that established us expired us, so that we don't have a formal role. Some of the Task Force members are members of veterans' advocates' organizations. I know that they have been and will be in contact with you. And so the expertise is available.

This was not, as you know by both my testimony as well as you know by the executive order, a task force that was set up to look at funding issues specifically. We were a task force that was set up to look at ways to improve collaboration and sharing, and to improve resource allocation. It really was the finding of the 15 of us that, while that is important, we think that it is important for a way to have access to good health care.

We think it's especially important for the seamlessness issue, which we think is fundamentally the goal that ought to exist between active duty and veteran status. But that our observation was we couldn't see what we were asked to do done if this fundamental mismatch wasn't resolved, and that it was having and would have an impact on the ability of veterans to receive access—timely access—to health care.

So it was an issue that although was not directly in our charge, was inescapable to us, and we regarded as a serious one.

We do think making the distinction—and obviously, as you know by the report itself, and as I'm sure you know by the discussion around it, which again was very public, because everything we did was very public—there was disagreement about the distinctions we made between the service-connected veterans and low-income veterans and those who were neither, the so-called Category 8's, in

our view was first things first. Although I don't know that other people would have used that language. But there are historical, traditional users of the VA, and those are the people with service-connected disability and low income, and that they have not been able to get care in a timely way. And that needs to happen.

And then the lack of clarity, along with the funding to follow, needs to be resolved for the 8's however the Congress and the President wants. But it is a serious issue.

Mr. MICHAUD. Thank you. Also, the Task Force, one of the recommendations is to provide with an electronic DD214. This is an issue which has been underway for some time. Did you look at what obstacles have been in the way, prevent it from being accomplished thus far?

Ms. WILENSKY. I'll tell you what our conclusion was, which is that it was not a technology obstacle. I mean, the one thing that was pretty clear as we went along is that none of the barriers in terms of electronic sharing of information were technological obstacles.

Now, there is one issue that we had to deal with, which it was HPA provisions, that the privacy provisions are such that we need to make sure that for purposes of transfer of information, that DOD and VA be regarded as a single organization so that we don't trip on HPA requirements. And we dealt with that.

But there is nothing that we are aware of that is a technical issue, and that there is not other issues that can't be circumvented, like the privacy concerns, and dealt with in terms of the single organizational statute.

It was particularly frustrating, because both VA and DOD really are exemplary in terms of their use of electronic medical records relative to the rest of the health care system, and in credentialing. But unfortunately, they have tended to be separate and independent, and not able to communicate.

The CHAIRMAN. Mr. Michaud, thank you. Dr. Murphy.

OPENING STATEMENT OF HON. TIM MURPHY

Mr. MURPHY. Thank you, Mr. Chairman, and thank you, Dr. Wilensky, for your report. I'll try and get in all my information quickly in my allotted time.

First of all, on the issue of waiting lists, I have a question about those folks in particular who are trying to get in to see a VA doctor in order to obtain some of their prescription drug benefits. I didn't see it in here. It may be in here. But issues involving allowing veterans to see their own physician in order to use that as an avenue to at least take part in some of the benefits of prescription drugs, is that an area you looked at, or something that maybe you'll look at in the future?

Ms. WILENSKY. We did look at it. It was a controversial issue. We struggled whether we wanted to have non-VA or DOD physicians writing prescriptions that would be filled by the VA. We raised—again, this is all part of the record—whether we wanted to at least suggest an option would be a stand-alone pharmacy benefit. Not exactly a surprise that some of the increased pressure in the VA, is it reflecting increased spending on pharmaceuticals and the lack of an outpatient Medicare pharmaceutical benefit.

But we thought there were concerns—sufficient concerns and sufficient disparity of opinion—on all of these issues, that we had a very narrow focused recommendation.

What we did recommend was that the VA fill prescriptions that were written either by VA providers or MTF providers—the direct providers, not the people in TRICARE who are outside of the facility—for those who received care in either place be able to be filled by the VA. We had a lot of discussion about whether to have people who were seeing their physicians on the outside come to the VA. We decided against it, not to make that recommendation, at least. You know, it's something that the Congress can choose to decide. But we were concerned on several grounds.

One thing we were concerned about, making VA into the CVS or Walgreen's, changing the function that the VA provides, which is comprehensive health care benefits. That's how they regard themselves. That's how they pride themselves. We were worried as to whether there might be some distorting over time because of the very large number of veterans who might choose to get low-cost pharmaceuticals at the VA who are not currently doing so.

Mr. MURPHY. Well, recognize that when we have waiting lists, it may be 6 months, a year, year-and-a-half from the point of view of the veterans. I still hope we can explore this issue.

One example might be that if a person is on a waiting list, they can have a prescription from their physician they may be able to access, even if it's such a thing as a mail order system. And purchasing the medications at cost so they still have some substantial discount may be particularly beneficial for all veterans while they're still waiting to go through the network.

A second area I want to get into has to do with how procurements are done. We don't have the time to go through this whole process. But when it comes to prescription drugs—and you made some good recommendations of continuing on the DOD and veterans collections of—or working on discount drugs together—real quickly, how do we currently now negotiate purchases and prices of prescription medications?

Ms. WILENSKY. Well, I've become more of an expert at this than I have in the beginning, but I'm not the expert that was on the Task Force, of whom we had several. Basically, we used the federal supply schedule. It requires a minimum discount by the manufacturers in order to get into the first round of being available on the federal supply schedule. It's an AWP——

Mr. MURPHY. So they have to agree to that discount.

Ms. WILENSKY. They have to agree to the discount. But then the VA frequently negotiates even greater discounts in order to be on their closed formulary.

Mr. MURPHY. And how do they negotiate those? Through closed bids, or through——

Ms. WILENSKY. I'm not sure. But there is—now, what we have recommended—because part of what goes on is the nature of how closed the formulary is. Both the VA and the DOD allow some local decision-making to override a formulary. We have recommended that there be a joint national formulary for the VA and the DOD. We do recognize that the two systems and the ability of TRICARE

individuals to be much more on the market, so to speak, puts different kinds of pressures.

And so the jointness may—I mean, we think it can expand over what it is, but we recognize that because they are different populations, they tend to have different use of in-house facilities. And not being part of the larger private market in the VA versus the DOD will impact just how far they go in terms of their joint formula.

Mr. MURPHY. One area I hope we can continue to discuss and explore is using—I know a company Free Markets On-Line is one that allows reverse auctions on line when you are making large purchases of things. To do that, I think could lead to some substantial cost savings. I know many industries use that approach. Different from the closed bid or negotiations, they simply have everybody bidding at the same time, and it can lead to some massive savings.

So I think we're all concerned that we want to make sure, as you do, that the discount's there. Because the more we do that, the more we save, the better the benefits can be for those who need it. So I'd certainly encourage it, and I'd be glad to continue talking with you about that.

Ms. WILENSKY. And I think the—it's not only you could do better with pharmaceuticals—that's the are where they do the best, and have been most aggressive. And because they can tend to offer some volume in exchange for the lowest price in terms of their position on the formulary, we think, have been pretty effective. Certainly much more effective than anyplace else in the economy.

What we have seen much less of is that same kind of aggressive bidding, whether or not it's through closed bids or on-line auction bidding in all the medical device and other areas. And we think that's important for DOD and VA to explore, that they could do some of what they're doing now in terms of the pharmaceutical area in many other areas that they're really not doing.

Mr. MURPHY. To rebid the medical equipment could do that too.

Ms. WILENSKY. Exactly. Acknowledge the equipment. Information sharing.

Mr. MURPHY. Thank you, Doctor. And thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Doctor. Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman. Dr. Wilensky, I thought I heard you say at the beginning of your statement that you and the others had volunteered your time for this important task? Is that correct?

Ms. WILENSKY. Oh, yes.

Mr. STRICKLAND. I just think it's important for all of us to recognize that, and to be appropriately appreciative, because it's a wonderful thing you've done. And I, and I'm sure all of us, really appreciate the fact that you and the others were willing to do this.

You've said in your testimony that in response to, I think, Mr. Bilirakis's question that you tried to keep the White House informed periodically, as well as the heads of the agencies, as to your Task Force findings and so on. And I assumed that included information about what you've been finding regarding the efficiencies that the VA has achieved.

And I appreciate the fact that you've spoken about the fact that the VA has achieved a high level of efficiency. In fact, you specifically say, and I'm quoting, "Even if the VA were operating at maximum efficiency, it would be unable to meet its obligations to enrolled veterans with its current level of funding."

And the reason I think that's important is because as a part of the budget request, the administration has identified almost a billion dollars in so-called management efficiencies for the medical care program. And I go back to one more quote that's found in the summary. "But increasing enrollee demand, combined with available funding, has forced significant reductions in per-patient expenditures beyond what could be expected from improved efficiencies."

And I'm wondering if you'll just comment on that, because it seems like there's a contradiction between what the administration is suggesting is possible and what your Task Force has concluded.

Ms. WILENSKY. I don't think there is a contradiction because of specifics either that we've identified or that have come to light in the newspapers. We believe that there is a need for an increase in the resources, and we think that's important. We think there is especially an urgent need to resolve the issues of the 1 through 7's versus 8's, make sure that the funding is there for the 1 through 7's, and decide what you wish to do with the 8's with the funding behind it, that we think a lot of the problem has gone on because of the change in those rules.

Having said that, we've identified, and the newspapers have now raised a further issue to suggest that there are, even though the VA in general operates quite efficiently, we think there are billing efficiencies that are out there that have not been met in terms of billing third-party payments.

Mr. STRICKLAND. Could I interrupt? So are you suggesting that in spite of what's obviously very thorough work of this Task Force, that stories that have appeared in the newspapers could indicate that there may be as much as a billion dollars or more in inefficiencies that have not yet been identified by the Task Force?

Ms. WILENSKY. I mean, a billion dollars is a big number, other than relative to the total budget that's being requested. And I don't think that they're contradictory to say that well, in general, there's need for more resources. We think that there are inefficiencies that are out there, some of which we've talked about in our report with regard to the billing of third-party payers, which the VA has been working on, but for which there is some indication there are still some issues that have been resolved in terms of the timeliness of getting the bills out and in terms of how long it takes them to actually collect the information.

I don't know the accuracy of the report that was in the media a little while ago about the cases of physicians who were being paid by the VA who were not providing very much service. But having assumptions of improving productivity over time, even for generally efficiently-run organizations, is not uncommon. In all of your Medicare budgets for hospitals and physicians, where each year there is some increase being requested, and usually some increase being provided, there is an assumption about improving productivity.

Mr. STRICKLAND. So I think it's fair to conclude, from what you're saying, that efficiencies have been achieved, but there are possibly—it's possible that there are much greater efficiencies that could be achieved in the future?

Ms. WILENSKY. I mean, I would be willing to say that about any place in the health care system in the U.S. at any moment in time.

Mr. STRICKLAND. But also recognizing that no system is ever going to be as efficient as it could be, and we're going to have to live with a certain level of inefficiency in every system, even the most perfect.

One final question. The report continuously makes reference to the phrase "enrolled veterans." Is that an attempt or an effort to distinguish Priority 8 veterans from all of the others when that phrase "enrolled veterans" is used?

Ms. WILENSKY. Not entirely. It is certainly in part that, but we were actually much blunter of saying we want the Congress and the White House to rethink all Category 8 veterans status in the funding that is willing to be put in. So it actually—I mean, we were not as delicate in our distinction.

What we're recognizing—as again, you know better than I do—that the number of veterans who are out there, and the number of enrolled veterans in all categories, leaves many veterans who, for whatever reasons, are not currently enrolled. That's certainly true in 5. But it's true even in 3's and 4's, that we looked at enrolled veterans relative to the total number of veterans, particularly when we were talking about issues of full funding, recognizing that it not only would provide services to those who are currently in the system, it may well provoke people, 1 through 7's, who for whatever reasons have hysterically not enrolled to decide that they wanted to come be part of the VA system, given that the VA would be meeting its own access standards, and that that could have repercussions.

So it certainly goes to the fact that of the many, many potential Category 8 veterans, some are enrolled and many are not. But we think it's important for the Congress and the White House and the public to understand. That is true for 1 through 7's, I think, maybe more than people—again, I think this committee is well aware of it, but many of us were surprised at, particularly in some of the categories, how many were yet not enrolled who might enroll.

Mr. STRICKLAND. Mr. Chairman, could I just make a concluding statement?

The CHAIRMAN. Sure. Go ahead.

Mr. STRICKLAND. This past weekend, I attended a health fair, a veterans health fair, in Steubenville, Ohio, where personnel from the Pittsburgh Medical Center came. We had that health fare as a result of a conversation I had with the secretary. And I think it is important to note that the official policy of the VA right now is to not have aggressive information sharing with veterans, regardless of what priority group they may fit into. It's the official policy.

So I think you're correct. There are many veterans 1 through 7 who are not enrolled who certainly should be enrolled, and may not even understand what services they are legally entitled to receive. Thank you very much.

The CHAIRMAN. Chairman Simmons.

OPENING STATEMENT OF HON. ROB SIMMONS, CHAIRMAN, SUBCOMMITTEE ON HEALTH

Mr. SIMMONS. Thank you, Mr. Chairman. It's been a fascinating hearing, and I appreciate you holding it. I'm also grateful to the President of the United States for issuing an executive order which created this Task Force. As a veteran, I am truly grateful to him and to the White House for doing this, and I share Mr. Strickland's view that Dr. Wilensky and others have done us a great service over the last 2 years by producing this report, which is a very welcome development.

I happen to be a Category 8, and I appreciate my colleague's concern about Category 8's. But I will simply say that I don't feel I need these services that VA provides, and I would hope that I would not demand services that would displace any other categories 1 through 7, because I think they're in greater need. And I think that's probably true of other veterans who are Category 8, that we all feel that way. So I'm not in the least bit discouraged by your comments about 1 through 7 and the issues regarding 8's.

My question goes to the issue of full funding, and this is something that I think we've all been wrestling with. And I was intrigued that in the summary book on page 15, there's reference to mandatory funding mechanisms. In the full report, we have references on page 77 and 78 to "mandatory." Page 76, refers to "entitlements." Yet in your written statement, I cannot find the word "mandatory" at all, and I was curious as to whether that was just the way the words flowed out, or whether you were trying to avoid using the word "mandatory" or "entitlement" in your written testimony, when it does appear in the text of the documents, and when it is a substantial issue.

And then if I could ask a second question to conserve time. You can answer as you see fit. Recommendation 5.2 states that in instances where VA cannot offer an appointment to 1 through 7 within its access standards, the VA would be required to arrange for care with a non-VA provider. And that's on page 5 of your testimony. What system or process do you visualize when you talk about arranging for care with a non-VA provider? Would that be in the form of a referral, let's say, to a hospital or health care clinic? Would it be issuing a card of some sort—a voucher, if you will—to a veteran, and allowing them to go to a non-VA provider?

So two questions. One, I really am intrigued in the use of the word "mandatory" in the context of full funding. And two, what did you have in mind by non-VA providers?

Ms. WILENSKY. There is no recommendation for mandatory funding. The word does show up in at least two or three places, but it is as an example to get to full funding. It is not in any way in recognition that some have proposed, for example, the Chairman, legislation in the past that relies on this as a strategy to get to full funding.

So some of us, if we had our druthers, would have not had the word ever appear anywhere, because it's a lightening rod that we think isn't helpful.

Again, for us, the relevant concept was full funding, and exactly how you get there is something that we recognize people will differ. The reason we felt so—there were two reasons some of us felt so

strongly that to the extent it was in the recommendation at all, which is as by way of a example, as opposed to a recommendation, that it will be a lightening rod for people who might not fight you if you used a different concept. And that's not helpful in accomplishing the goal of full funding.

And we also actually agreed very much—I was glad to hear the Chairman say it—that several of us are not at all convinced that mandatory funding as it has sometimes been defined would actually accomplish what you thought it would accomplish. So, I mean, you know, with all due respect, we didn't think that was a mechanism to improve on a situation relative to where we were, but we actually didn't think it did what you wanted done. And in any case, it didn't do what we wanted done, which is to have the VA be able to provide services at its own 30/30/20 access standard.

Now, with regard to the second, we were—I mean, as I said, I personally would have wiped out such words, because I think they just get you in trouble. But I am positive there is no place in a stated recommendation other than the 5.1, where it is shown as an example of a way to get to full funding, but very clearly states that "or some other changes in the process that achieve the desired goal." And the text then says, "Here are examples of ways to do it. There are many others."

With regard to what we meant with regard to purchasing it on the market, we didn't really go into it as to how you would do it. But we thought it was more to indicate we really mean this about access standards. Because the VA has had access standards. And this gives a consequence to having the access standards, which is if you can't meet it in your own facilities, you have to be prepared to pay for it.

Now, whether or not it would be by establishing a pool of physicians who would agree to take VA reimbursement rates, or facilities that would agree to take VA reimbursement rates, or whether you would give somebody a voucher to go out and buy it, that's clearly a level of implementation that we didn't even attempt to do. But there are other models. But it was as much to say full funding and we mean it. And this was the accountability part.

Mr. SIMMONS. Thank you. Mr. Chairman, if I could ask unanimous consent to insert an opening statement into the record——

The CHAIRMAN. Without objection.

Mr. SIMMONS (continuing). I would appreciate it. And let me just simply say that the words that appear in the report under Recommendation 5.1 do refer to "mandatory." I realize there are commas on both sides of the phrase.

But I'm for full funding. If we need "mandatory" or "entitlements" for full funding, then that's what we need to consider, because it's incumbent upon us as members of this committee to formulate a policy which reflects the values that we share. And so I read that in the text, and I take it for what it is. Thank you.

[The prepared statement of Congressman Simmons appears on p. 111.]

The CHAIRMAN. Dr. Snyder.

OPENING STATEMENT OF HON. VIC SNYDER

Dr. SNYDER. Thank you, Mr. Chairman. Thank you, Dr. Wilensky, for being here. I have four, five, or six question I want to try to cram in here to our 5 minutes. The first one is on page 6, I think, of the summary, and a couple pages later in the full report, this chart about funding-per-patient expenditure. Funding-per-patient, a way of looking at expenditures. And you talking about the current mismatch is far greater than it has been in the past years, which this chart demonstrates.

One point that you might want to comment on, but then a question. My point is that whenever Members of Congress go back home and brag on "Gee, we increased our veterans budget by this much, this much, this much" is meaningless, unless we look at a per-patient expenditure. Because if you increase a certain amount and you've got increase in medical cost of living, plus increase the number of patients you're taking care of, a total number is just a bogus thing to talk about back home is my reaction to seeing that.

My second point and a question is, I mean, if I do—my math is not very good here. But if we try to get back just to where we say we're a baseline in 1992, are you talking about adding 18 to $20 billion to a budget that's about——

Ms. WILENSKY. Well, you have to be very careful how you look at this chart.

Dr. SNYDER. I'm just looking at your chart.

Ms. WILENSKY. Well, and let me indicate why I'm saying that. I don't remember—I'm hoping it's clearer in the full text than what would be obvious in the short version. Starting in the last 4 or 5 years, you have increasing numbers of people who are not using the VA for their full services. So you have——

Dr. SNYDER. I understand all those issues. I'm going to ask about that later.

Ms. WILENSKY. Well, it just means that—now, the reason I say that is that some of the reason you see a decline in resources per person is that you really have categories who are using this for their full service. Then you have substantial numbers of people who have been coming in. And the reason you're seeing fewer resources per person is they're basically coming in for their scripts.

So it's not to suggest that in order to get things back to where they were in 1992 that you would need to have the resources per person that you hand in 1992. Because in 1992, you didn't have these people who were coming in just to get scripts.

So you would really have to go out—which, unfortunately, with the information system is exceedingly difficult, if not impossible, to do—is to be able to distinguish the number of people who have come to the VA in the last 4 years, say, basically, who have insurance, either Medicare or private insurance, who use that other insurance for most things, but who are coming for low-cost drugs.

Now, the reason it's so tough to figure it out is, by definition, in order to get into the VA, you've got to have had at least one physician visit. So sorting out the people who are basically doing that as their entry point, as opposed to who are making full use now, as I recall in the report, we make an attempt to distinguish between the full users and the very partial users.

But in terms of answering the question you've asked, what would it take to get back to 1992 levels, you really have to only look at the people who would want to be full users and who aren't. You can't take the resources that were being used then, because basically, that wasn't an issue then.

So I don't know. I couldn't do it. I mean, somebody else—except we don't have a staff anymore—could be able to try to make that distinction. But I want to be very sure you understand you can't take the resources per enrollee that exists in 2002 and 2003 and go back and say, "Well, if we had those same resources."

A lot of those people, I mean, they're in there for $7 co-payment pharmaceuticals, which even if you have insurance, which even for most of you for your federal employees' health care plan, of which I am a great fan, you are paying more than $7 co-payment for your script. So there are a lot of people who are really distorting that number.

Dr. SNYDER. So that chart there, without the information you just described, isn't as helpful as it appears to be at first reading.

Ms. WILENSKY. Yes. I hope that in—I know there's some discussion in the full report. There certainly is not in the short report.

Dr. SNYDER. I don't think the numbers were there, though.

I wanted to ask about—Mr. Simmons asked about this going to outside doctors. And I understand that you—if I understand, you're talking about perhaps using it as a bit of a hammer to say we're really serious about full funding. But in practice, if we were to pass a law and sign it by the President this week that says, "VA's, you have to do that," that would not help. I mean, all that would happen is each VA would have to find money to pay the private providers, which they would pool from their current budget, which may mean they would have to cut back on a number of VA cardiologists in order to pay for a private cardiologist.

I mean, you can just start chasing your tail. A mandate like that, it just seems to me, would not be helpful.

Ms. WILENSKY. Well, you are absolutely correct. How you would actually implement this is very important. That we don't think where there are shortages in physical facilities, either in the beds or in the physicians or nurses, that it necessarily means build more. Because I know there was something, "Well, does that mean we ought to run out and build more facilities?"

And the answer is if you think in the future, I mean, if you can support that as a strategy, that's one possibility. If you think what is going on now is a short-term increase in demand that is not likely to be sustained, you probably don't want to either try to hire, and you certainly don't want to build. The hiring is a little more flexible.

The VA has traditionally not been a funder of services. It has been a provider. And it's a very important issue for the VA. I mean, they don't really want to be a funder, as opposed to a provider. And we respect that as what the VA is all about.

We do recognize that in the short term—you are correct—money wouldn't solve the problem alone. And the question of when to build or expand and when to buy because of a short-term issue is something that you would have to be very careful about. And you better use a fee schedule, because the VA has been known for hav-

ing relatively lower expenditures in some areas, and you want to make sure that you don't just end up increasing fees to providers on the outside and making it much more expensive than it would be if it were on the inside. So exactly how you would do that is something that would have to be worked out.

Having said that—and this is not rocket science—it is something that could be worked out if there was a willingness to make the funding available, and a set of steps as to how you would do it. But you would have to do it carefully if you wanted to do it at the lowest cost possible.

Dr. SNYDER. Thank you.

The CHAIRMAN. Mr. Bradley.

Mr. BRADLEY. Thank you very much, Mr. Chairman. Dr. Wilensky, thank you too.

I just wanted to touch base on, I think, what you said in your oral testimony, where we are with the 2004 budget and these recommendations on Priority 1 through 7. And I believe, and I'm just confirming this, that you said that the 2004 budget as it's presently constituted fully funds the goal of full funding for Priorities 1 through 7.

Ms. WILENSKY. That is my understanding. It was an issue that, obviously, having come to the recommendation that we did, we wanted to be able to address. And that is my understanding, based on our staff estimate of what it would cost for full funding.

Mr. BRADLEY. And did your staff look at where that budget lay in regard to Priority 8 in terms of the funding availability for Priority 8 veterans?

Ms. WILENSKY. No, not specifically.

Mr. BRADLEY. So you don't know whether that budget has some allowance for Priority 8 veterans.

Ms. WILENSKY. It has some. The question is how much.

Mr. BRADLEY. How much. Okay. Thank you very much.

The CHAIRMAN. Ms. Brown-Waite.

OPENING STATEMENT OF HON. GINNY BROWN-WAITE

Ms. BROWN-WAITE. Thank you very much, Mr. Chairman. Dr. Wilensky, first of all, thank you. I met with you before this, and you really have a great grasp of what's going on with veterans' health care, and I want to thank you for your service.

I have a large number of veterans in Florida, as does Mr. Bilirakis and some of the other Florida delegation. And this past week, Secretary Principi came down, because I think he—well, he told a reporter he was tired of hearing me complain. And so he came down to the District. Which was great. Because he got to see firsthand the problems that we are having in Florida dealing with so many transplants who leave other states, come to Florida, and have to wait an inordinate amount of time for an appointment.

When I reviewed your report, I saw the recommendation that the VA consider if they can't meet their access standard, which is 30 days, that they provide some sort of fee for service outside of the VA system. That certainly would work. But were you ever able to quantify the cost of that?

Ms. WILENSKY. We did not, frankly, attempt to do that. It would have first required going to identify the areas where we think in

the short term the geographic mismatch between demand and supply, as opposed to funding, is most severe. I think Florida is clearly a case. Probably places in the southwest, Nevada and maybe—I don't know about Arizona, but Nevada seems to have a lot of retirees as well.

What is slightly less obvious is if we are looking at the 1's through 7's, as opposed to 1's through 8's, since we know at least in some parts of Florida, there has been substantial enrollment of 8's. And so that is a different issue, and it depends very much on what the Congress and the President were to decide with regard to the Category 8's.

So we think before you went about actually making arrangements for paying for services on the market, that you have to distinguish the 1 through 7's that you are now claiming full funding responsibilities for for the 8's.

As past HCFA administrator, we do have experience setting out fee schedules and making it be payment in full if there is to be participation. Now, some places do that much better than others. And depending on exactly what part of Florida you're in, Medicare may not be a good example to use as to how you can have a fee schedule and have good participation or not. In general, there is good participation both among physicians and hospitals in Medicare, although sometimes there's more grumbling in some areas than in other areas. But you would have to be very careful about the fee schedule that you used. Otherwise, you would find yourself going through money at a faster level. Our presumption——

Ms. BROWN-WAITE. But isn't Medicare pretty much the standard? I mean, most insurance companies base their reimbursement to providers based on the Medicare rate.

Ms. WILENSKY. Sometimes they do. It used to be on more than a hundred percent. Now sometimes, it's on less than a hundred percent of Medicare. It is usually Medicare, but it may be a multiple that's greater or less than one.

Ms. BROWN-WAITE. I'm drafting a bill that basically says that VA has had these standards of 30 days for an appointment, that if they can't meet those standards, that they would have to offer health care outside of the VA system. And the reason why I'm drafting it is obviously because of the problems that many of my veterans are currently having.

Do you think that VA could meet that self-imposed standard without specific legislation? And are you aware of areas where—you know, obviously, if it's a supply/demand issue, you know, they're probably meeting it in areas where veterans have left and moved elsewhere. But in areas, you know, where the senior veterans are moving to, there is a problem.

Ms. WILENSKY. I think there are two issues. One, again, is you really have to sort out how many enrolled 8 veterans are present in particular areas, and how much that's contributing to the problem, and what, if anything, is the Congress and the President about to do with regard to that issue?

And then the second thing is that it is my impression—but it's only an impression—is that there is some—that you may need to look and make sure that as the veterans move, the money moves. It may be just the jaundiced view of those places that are receiving

veterans. There certainly is the belief by some of the places in the south and the southwest that the veterans are moving faster than the money.

Now, I mean, it is not something I attempted to ascertain. But to the extent that you're in a receiving area rather than in a donating area, this becomes an important issue.

The CHAIRMAN. Thank you. Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman. Doctor, you seem to be saying that the current funding process has yielded an adequate budget, at least for the fiscal year 2004. And yet the report contains some pretty substantial suggestions about changing the funding process.

If from your point of view the current process is adequate, why all the discussion of a funding mismatch and the new funding strategies?

You know, I guess full funding for veterans is a term we like to use in Congress. It's also subject to the determination that it will help all people. And for example, my definition would include adequate funding for any veteran who requires health care. What is your definition of full funding?

Ms. WILENSKY. In the first instance of why do we talk about strategies to insure full funding when it appears that the 2004 budget meets full funding for the 1's through 7's is that it meets it for 1 through 7 in 2004. We recognize that if we were to see this recommendation implemented, you might want to have some strategy that assures that what is true in 2004 is true in some other year.

And so we have indicated there are a variety of ways to get there, and it is an issue for the Congress to decide how to do that. But we do think it's important to note that the 2004 budget does appear to do this, as requested by the President. But whether that would be true some other year with this or some other President is a different issue. So we're suggesting that those are two issues.

With regard to the second part of your question as to who is to be treated—was that the second——

Mr. EVANS. A definition.

Ms. WILENSKY. Pardon?

Mr. EVANS. A definition of a fully funded——

Ms. WILENSKY. Well, I don't—I mean, the definition is whatever the Congress chooses to make eligibility for services. Our concern is that there has been an opening of the door for 8's, but there hasn't been funding that provides services for the 8's. We do recognize that the Congress, in fairness to the Congress, did put in a very politically difficult charge mechanism, which is that the secretary in any year can stop enrollment. It is easier for a group of non-politicians to say, "We don't think this has worked very well." It is a highly politically-charged issue to invoke.

And furthermore, the group that the VA has traditionally served, which is veterans with service-connected disabilities and low-income veterans, are finding themselves unable to get services that meet the VA's standards. We think this needs to be rectified first and foremost, and we are not telling the Congress they couldn't or shouldn't put some extra money in to do something for 8's. We're saying, "Fix the problem for the traditional historical users of the

VA, and then clarify with the money attached what you want to do for the 8's."

I mean, I understand that there is disagreement. We certainly heard it among some of our Task Force members. And I'm not going to tell you not to put more money in so that you could offer some or all benefits for 8's. That's your decision.

What I'm going to say is the traditional users are not getting services in a timely way, and it is being exacerbated, in my opinion, because of the opening up of the 8's. So take care of this issue first, and then clarify with funding whatever you want to do for the 8's.

Mr. EVANS. At this point, I'll yield back to the Chairman. Thank you.

The CHAIRMAN. Thank you. Let me just ask you a couple of follow-up questions as well. Chairman Simmons, like myself and others, raised the issue of Recommendation 5.1, which I think is very clear in at least suggesting that there are alternative approaches, including "mandatory."

As I indicated earlier as well, I remain concerned that a capitated formula might miss—might hit a bulls eye, but it might miss by a mile. As opposed to the flexibility inherent in the first recommendation that's made, it's more likely to get a number that's real, sustainable, and actually marries up resources with need.

I think what should come out of this hearing—and I do appreciate your testimony. You've been here for now 2 hours, and have provided expert testimony—not getting there. That is to say, full funding is not an option. We have to get there.

And this committee—and I do believe we'll work in a bipartisan way with the administration, with the other body, will work to make sure that we get there. And some people, hopefully, will look at the details and the fact that veterans are not getting care that they deserve, that rationing of care has become a very serious problem, as you point out. A quarter of a million people as of January—and the number could be higher or lower since—have been told wait 6 months or longer. That's unconscionable and totally unacceptable.

But not getting there just simply isn't an option. We have to get there, and this committee will do everything possible to do so.

In talking about the number for this fiscal year, which has been an issue of considerable debate during the budget resolutions that have gone through and have been accepted by House and Senate, we were looking at the full demand model. And I was wondering if the—in terms of what is really needed again to put the resources into play to make sure that health care is adequately provided, did the Task Force examine the VA's full demand model when it forecast which forecast that the VA would need 31 billion in fiscal year 2004?

I looked at the $28 billion number that you've mentioned, and, I mean, that includes moneys that have been—you know, collections, perhaps enhanced co-pays that were anticipated by the President. I'm not sure how that number was arrived at. But the demand model, which hopefully gives us the honest to goodness what's needed, you know, based on our best projection, VA's best projection, did the Task Force look at that?

Ms. WILENSKY. We did not specifically attempt to do the kind of reconciliation that you obviously have done. In general, we talked about the different forecasting models that were used, including the VA's demand model, but we did not attempt to do this.

The CHAIRMAN. Okay. Let me just ask you with regards to some of the other recommendations that I think, as you indicated, could be done administratively. And we'll go through this very carefully to see where legislation is needed and work with the VA to determine if the authority is sufficient, or if they need new authorities in order to carry out these great recommendations.

When it comes to facility life cycle management, on page 56, I couldn't help—I mean, we have tried in this committee—it's been bipartisan. I offered H.R. 511. Mr. Evans is my principal co-sponsor. We got it passed. We got it in the budget. We got it in the Appropriations Act. Went over to the Senate. Five hundred eleven million dollars for fixing and repairing facilities throughout the country, most of which were on the west coast, just died an unceremonial death.

Mr. Moran, who was chairman of our committee previously, got a good VA construction budget bill passed. Died over there. Mr. Simmons is now drafting legislation to do the same.

I hope that we can use your recommendations here where you point out the paltry amount of money that's been provided. If you're going to have an infrastructure, you've got to pay for it. You've got to keep it updated. Otherwise, in the end, you pay even more, or you lose it. And you make the point, the VA—at the rate that we're currently going, the VA would have to recapitalize its infrastructure every 155 years. I mean, it will go to sod if we do not step up to the plate. You might want to comment on that.

And the other point I just wanted to make, on page 27, you say the VA and DOD should develop and deploy by fiscal year 2005 electronical medical records that are interoperable, bidirectional, and standard space. Is the 2005 number doable?

Ms. WILENSKY. We had several rounds of discussion with VA and DOD. They said yes. Pushed, but yes. They would have been happy to see a slightly higher number out there, but when pressed, thought it was doable.

The CHAIRMAN. Okay. Let me ask you, did you want to comment on the facility life cycle?

Ms. WILENSKY. No. I mean, I think it stands for itself.

The CHAIRMAN. Let me just say, one of the footnotes I noted—and I didn't realize this until I saw it. And that was that pursuant to BRAC, there was a reduction of 48 hospitals within the U.S. and abroad, approximately 40 percent of the 1988 infrastructure, as well as 400 clinics and 45 hospitals to clinic realignments, as part of the DOD side of it. That is a significant, almost slashing of health care infrastructure. And now we have a CARES process, and Edward Alvarez, as you know, chairs that. That will be coming out, I think, sometime in the fall. He was a member of your panel. What's the interface there with the recommendations here in terms of the CARES process? I mean, much of our money—matter of fact, when we got to the Senate side with our VA construction budget, we were told, "Well, let's see what CARES does first." And we said, "Wait a minute. These projects are going to survive any CARES

process," at least according to the VA. "Let's get this done now." But it still became a nice pretext for killing those bills.

Do you anticipate—what's the interplay there?

Ms. WILENSKY. Well, the first is that part of what went on with BRAC is that where the facilities were and where the people were weren't always the same. And in any case, the movement away from necessarily on-site military provision, as opposed to a more integrated use of the market, and use military treatments facility in a more integrated way, has put the DOD in a very different position.

With regard to the CARES project, there certainly is going to be some transition because of Edward Alvarez's involvement in both. I had been asked to address them, but was out of town earlier in the month of May. But one of the other Task Force members shared with that group where we were and why we got to where we are. And I presume that that will continue.

Having said the discussion we had this morning about even the money might not be sufficient for the VA to directly provide, where the facilities are is also not always where the veterans are. And having a thoughtful review of whether existing facilities make the most sense. And there are, as you know, some areas of the country that have high concentrations of what look like, on the face of it, multiple VA facilities. So the process is not unreasonable, even if in the aggregate, you may need more.

The CHAIRMAN. Thank you. Mr. Bilirakis.

Mr. BILIRAKIS. Mr. Chairman, I don't know. I've been cautioned not to even bring up the subject, so I'm not sure that I will. Well, all right. Let me just say this. I believe in mandatory funding. I believe that the entitlement—I mean, if anybody is entitled, we have a lot of entitlements. People get entitled because they reach a certain age. People get entitled because they're poor. People get entitled because they're sick, after they reach a certain age, et cetera, et cetera. The other people who are entitled on the basis of their conduct and what they've done for the country are the veterans. So do I believe in that? Yes, I do.

For the longest time, we've been fighting the battle of third-party payer insurance billing. We're not satisfied that it's being done as officially as it should be, et cetera. I just wonder, has your Task Force considered or discussed that subject at all?

Ms. WILENSKY. Of the third-party billing?

Mr. BILIRAKIS. Yes, the insurance billing.

Ms. WILENSKY. We discussed it as an issue with regard to one of the earlier questions of whether the VA was operating as efficiently and effectively as it could. And while we recognize that the VA has made substantial efforts to improve its funding and its billing, it does seem like there is more yet to be done in terms of the timeliness of the billing and the collection process of the billing.

It is, of course, an issue of whether or not collecting the money really helps them, or whether it's just offset in the next year's appropriation. That's always an issue. When you have multiple billing strategies, you do need to incent the VA and the local level to make sure there's something in it for them.

Mr. BILIRAKIS. Yeah. That's certainly a good point.

Ms. WILENSKY. They could do more.

Mr. BILIRAKIS. If it's just going to replace money that ordinarily would be appropriated, that doesn't do any darn good.

Ms. WILENSKY. Right.

Mr. BILIRAKIS. It should be money that's in addition to the ordinary appropriation.

Ms. WILENSKY. Yes, they have not—this is definitely one of those areas they have not maxed out everything they could do. It is better than it was, but more to come.

Mr. BILIRAKIS. You all didn't look into whether it should go into the service-connected category.

Ms. WILENSKY. We did not specifically look at it. I mean, we had a fair number of discussions about the general issue of third-party billing and how much that would relieve it. We were convinced that, as important as it was, this was not the answer to the mismatch.

But we don't want that. Just like we felt with regard to increased efficiency, we didn't think that was the answer to the mismatch either, but that doesn't mean it's not important, and that you shouldn't push it as hard as you can.

Mr. BILIRAKIS. Well, I'm not pushing it. My problem is I know darn well that yes, it's the role of the taxpayers, the government to take care of our service-connected people, just as it was before we went into third-party billing, insurance billing, to take care of even those in the other categories.

But I also know that the insurance companies are the ones who are benefiting by virtue of not being billed. And there's something wrong there. We've got veterans. We've got people who can't be served. We don't have enough money for this. We have mismatches, et cetera, et cetera. And yet the insurance commission pick up the damn premiums, and then they don't pay it out, because they're not billed. And then that bothers me. I don't mind telling you. And I don't want to run—I mean, all my friends are back there at the service organizations, and they know how I feel about veterans. But it's got to bother them a little bit too. And I'm not sure how in the world to get around that. I know the feeling of a veteran, and that is that it ought to be gotten done by the government. But in the meantime, should we be benefitting the insurance companies? I don't know. That's just something that bugs me. If you have anything further, I'm done.

Ms. WILENSKY. I mean, we have encouraged the VA, which is not by being a direct provider agency. Its natural strengths are not to do billing for services to make sure that it is being as aggressive as it can be in terms of billing third-party payers and going after third-party payment that they're entitled to. We do think it's important to make sure that this is money that comes in and has some benefit to the VA, as opposed to being——

Mr. BILIRAKIS. Above and beyond

Ms. WILENSKY. Right.

Mr. BILIRAKIS (continuing). The money that ordinarily they would be getting in appropriation, yeah. Well, thank you, Doctor. You've always had the answers. And as usual, you're so very efficient. Thanks, Mr. Chairman.

The CHAIRMAN. Thank you. Dr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman. Dr. Wilensky, I think I got confused on what you were saying a couple times about the 2004 budget. Did I understand you to say you feel that that does meet your definition of full funding?

Ms. WILENSKY. I did not do these calculations, because this is not my relative expertise in terms of doing scoring. I did, however, request that the funding budgeting expert on our Task Force, once we had come to the recommendation that we did, I wanted to know what the immediate ramifications were, as did John Paul Hammerschmidt, as a former Member of Congress, felt very—you know, it was very important to understand the financial ramifications of what we had recommended or concluded.

The estimate that we had is that the 2004 budget requested by the administration would be sufficient to meet 5.1 and 5.2, which is full funding of the Categories 1 through 7. It did not have a lot left over, but it had some left over, which——

Dr. SNYDER. Who was the budget expert?

Ms. WILENSKY. Dan Blum.

Dr. SNYDER. I can't put together what you're saying there about the 2004 budget with what you said in both your opening statement—reading from the report here, "It was clear to us that although there has been a historical gap between demand for VA care and the funding available in a given year to meet that demand, the current mismatch is far greater for a variety of reasons, and its impact potentially far more detrimental to both the VA's ability to furnish high-quality care and the support the system needs from those it serves and their elected representatives."

You don't say the "mismatch in the future." You say the "current mismatch." I mean, I don't know how this—I mean, I think the reports are very, very helpful. But somehow, to say that the mismatch has been bad in the past, the current mismatch is far greater than it's ever been, but magically in 2004, it's going to be fully funded, there is no mismatch, I ain't buying it. I mean, it smacks that the Task Force is carrying somebody's water.

Now, how can you jive those two statements, that it's fully funded in 2004 under the President's number—by the way, I always think the President's hard to follow. I always blame OMB when we have a bad number for VA. But do you catch my—I mean, how can——

Ms. WILENSKY. Yeah. But there's actually two issues. And the answer is twofold. In the first place, the President had a big bump-up in his budget request for 2004. And in the second place, our recommendation goes to Category's 1 through 7. And a lot of the pressure that we have seen, a lot of the mismatch, is coming because of the 8's.

Dr. SNYDER. Because of——

Ms. WILENSKY. Of the 8's.

Dr. SNYDER. Of the 8's.

Ms. WILENSKY. And those two issues, the bump-up in the 2004 request, and the pressure if those are both treated—and I don't want to—this is not to blame the 8's. When people are offered services, it's not unreasonable to expect that some numbers of them will enroll and take advantage of them. What we have recommended unanimously is full funding for the 1 through 7's, and

our estimate done by someone who had a very long career at the Department of Defense, is actually not a VA expert, did not come directly out of the VA, but has a long history at the Department of Defense, was no longer there. He is not somebody who is a current government employee. His estimate was that the 2004 budget would accommodate the full funding of people who are in there in terms of 1 through 7 enrollers.

So, you know, is this a correct estimate? This was an estimate done over a very short period. It was done because both John Paul and myself felt very strongly that when we were making a recommendation that had obvious funding ramifications, that we needed to have some idea about the financial implications, and particularly where we were with regard to the current budget request. And the estimate of somebody who is not a current government employee, I have no idea whether an independent actuary or OMB staff person would have agreed. We didn't ask either of those, but we did ask somebody who I have great respect for as a budget person to do an estimate.

Dr. SNYDER. Before my time is out, Dr. Wilensky, I had one more question I wanted to ask you. And I understand what you're saying. It's just, to me, it's a very dramatic statement in there about the current mismatch as being far greater. And I understand what you're saying. I'm just having a little trouble putting it together with the President's budget number.

The other question I wanted to ask was you had mentioned about the—referred to the VA's negotiating power when it comes to dealing with drug companies. And that has given you some pretty good discounts. Not you. Gives the VA pretty good discount; is that——

Ms. WILENSKY. That's correct.

Dr. SNYDER. Yeah. As a former HCFA administrator now seeing—I'm sure following closely the continued problems we have in funding for Medicare, would it be helpful, do you think, that if Tom Scully had that same ability to negotiate on behalf of the 40 million Medicare recipients with the drug companies?

Ms. WILENSKY. I think it wouldn't happen. And I think you would hurt the veterans at the same time.

Dr. SNYDER. I'm sorry. I'm not linking this with the veterans. I'm making it as a total——

Ms. WILENSKY. I know. But let me explain why I think it would have negative repercussions on the veterans. There are several reasons why the VA can negotiate really good, really low discounts. In the first place, it's not a retail facility. It takes care of all the wholesale and distribution functions in a way that Medicare does not, and I hope Medicare will not. But certainly does not. So all the distribution and retail functions are not present in the VA that they are in Medicare.

The second thing is that it's a closed formulary. So when you come in, you limit—if you're willing to come in and give a low price, you know that you may be one of only one or two drugs in your category on that formulary. Most people who are discussing outpatient prescription drugs—and this is also true, by the way, of the DOD—do not want to have that tight, closed formulary. Now, that's not to say there isn't any allowance in the VA if a physician

at a local level feels that there's a drug that they must access. But it's tough to get around.

So the second reason that you get is that you have a volume for discount trade-off, and you have a relatively limited number. I believe that this is an issue—the reason that I'm speaking as I do is I was asked this question with regard to Medicaid when I was the HCFA administrator of why can't we just have the federal supply schedule for the Medicaid population? And part of the answers are the ones I just provided.

But there's a third reason, and that is that you have individuals, you have companies who would be willing to give discounts when the population being served is four million that are not going to get——

Dr. SNYDER. I'm sorry. Is what?

Ms. WILENSKY. Is four million. That are not going to get the same discounts. And I'm not saying it having talked to them; I'm saying it as an economist. If you're now talking about give this discount to 25 million, or in the case of Medicare, give the discount to 41 million, growing to 78 million, now you have a whole different story. Now the volume price trade-off becomes something else.

So I think it's not only unreasonable to expect the kind of discount if you don't provide the same functions that the VA provides, which is all the wholesale distribution functions. But you also have to understand, the bigger the population, the less you're going to be willing to provide quite as low discounts, particularly if you don't have the kind of volume trade-offs that the VA gives.

So it is—I mean, the administered pricing and the competitive bidding power of the Federal Government is pretty impressive. But we shouldn't confuse what the VA has been able to do under very special circumstances for a limited population in a very closed formulary, which normally, Members of Congress do not want to consider for the Medicare population, is you are not going to go there. And if you tried to go there, you'd probably end up bumping up the prices to the veterans.

Dr. SNYDER. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. Chairman Simmons.

Mr. SIMMONS. Thank you, Mr. Chairman. Again, kudos to the Task Force for the wonderful job they've done. I have a general question. You might even call it kind of a political science kind of question. But one of the tasks of the Task Force was to try to make the Defense Department health system and the VA health system work together better to find areas where resources could be shared or costs were covered, savings made.

And yet, these are two different organizations, very substantial organizations, with a somewhat different mission, one could argue, and even a different culture, that one could argue that the primary purpose of the medical health care system of the DOD is, first and foremost, to make sure that our men and women are fit and able to perform the mission, and that their families are in good hands so that their morale is high, and that the Veterans Administration focuses more on those who have been disabled, injured, wounded, hurt, damaged by war, or those who have served with honor and are growing older and need help and assistance, maybe because of their financial situation.

In your 2 years of inquiry, did you encounter what we might call cultural differences between the two organizations? And if so, do those cultural differences make it difficult or impossible to accomplish the tasks that we've set forward for joint cooperation?

Ms. WILENSKY. That's a good question. They have different missions. You've described them quite well in terms of readiness on the part of the DOD in taking care of veterans and retirees on the part of VA. But, of course, there's some overlap, because the DOD also has the military retirees to worry about, who are growing more numerous and older. And so that gives them some common ground.

We obviously recognized, and were pushed to recognize on numerous occasions, that they have different missions. And we acknowledge that, and it's important to acknowledge that.

But having said that, there are ways in which they can work better together. The fact is, there are some different cultures within the DOD, which doesn't come as a big surprise to people who have followed that, and that's an issue that they have to deal with with their three services.

But we think that there are things that can be done that really improve the transparency and the movement from current to retiree status, which is an important issue for the DOD. It's important for its recruiting, for its own career people and retirees to know what will happen to them. It's important, because there is overlap in the people in terms of who go to the VA and the DOD facilities.

And some of what happens in the DOD period, the active duty period, has obvious ramifications for the VA. It really raised this issue of seamlessness and electronic information sharing, so that you can go back and do surveillance, public health surveillance, when you've had exposure. You've been able to track where the person was when they were active duty and what happened to them, so that after the fact, you're not left guessing as to whether something that appears to crop up actually signifies something or not. You can only do that if you have something that's in place to have followed people.

And by the way, there are a lot of things that will work better if the electronic medical records can move information back and forth, and once present, allows for sharing to go on in ways that make sense, still recognizing that they have different functions.

And the same—it's obvious when you go to a base—and we went to the—Great Lakes Naval is one of the many places we visited. And we had some real extremes, where you had, you know, the youngest recruits coming in, being there a very short time, and then you had some of the VA facilities, who had much older population. In this case, you didn't have so many of the dependents on the military side. But frequently, you have a lot of dependents, so you have much more in terms of pediatric and women's care. Although, obviously, not exclusively a DOD issue.

But having said that, there's a lot of potential for joint procurement. They've been doing well in the pharmaceutical area. There are a lot of other areas.

And so if used smartly, we think there's a lot out there. And the fact that this President has made it such a big issue, which has

gotten the attention of the two secretaries, and with a new leadership council, it's apparent that there is something there that can happen if there is the leadership and the drive at the top, and if you help remove some of the barriers.

So you are absolutely correct that they're different cultures and they're different missions, and you need to acknowledge that. But it doesn't mean you can't do a better job collaborating and sharing. And I think you'll actually save a little money in the process. But it's not going to solve all your problems.

Mr. SIMMONS. Thank you very much. Thank you, Mr. Chairman. This was fascinating.

The CHAIRMAN. Thank you, Chairman. I just have one final question, if I could. And it's an important question. In recommendation of 5.3, you speak about the present status of 8's being unacceptable. In the footnote, you point out, which we all know to be the case, 1 through 7's, there was a strong consensus about the full funding, but there was no consensus on what to do about the 8's.

It seems to me that as we move forward with legislation, you know, how do you do one without the other? Could you explain some of the alternatives that were discussed vis-á-vis the 8's, and why a consensus could not be reached?

Ms. WILENSKY. There was a majority all along that thought the specifics about the 8 was just too far beyond our charge, and too far beyond our expertise. We did consider whether to talk about options without making a recommendation, but in the end decided that many of the options that came up had as many problems as they had attractions, like pharmacy-only benefits, or pay-as-you-go benefits, self-pay benefits.

And so the majority opinion of the Task Force was that where we had agreement is that the current situation was unacceptable and needed to be resolved by the Congress and the President. And putting this on the shoulders of whoever happened to be VA secretary, with all the political heat that that would have, was not a good way to resolve it.

So as you know, there were two different versions among the minority who did not agree with the majority recommendation of the present situation was unacceptable—although everybody agreed with that—but had two different strategies they would have wanted to have. There was just not a consensus that people were willing to go there.

The CHAIRMAN. Practical question. Can reform for 1 through 7's proceed without concurrent reform with Category 8's?

Ms. WILENSKY. I absolutely believe that. Whether other people are—I don't want to say that there aren't any political issues that you would have to deal with. But I absolutely believe in terms of a first-things-first world, that yes, you can and should proceed in that way.

The CHAIRMAN. Pat Ryan, our general counsel and staff director.

Mr. RYAN. Thank you, Mr. Chairman. The administration's 2004 budget proposal proposes to reduce VA's current role in providing institutional long-term care. You mentioned it in the report that the Department of Defense has closed many of its facilities, resulting in thousands of retirees seeking care from the VA.

The question is do you think it's a problem that—sort of like musical chairs in the sense that there really is a lack of coordination between the programs that may pay for a veteran's care, referring to both VA and DOD, but also Medicare and Medicaid? And isn't there really a crying need for some kind of effort to coordinate among those four programs?

Ms. WILENSKY. The answer is having more coordination would help, but exactly how you coordinate is not a small issue. We did support one effort that has been made between Medicare and the VA, which is to allow—it was not a part of a formal recommendation, but at least acknowledgement—that veterans ought to be able to choose the VA as their place of care and carry their money with them. I personally think that is a good strategy to have happen, and it would help the coordination.

The coordination is not an easy issue, but I don't want to say that it would be bad. I mean, it is not an easy issue, because historically, there are patterns of benefits that have been difficult, and that unless you're willing to take to the highest level of any recipient in any possible situation, there was always a difficult decision to be made. But it's hard to argue against coordination.

The CHAIRMAN. Dr. Wilensky, thank you again so much. Jim, do you have any——

Mr. HOLLEY. No.

The CHAIRMAN. How about the ranking—the new ranking member, Mr. Simmons.

I want to thank you again for your extraordinary commitment. As we all know, this was a labor of a number of hours, hundreds of hours, if not thousands, on the part of you. And when you realize you're talking per diem, I mean, we are deeply appreciative for the great work that you did, and the Commission members, as well as the staff.

This is a blueprint for action. We will not let it gather dust, I can assure you. There are so many mutually reinforcing ideas in here that we will act on. And I thank you so much. You have done all veterans in America a great service.

Ms. WILENSKY. Thank you. And please, again, let me emphasize that this was the joint effort of 15 commissioners who all volunteered their time, and a lot of hours of dedicated staff, some loaned by the departments, but many others who came on specifically for this effort.

The CHAIRMAN. Thank you, Dr. Wilensky. The hearing is adjourned.

[Whereupon, at 12:27 p.m., the committee was adjourned.]

HEARINGS ON THE REPORT OF THE PRESIDENT'S TASK FORCE TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATION'S VETERANS

TUESDAY, JUNE 17, 2003

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

The committee met, pursuant to call, at 10:04 a.m., in room 334, Cannon House Office Building, Hon. Christopher H. Smith (chairman of the committee) presiding.

Present: Representatives Smith, Buyer, Simmons, Brown of South Carolina, Bradley, Beauprez, Brown-Waite of Florida, Renzi, Murphy, Evans, Snyder, Michaud, Strickland, and Davis.

OPENING STATEMENT OF CHAIRMAN SMITH

The CHAIRMAN. Good morning, ladies and gentlemen.

Today's hearing is the second hearing on the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF). Two weeks ago we received the task force's final report from Co-Chair Dr. Gail Wilensky. Dr. Wilensky, along with Co-Chair John Paul Hammerschmidt and 13 other dedicated members of the task force, have produced a remarkable document, one that I hope will serve as a blueprint for reforming the VA health care system.

Established 2 years ago to strengthen and expand resource-sharing and collaboration between the Departments of Defense (DOD) and Veterans Affairs (VA), the task force quickly found that a larger obstacle to improving VA health care needed to be resolved first. Confirming what this committee and others have found over recent years, the task force concluded that optimal collaboration and resource-sharing could not occur until VA first corrected the funding mismatch between demand for health care services and available resources. According to the task force, this funding mismatch not only prevented VA and DOD from achieving maximum efficiencies in sharing, it also threatened the very quality of care for veterans.

The task force unanimously recommended that changes be made to VA's funding system in order to achieve full funding, which the task force defined as providing timely and comprehensive care to all Priority 1 through 7 veterans, within VA's existing access standards. It also calls on Congress and the administration to devise an appropriate response to Priority 8 veterans who desire to use VA for their health care.

The report identifies two examples of full funding models. One, a formula-based mandatory funding scheme, based upon legislation, H.R. 5250, that I introduced last year with Representative Lane Evans as the principal cosponsor. The other approach established an outside board of experts to determine funding levels, similar to what is currently used to fund TRICARE for Life. Yesterday I introduced that bill, along with Congressman Rob Simmons, the Chairman of our Subcommittee on Health, as the principal cosponsor, which would build upon this recommendation.

Let me briefly summarize our legislation. First, the bill would establish a three-member funding review board to be appointed by the Secretary of Veterans Affairs for 15-year staggered terms. The board would have full access to VA's economic, actuarial, and other data relevant to veterans health care funding, as well as the Office of Management and Budget's (OMB) economic and forecasting analysis, but would be completely independent of both OMB and the Secretary.

The board would produce an annual budget request and a budget forecast for amounts required to provide full health care benefits to all enrolled veterans in Priority Groups 1 through 7, primarily those injured or disabled while serving their Nation, or with low income levels. The amount calculated by the board would become the President's budget request submitted to Congress, while its forecast for the following year would be the basis for planning initiatives. From that point forward, the congressional budget and appropriations process would remain unchanged.

To ensure that veterans are receiving timely care, the legislation would require VA to meet demand within its own access standards. If VA is unable to furnish care to veterans who need it within these reasonable time frames, it would be obligated to contract for that care with private sector health care providers.

To promote fiscal discipline within VA health care, the board would be required to identify areas where VA program efficiencies and savings can be achieved, as well as consider recommendations from OMB.

While our new approach takes a different course than the legislation I introduced last year, and which Representative Evans has reintroduced this year, the goal remains unchanged, full funding for veterans health care.

This committee, veterans service organizations, and now a Presidential task force, have all concluded that the VA health care funding system, not VA health care itself, is broken. We can disagree on the details over how to fix it, but we must fix it, this Congress, this year.

[The prepared statement of Chairman Smith appears on p. 124.]

The CHAIRMAN. I yield to my good friend and colleague Mr. Evans for any opening comments he may have.

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

Mr. EVANS. Thank you, Mr. Chairman, for agreeing to hold this second hearing on the report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans.

Reiterating my statement for the June 3 hearing, I appreciate the task force's hard work and generally accept its findings in regard to the considerable mismatch between demands on the VA health care system and its funding and the call for increased VA/DOD sharing. I remain concerned, however, that while the task force as a whole felt, and rightfully so, that it could offer recommendations on funding for Priority Groups 1 through 7, it also felt it necessary to abdicate responsibility for Priority Group 8.

Our witness on June 3 testified that Priority 8s were "too far beyond the charge and expertise" of the task force. Why? And apparently I am not the only one asking that question. As one organization pointed out, the conclusions of this report are like a long putt for par that is left hanging on the lip of the cup. I was pleased to see that the dissenting opinions of one-third of the task force address guaranteed access to VA care for this equally deserving group of veterans.

It certainly is no secret to those in this room, and throughout the veterans community, that the VA has been plagued by chronically deficient health care budgets resulting in hundreds of thousands of veterans being forced to wait for care and one group being denied access to VA care totally. So it came as a surprise that our sole witness on June 3, the chairperson of the PTF, would claim that the current funding process has yielded an adequate budget. That position is out of sync with the language of the PTF report.

VA's budget has not kept pace with either medical costs or the needs of a dramatically increasing patient population that has risen from 2.9 million veterans in 1996 to nearly 5 million veterans expected to use VA health care services this year. As of January 2003, more than 236,000 enrolled veterans were still on waiting lists of more than 6 months for a first appointment or an initial follow-up for health care. An unknown is how many veterans were, and are, being told that they must wait to even schedule an appointment.

I want to point out that the President's task force claims that mandatory funding, quote, would most likely eliminate one of the major impediments to providing access: unpredictable or subjectively developed budget requests, end of quote.

I look forward to the statements of our witnesses, particularly in regard to the need for mandatory funding of veterans health care and guaranteeing access for all veterans who have honorably served this country.

Mr. Chairman, I am happy you are holding this hearing today, and look forward to your leadership on this issue.

The CHAIRMAN. Thank you very much, Mr. Evans.

[The prepared statement of Congressman Evans appears on p. 125.]

The CHAIRMAN. I appreciate your cooperation, and my hope is that this committee will produce a bill that will reform, change and provide the full funding that we are after. I look forward to working with you as we go forward.

We do have 13 witnesses to testify today, but I ask, as this is such an important hearing, that if any Members would like to give a very brief opening statement, please let me know at this point.

If not, I would like to introduce our first two panelists today. Panel number one, beginning with the Honorable Leo S. Mackay, Jr., the Deputy Secretary of Veterans Affairs, and the Honorable David S.C. Chu, the Under Secretary of Defense for Personnel and Readiness.

As the VA's second in command, Dr. Mackay chairs the Department's governance process through the Strategic Management Council, and drives its management through leadership of the Business Oversight Board and the Capital Investment Board. He is Co-Chair of the VA/DOD Joint Executive Council that is forging new ground in VA's cooperation and resource-sharing efforts with the DOD.

A 1983 graduate of the U.S. Naval Academy, Dr. Mackay completed pilot training in 1985 and graduated at the top of his class. His military decorations include the Defense Meritorious Service Medal, the Navy Achievement Medal, and the Armed Forces Expeditionary Medal.

Following a brief stint as a teacher at the Naval Academy, Dr. Mackay served in the Office of the Secretary of Defense from 1993 through 1995 as military assistant to the Assistant Secretary of Defense for International Security Policy. Leaving active duty military service in 1995, Dr. Mackay worked for Lockheed Martin and later Bell Helicopter until his nomination by President Bush in 2001.

Dr. Chu is the senior policy advisor to the Secretary of Defense on recruitment: career development, pay and benefits for 1.4 million active duty military personnel, 1.3 million Guard and Reserve personnel, and 680,000 DOD civilians, and is responsible for overseeing the state of the military readiness. Dr. Chu also oversees the $15 billion Defense Health Program; Defense Exchanges Program, with $14.5 billion in annual sales; the Defense Education Activity, which supports over 100,000 students; and the Defense Equal Opportunity Management Institute, the Nation's largest equal opportunity training program.

Dr. Chu served from May 1981 to January 1993 as the Director and then Assistant Secretary of Defense for Program Analysis and Evaluation. In those positions, he advised the Secretary on the the future size and structure of the Armed Forces, their equipment, and their preparation for crisis or conflict.

In 1968, Dr. Chu was commissioned in the Army and became an instructor at the U.S. Army Logistics Management Center, in Fort Lee, Virginia. He later served a tour of duty in the Republic of Vietnam, working in the Office of the Comptroller, Headquarters, First Logistical Command. He obtained the rank of captain and completed his service with the Army in 1970.

Dr. Chu also worked at RAND, holding several senior positions prior to rejoining the Department of Defense. He holds the Department of Defense Medal for Distinguished Public Service with silver palm.

Gentlemen, welcome. And, Dr. Mackay, if you wouldn't mind beginning.

STATEMENTS OF LEO S. MACKAY, JR., Ph.D., DEPUTY SECRETARY, DEPARTMENT OF VETERANS AFFAIRS; AND DAVID S.C. CHU, Ph.D., UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS, DEPARTMENT OF DEFENSE

STATEMENT OF LEO S. MACKAY, JR., Ph.D.

Dr. MACKAY. Thank you, Mr. Chairman, Mr. Ranking Member, and members of the committee. I am very pleased to join you today to discuss the recommendations in the final report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. I realize that my statement was delayed in reaching the committee, and I would like to offer my apology for that and ask that my entire written statement be entered into the record.

The CHAIRMAN. Without objection, so ordered.

Dr. MACKAY. Thank you, Mr. Chairman.

I speak for the entire VA and America's grateful veterans when I express appreciation for what the task force has accomplished at the request of the President. The President has included VA/DOD collaboration as one of the top management agenda items for his administration, and we are committed to fulfilling the President's mandate.

I commend the task force co-chairs, Dr. Gail Wilensky and your former colleague John Paul Hammerschmidt, and the other commissioners for their leadership, analysis, and dedication to resolving the issues before us. They were inspired, I am sure, by the legacy of the late Congressman Gerald B. Solomon, an original co-chair, a true patriot, and a great friend of America's veterans.

Much of what I say today, Mr. Chairman, will be a report on the progress we have made since last summer when the task force published its interim report, and we have indeed made progress. Critical to that progress is the VA/DOD Joint Executive Council, which I co-chair with my colleague and good friend Dr. Chu. Through the the JEC, senior leadership of both Departments work together to institutionalize VA and DOD sharing. After more than a year of discussion and planning, we recently approved the Joint Strategic Plan. Three principles guide the plan: collaboration, stewardship, and leadership. And based on these principles, the Joint Strategic Plan contains six goals and associated time lines and metrics which are linked to the PTF final recommendations. The goals are leadership commitment and accountability, high-quality health care, seamless coordination of benefits, integrated information-sharing, efficiency of operations, and joint contingency/readiness capabilities.

Within VA we have also included VA/DOD sharing in our monthly performance tracking system, setting a goal which we should reach this year for $100 million in joint sharing. That is up from $83 million last year.

A number of areas that the PTF emphasized we are already addressing. For instance, in the area of electronic medical records, we have the goal of an interoperable, bidirectional, standards-based medical records exchange by the end of 2005. The two Departments are working together under the Federal Health Information Exchange and the Healthe People Program to give VA's clinical staff

access to information collected in DOD's Composite Health Care System.

Benefits delivery at discharge. The Benefits Executive Council is working to implement a single separation physical and transfer of records. Currently there are 25,000 claims per year that are filed through the Benefits Delivery at Discharge program, operating at approximately 30 sites nationwide. We also have a pilot program where we are working with the staff of the Pentagon's DiLorenzo TRICARE Health Clinic, DTHC, to develop a separation examination protocol that will be accepted nationwide by all service departments. DTHC was chosen as the site for this project because of its unique position as the only site where servicemembers from all branches are discharged.

Our area of greatest success is in the area of joint contracting. In pharmaceuticals we have projected savings this year of some $450 million on over $5.4 billion of joint spending. This is up from $369 million of realized cost avoidances in fiscal year 2003. We have a very successful CMOP pilot that is being conducted at the Leavenworth CMOP, the naval hospital in San Diego, the Darnell Army Community Hospital at Fort Hood, and the Kirtland Air Force Base in New Mexico. That pilot should conclude here next month, and we will be evaluating the results and hoping to move forward with the Department of Defense on that.

In the area of medical and surgical commodities, where we are moving after pharmaceuticals, we have already consolidated procurement with initial savings of $750,000 annually as we convert DAPAs to the FSS schedule.

In capital asset management, the JEC is developing an integrated approach to identifying best opportunities, and there is active DOD representation on our CARES team.

With respect to VA//DOD pilots, we will establish and report to this committee the three pilot sites where budget and financial management systems, staffing and personnel, and medical information and IT systems will be jointly applied by the end of this fiscal year.

Mr. Chairman, indeed this is a good start, but we must continue to press the work outlined in the Joint Strategic Plan to reap the true benefits of savings.

Lastly, the PTF stated that the government should ensure that enrolled veterans in Priority Groups 1 through 7 are provided current comprehensive benefits in accordance with VA's established access standards, and suggested that full funding should occur through modifications to the current budget and appropriations process by using a mandatory funding mechanism or by some other changes in the process that achieves the desired goal. The PTF agreed that the fiscal year 2004 President's budget fully funds enrolled veterans in Priority Groups 1 through 7. Our budget also fully funds those Priority Group 8 veterans already in the system, ensuring that no veteran currently in the system will be denied care. In addition, the funding levels in the President's budget will allow VA to eliminate the waiting list of veterans seeking medical care by January 2004.

With our fiscal year 2004 VA medical care budget request of $27.5 billion, President Bush has requested the largest medical

care increase ever, some $2.1 billion or 8 percent, it is more than 30 percent greater than the fiscal year 2001 budget which was in effect when the President took office. The administration's record in this area is unprecedented, and it is good, and we would strongly oppose any form of mandatory funding, including formulas set in statute and independent bodies directing budget levels.

This concludes my oral statement, Mr. Chairman. I will be happy to answer any questions along with Dr. Chu that you and other Members may have.

The CHAIRMAN. Thank you very much, Dr. Mackay.

[The prepared statement of Dr. Mackay appears on p. 126.]

The CHAIRMAN. Dr. Chu.

STATEMENT OF DAVID S.C. CHU, Ph.D.

Mr. CHU. Thank you very much, Mr. Chairman. I am indeed pleased to be invited here today to discuss with you and——

The CHAIRMAN. Would you hit the microphone button, please?

Mr. CHU. My apologies—discuss our views on the report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. I have a somewhat longer statement for the record, which I would hope, Mr. Chairman, I could submit.

The CHAIRMAN. Without objection, your full statement will be made part of the record.

Mr. CHU. Thank you, sir.

First, I want to express my deepest appreciation for the impressive work of the task force. The co-chairs, Dr. Gail Wilensky and John Paul Hammerschmidt, exemplify public service in their dedication to improving health care for our military and our veterans. We commend them for their leadership and their thorough and creative analysis of the issues.

During the 2 years of deliberations, we have worked closely with the members and staff of the task force to provide critical information on key areas of collaboration that have contributed to the recommendations in the final report. I have met monthly with Dr. Wilensky to ensure an ongoing dialogue on the findings of the task force. Consequently, DOD has been well-informed of the direction of the task force and has already begun to implement many of the recommendations in the final report, as Dr. Mackay has already indicated. We have likewise tried to keep the task force informed on major initiatives and policy decisions regarding DOD/VA collaboration that have occurred through our Joint Executive Council.

I am also very pleased to be here this morning with my VA colleague, Dr. Leo Mackay. As Dr. Mackay has indicated, we and the senior leaders at the Department of Defense and Veterans' Affairs are committed to working together to institutionalize collaboration between our Departments. In April of 2003, DOD and VA signed a charter that institutionalizes the Joint Executive Council structure Dr. Mackay outlined. Through our Joint Executive Council, which Dr. Mackay and I co-chair, we have established a forum for senior leaders from both Departments to provide support and oversight of all of our collaborative duties between DOD and VA.

One of the most important accomplishments, as Dr. Mackay has noted, of the Joint Executive Council has been the development of a Joint Strategic Plan. He has eloquently identified its goals and

objectives. Through this strategic planning process, we have launched, we believe, a new era of DOD/VA collaborations which promises unprecedented strides toward a new Federal partnership that should transcend business as usual and we hope will serve as a model for interagency cooperation across the Federal Government.

The plan is consistent with the recommendations of the task force in that it addresses the same key issues, recognizes both our common and our unique mission requirements, and ensures accountability for results. We support the recommendations of the task force to provide a seamless transition from Active Duty to veteran status. Our concern for the well-being of servicemembers extends well beyond their time on Active Duty. We have already made significant progress, as Dr. Mackay has outlined, in ensuring pertinent medical data is transferred to the VA on servicemembers upon their separation from Active Duty. Through our Federal Health Information Exchange, DOD has transmitted to VA information from 3.8 million records on 1.5 million discharged or retired servicemembers.

To further strengthen the DOD/VA electronic medical information exchange, we are working with our VA counterparts to ensure the interoperability of our electronic medical records by the end of fiscal 2005. It will be a significant step to a seamless transition and should markedly enhance the continuity and care for our Nation's veterans.

Through our Joint Strategic Plan, we are continuing our emphasis on improving access to benefits, streamlining the application process, eliminating duplicative requirements such as physical exams, and smoothing other business practices that complicate servicemembers' transition from military to civilian status, and improving the continuity of care to our Nation's veterans.

Despite the fact that the two Departments have different missions, we are working together to remove barriers to collaboration. Our success in joint contracting for pharmaceuticals, which Dr. Mackay has noted, is a model. In fiscal year 2002, DOD/VA joint pharmaceutical procurement purchases totalled over $200 million and resulted in almost $400 million in cost avoidance.

DOD concurs with the task force recommendation for a single common clinical screening tool that ensures reliable electronic access to complete pharmaceutical profiles for VA/DOD dual users across both systems. The Pharmacy Data Transaction Service, sometimes known as PDTS, already allows DOD to build a patient medication profile for all beneficiaries regardless of the point of service, including, and most important, prescriptions filled in the private sector.

Because of our many successes in the pharmaceutical arena, DOD has some concern with the task force's recommendation to develop a national core joint formulary. We believe we are already achieving many of the goals of such a formulary through our ongoing pharmaceutical contracting initiatives. For example, virtually all the medications listed on DOD's basic core formulary are also on the VA national formulary, which comprises a common subset of medications that must be available to beneficiaries served by both Departments.

The development of a single national joint core may result in either greatly expanding the drugs made available to VA beneficiaries or reducing DOD beneficiary choice to use the civilian health care sector, including retail pharmacies. Moreover, a decision to establish a joint VA/DOD formulary would not relieve the DOD from complying with current law mandating many aspects of formulary management, including how drugs will be selected and associated co-pays set.

Collaboration just between our two Departments will not address all the opportunities to solve demand, access and funding issues associated with delivery of health care. We think it is time to discuss a new paradigm in sharing, one that takes advantage of the multiplicity of opportunities that leverage DOD, VA, and quality civilian health care institutions to provide the best quality of care for our beneficiaries. The University of Colorado project in Denver is one example of how both agencies and the private sector can benefit.

Mr. Chairman, our goal is to build a world-class partnership between the Department of Defense and the Department of Veterans Affairs, guided by the principles of cooperation, stewardship, and leadership. The recommendations of the Presidential Task Force to Improve Health Care Delivery to Our Nation's Veterans will greatly assist us in accomplishing this critical goal. Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Chu, thank you very much for your testimony.

[The prepared statement of Mr. Chu appears on p. 140.]

The CHAIRMAN. Let me just ask a couple of opening questions, and let me begin with you, Dr. Mackay.

First of all, I think virtually every member of this committee and staff, have read and then reread this very fine, mutually reinforcing set of recommendations from the Presidential Task Force. When it comes to seamless transition, and to the administrative changes that can happen almost overnight, we fully expect and we will be doing oversight to ensure these recommendations are faithfully followed.

It seems like the point of departure occurs when we hit section 5 and recommendations that emanate from section 5, beginning with recommendation 5–1. I just wanted you to know I have been on this committee for some 23 years. Mack Fleming, who was a member of the Presidential Task Force, and who used to sit where Pat Ryan was chief counsel and staff director of this committee. He did an outstanding job for Sonny Montgomery, who was then our Chairman and actually wrote the Sharing Agreement between VA and DOD. Mack will recall that we had high hopes that it would lead to economies of scale and greater efficiencies between DOD and VA. Much of that has not been realized years to date. But, we are pleased and I think the committee is very happy that at least recently there has been a major effort, a hurry-up offense, if you will, to do more sharing. But the vision that Mack and all of us had 20-odd years ago is only now bearing some fruit.

But we have had some major changes, as the task force pointed out. Since the early days of the Reform Act, we have seen almost an exponential rise in unique patients, 70 percent more unique pa-

tients voting with their feet or their wheelchairs, going to VA health care because of all of the CBOCs that are out there and access points, if you will. It is a success story. And I am somewhat chagrined and disappointed in the lack of embrace of these recommendations beginning with section 5–1.

VA gets it right in terms of what the demand model is. And perhaps, Dr. Mackay, you can tell us, what is the purpose of the veterans health care expenditure demand model? Does OMB approve of this model? And if OMB has approved this model, can you explain why the funding number that is generated by the model is not included in the budget submission? The bill I have introduced H.R. 2475 seeks to bypass OMB. They do a great job in a lot of areas and have mission impossible, but when it comes to VA, we have a demand model that says this is what is needed, but somehow it falls short.

Dr. MACKAY. Mr. Chairman, you are correct. We budget with what we call internally a full demand model. It is important to understand as we go through fiscal year 2004 the way the calculations and other things that are part and parcel of that budget.

First of all, as you mentioned, there has been a great expansion in demand for our services. We have identified the traditional core of VA's veterans that we serve, the Priority 1 through 6, in accordance with the statutorily derived priority and categorization schedule for highest priority, sir. And as we all know, when Priority 7s and 8s were allowed into the system, it was with the understanding that there would be other sources of funding for them, that they would not be taken care of solely by appropriated dollars. There was to be Medicare subvention, third-party charges for insurers, first-party charges, perhaps HMOs and PPOs. All of those funding mechanisms have not arrived, and so there is the provision in the statute, as you well know, that the Secretary has to make a decision every year. Resources are provided, and then eligibility is decided. We had 4 years of open enrollment. The decision was made looking at the resources available and the demand to balance that, adjustments in copays and enrollment fees, but also the suspension of enrollment for new Priority 8s coming to us.

So when we say, as I said very carefully in my statement, the fiscal year 2004 budget has full funding for our core veterans, it also continues to allow Priority 7 veterans to enroll and meets their needs with associated fees and copays. This has always been the understanding. And then all Priority 8s that are currently enrolled are preserved in the system in the fiscal year 2004 budget.

The CHAIRMAN. With all due respect, Dr. Mackay, first, Lane and I and members of this committee, changed the system we created the new priority 8s, because so many truly poor veterans were being listed outside the bounds of VA health care. They were not construed to be indigent when they were, so we applied the HUD index to get a more accurate barometer of who is poor and who is not. But with all due respect, when we talk about meeting the needs, the demand model suggests that we are not. The mismatch that is spoken about in the Presidential Task Force report, calls it significant core underfunding.

Now, I don't think we should play a blame game, and if this is politicized, I think that is to the detriment of veterans. I think we

have to deal with absolute transparency and realize that we have more veterans that are using the system. We need to come up with the money. Otherwise, we will see an erosion of quality of care certainly increased waiting times, as the PTF pointed out, over 230,000 veterans waiting 6 months or longer to get their appointment. That is unconscionable, and that could be changed. Money does make the difference.

I would hope that the administration would rethink its opposition to both my bill or to the alternative. We will move on this. Maybe we will be stopped or checkmated somewhere along the line, but it seems to me that is an idea whose time has come. We cannot continue business as usual. Even on the Category 8s, I thought that PTF made an excellent point when they said the status of Category 8 veterans is unacceptable. This limbo, this not knowing where you stand in the queue, or whether or not you are even in line for VA health care needs to be cleaned up, we need to work on that. There was dissension among the PTF members as to what is the best course, but on Categories 1 through 7 there is not. Rarely do we get unanimity when you have such a qualified and disparate group of people as the PTF board members and their professional staff.

I think the PTF report is a magnificent document that ought to be seen as a blueprint, and I would hope that there will be some rethinking when it comes to the opposition to these initiatives. And I do hope that there is some openness on the part of the administration to my bill, H.R. 2475, just introduced yesterday. I ask you to take a second look at it. It has been my experience that when the President sends up a number, it is highly unlikely, I won't say impossible, but highly unlikely that the appropriators will breach it and go less than that. So if we get the right number, if this board comes up with the right number after crunching all the numbers, my sense is that it would become the number for that fiscal year.

The recommendation is not formula-driven. I do have some concerns about the formula. I introduced it. Pat and I, and Lane and all of us, we worked the legislation. Last year the number was at 120 percent over 2002 numbers. This year Lane's bill is 130 percent over 2003 numbers.

What is the right number? What if we miss it? I think there is a case to be made that there is some inflexibility when we go that route. But the bottom line is that the status quo is unacceptable. I would hope the administration will work with us. The 30 percent increase you have talked about, we welcome that, but it is a floor. We need to build upon it because it is just not enough for that core group.

Again, not to reiterate too often, but significant core underfunding was the consensus, the unanimous view, of the PTF. We need to fix it.

Mr. Evans.

Mr. EVANS. Doctor Mackay, following along the same lines as the Chairman, you state your strong support for the PTF report, yet reject its two key findings for funding the VA. TRICARE for Life is funded using an approach that has elements of both my bill and Chairman Smith's. It seems to be working for the military retirees, and I wonder why the VA feels that it won't work for them.

Dr. MACKAY. Mr. Ranking Member, there are significant differences, as you are well aware, between TRICARE for Life, which is an insurance program where the bulk of care is purchased, and the VA system, which is a living, breathing, dynamic health care system that undergoes changes in employment, changes in technology, changes in standard of care.

Because we are a provider of health care, there are some virtues to the current system. The system provides for the elective Representatives of the people and the President, who was elected, of course, by all the voters in the country, to enter into a process by which they determine—because they are responsible and accountable to the voters—how much money will be accorded for veterans health care in competition with the many other things that the budget of the United States has to fund. And I would point out that the track record in the last 3 years has been good. The flexibility that that system affords has allowed for strong leadership from the President, strong leadership from this council—to put resources where they are needed for veterans, that 30-plus percent increase in funding, that kind of flexibility.

We just last week had a hearing here where there was good, strong oversight exercised by this committee, that kind of give and take. It seems to me that if there is some sort of formula or some sort of board of experts that dictates what funding shall be, that we will significantly compromise the flexibility and the potential to drive efficiencies that we have under the current system.

I think there are virtues in this system. I think there is not a Cabinet member in the Cabinet that would say that they wouldn't like to have more money. But we deal in a real world, and the statutory construction is that resources are accorded, and the Department provides the best care that it knows how. And I think there is good agreement that the VA health care is quality care. We provide that to veterans in accordance with the statutes that determine eligibility and the prioritization for care.

Mr. EVANS. I yield back the balance of my time.

The CHAIRMAN. Thank you. Chairman Buyer.

OPENING STATEMENT OF HON. STEVE BUYER, CHAIRMAN, SUBCOMMITTE ON OVERSIGHT AND INVESTIGATIONS

Mr. BUYER. I have a statement and then a couple questions.

I noted the Veterans' Administration, the Department of Defense Health Resources Sharing and Emergency Operations Act was in 1982. And let me commend both of you, because you have done more in 18 months than I think what we have done since 1982, and for that I applaud both of you.

The other point I would like to make, I have read the charter, and I invite my colleagues to read the charter, the actual executive order to put this Presidential task force together. And when you read the charter, it was actually to focus both of you on DOD and VA sharing and what initiatives to pursue and how we can work that out. And I had numerous conversations with Jerry Solomon at the time, because I chaired personnel, Dr. Chu, on the Armed Services Committee, so I had the benefit of knowledge in both systems. And the recommendations of the report got so far away from the originating charter that somebody in the process hijacked it. So

now we get this debate on mandatory or full funding, and they are so far away from the originating charter.

So we will find out a little bit more about that in the next panel, perhaps, if somebody is willing to step forward. Or maybe it was the VSOs. I mean, that is who I would point the finger at it would be the VSOs who hijacked the process.

The other is, I don't mind—I won't go fully down this road, but this is about our committee, about the committee and the VSOs unwilling to accept the responsibility for the mistake that we made in getting it so wrong in 1996. And, you know, I have told all my colleagues about how much even the committee had mocked CBO for saying that if you change the eligibility reform, there will be a run on the system. The Presidential task force even talks about it. It is amazing. The committee even says that, you know what? It would be budget-neutral. We all know that is very, very false.

So today, I guess, what some Members are going to do here, Dr. Mackay, to you, is they are going to have fun. They are going to have fun picking on you and making demands about why aren't you supporting full funding, when, in fact, this committee is the one that got it so wrong and are unwilling to accept the responsibility for the mistake for having gotten it so wrong. And I want to protect the system that is there for my comrades who are disabled, who are either wounded in battle or injured during peacetime or are indigent. And I am upset that they are my comrades out there that are willing to push them out of line because all they want to do is gain access to the meds. So I just want to go on the record and let you know how I feel.

The other question about DOD/VA sharing is that we have a couple facilities out there and have individuals that have some desires. One is in Denver, and the other is in Charleston, SC. So, how do we do this? If in Charleston, for example, we have a VA hospital down there that is sort of landlocked, they want to expand. You have got a medical university that wants to expand. You have the naval base that base was closed, but you still—have the naval hospital. I understand you don't want to have a future footprint, but you have a print.

So how do we come to sharing here? Because when you add the medical university in, and they have a Medicaid-Medicare that might be a dependency between maybe 53 or 71 percent, depending, the Federal Government has a tremendous outlay. So whether it is in Denver or Charleston, my question is shouldn't we be thinking smartly and making sure that they work cooperatively, and as we build these campuses which could cost in excess of $1 billion? So if you could share both of what is happening both in Denver and Charleston.

Mr. CHU. If I may start, sir. I appreciate your raising both of these examples, especially Denver, because Denver is an issue that we are working—as my written statement indicates, we are working on the situation there assiduously.

We are very excited in the Denver area with just the possibility outlined as, say, a trilateral cooperative relationship among VA, DOD, and the university. You know the situation in Denver. The university needs a new hospital, ironically, on the Fitzsimmons campus, interestingly enough. The university has been kind enough

to make space available so that both DOD and VA could operate out of that facility. We indeed are eager to proceed along those lines. We think it will help us with the whole Denver corridor south toward Colorado Springs, where we, of course, have the Air Force Academy Hospital, and south of that the Fort Carson facility. And we are seeing this all as a single collaborative arrangement, which also involves our TRICARE contractor, who likewise sees it the same way.

So I am very pleased with the progress made in the Denver arena. I think we are going to get to a happy conclusion from the perspective you have outlined.

I think as you imply, sir, with your question, each one of these situations has a little different factual reality in terms of the geography, in terms of what the local medical market looks like. We are increasingly at DOD taking a regional market approach to these. I think Charleston will be the next kind of situation that we ought to address along the lines that you have outlined, but we are not as far along in that particular area.

Dr. MACKAY. I would just say with respect, I think Dr. Chu did a good job of covering the situation in Denver. Our involvement with the Medical University of South Carolina has already begun. They have a major expansion under way, a renovation of their entire campus. We looked very hard at being part of their phase 1 renovations that would impinge upon our campus. We did—we are going to take a pass on phase 1. We are open to future phases of construction. There is a cross street, Dowdy Street, on the campus that is VA property, and that will be, through an enhanced use lease, made available so they can get on with their first phase of their new construction. We will, of course, continue to collaborate with respect to faculty interchange and the other relationships that we have with an affiliate. And we are going to very closely examine our needs going forward in the CARES process, and we are open to successive phases. There will be at least three in South Carolina.

It is another good example where, with the overlay of the defense facilities that are in the Charleston area, the Medical University of South Carolina, which is the major and, I believe, sole medical college of any real size in South Carolina, and VA, we can forge these kind of partnerships. DOD/VA cooperation is key to that. But this third partner, our affiliates, private sector health care, they also have a role to play.

Mr. BUYER. Thank you.

The CHAIRMAN. Dr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman. Thank you for calling the hearing, Although I did do some mathematics, and I multiplied the number of Members here by the number of panelists who will make 5-minute statements, and I hope we have got breakfast coming in tomorrow morning.

The CHAIRMAN. Dinner.

Dr. SNYDER. I thank the gentlemen for both being here. I am just curious, and I don't mean to embarrass you or anything—well, maybe I do, I don't know, depending on what the answer is. But I think the topic of the DOD/VA sharing is a very important one, and as Mr. Buyer pointed out, it has had a lot of hesitancies the last couple of decades. But I am curious how many times—you all

here are here as the leaders, and this report was all about leadership. How many times have you two together met privately to talk about DOD/VA sharing? Are we talking three? Are we talking 30?

Dr. MACKAY. No. The Joint Executive Council meets quarterly.

Dr. SNYDER. I mean the two of you.

Dr. MACKAY. And we have had several other meetings. We generally have a meeting in preparation for the quarterly meeting. There are many phone calls. We tend to be the chief interlocutors for pretty much all of DOD/VA business. Now, of course, Secretary Rumsfeld, Secretary Principi do talk. But at the day-to-day level, for these issues in medical care, Dr. Chu is the chief operating officer, is what I will call him, for those issues inside the Department of Defense. And I am, of course, the VA's Chief Operating Officer. So we have a regular and sustained dialogue.

We have talked about the Denver deal. We have talked about the other aspects. If you look at this report, we are going to talk a lot about chapter 5. But there is a good deal of real substance in the first four recommendations.

Dr. SNYDER. I agree with that, which are very complex and managerial and——

Dr. MACKAY. Yes, sir.

Dr. SNYDER. Thank you.

Mr. CHU. Yes, sir. Let me just reinforce that. We have a variety of communication mechanisms. Dr. Mackay is quite forward-leaning in sending me e-mails when he sees an opportunity out there. And we have, I think, an excellent private correspondence that allows us to try to get ahead of some of these issues.

Let me point to one of the success stories, back to Mr. Buyer's question. I think we made a lot of progress, for example, in north Chicago, starting from a situation where there really was no collaboration. Even though you have the Navy and VA separated by just a couple miles, there was really no exchange between the two, where now we really plan to operate together going forward, and the Congress has been very helpful in lifting some of the limitations on renovations that will advantage that process. And I think that is the outcome of these many private exchanges.

Dr. MACKAY. And I would just hasten to add that that collaboration in north Chicago is not only health care, it is also a business relationship on the energy side. There was a cogeneration plant that was produced with enhanced use lease authority that VA has that will service both Defense needs and VA needs.

Dr. SNYDER. Thank you for your answer. I appreciate your efforts.

Dr. Mackay, this issue of funding, which I don't think was the primary purpose of the report, but it certainly permeated it and created a lot of attention because of some of the discussions about it, but I got your written statement earlier this morning, and it seems to me you say some things about the President's budget number that was first sent here that I just don't think that anyone has confidence that that number was accurate. I mean, I don't know why that that was—why you felt a need to step forward and put a number out there and saying it does everything you want it to do, when this committee and the Congress with its votes has said that number was inadequate. I mean, credibility becomes a

problem. I mean, you specific—I had a problem with Dr. Wilensky stating last week that they felt the President's budget fully funded Priority Groups 1 through 7, but you go ahead and say it also takes care of Group 8, and I just don't see how we get to that.

You say, ensuring no veteran currently in the system will be denied care; but the old thing about justice delayed is justice denied, it applies to health care, too. I am a family doctor. If somebody is sitting out there for more than 6 months trying to get in to a doctor, bad things happen in 6 months if somebody is sitting out there with abdominal pain or chest pain or something.

And, you know, I have not signed on to either of these bills. I mean, I share your concerns. I am open to it, but I share your concerns about—you know, the President is Commander in Chief. I want him to come up with a number, I think, but I will certainly be open to it. But I don't know why at this point in the game we have written testimony from you that the President's budget number is going to do all these things, when it is clearly based on legislation to be passed that this Congress isn't going to pass.

But, anyway, I don't know if you want to comment on that or not, but I think you all are put in a bad position to carry water, but I don't think that water needed to be carried today in view of what the Congress has already done through its budget resolution.

Dr. MACKAY. Well, Mr. Snyder, I have a great deal of very real respect and esteem for you, for your expertise as a medical doctor and for your very reasoned approach to these problems, so let me just comment a little bit.

What I said in the testimony is that—and this is true: Priority Groups 1 through 7, enrollment continues for all those priority groups. And for Priority Group 8, even though enrollment rights for new enrollees have been suspended, no Priority 8 veteran that is currently in the system is going to be disenrolled from the system.

Also, with respect to the very real needs that may happen while people are waiting, emergent care supersedes all waiting lists. As a matter of good clinical care we get veterans in to see a doctor if there is an issue of emergent care.

We have a policy that we will not schedule appointments more than 6 months out, and we are abiding by that. Even though there is a waiting list for appointments, I would also tell you that our average wait for new enrollees is 47 days—that is from our last monthly performance review—so that the average experience is actually much better than those who have to be scheduled out 6 months. So, there are adequate funds in the President's budget so that by January 2004 we expect to have all veterans that are coming to us scheduled. And the Secretary has testified to it. We are working on it now.

I hope that in the next week or so he has an announcement to make about the relationship of prescription drugs and veterans who are currently on our waiting list. He testified that he was going to take action, and I think we are very close to that. We are working very assiduously on that. But I will leave that for the Secretary to announce at the proper time.

Dr. SNYDER. Thank you.

The CHAIRMAN. Chairman Simmons.

OPENING STATEMENT OF HON. ROB SIMMONS, CHAIRMAN, SUBCOMMITTEE ON HEALTH

Mr. SIMMONS. I thank you, Mr. Chairman, and thank you, gentlemen, for your testimony.

In reading through the testimony on page 6 of Dr. Chu's testimony, he states: "DOD and VA have different missions and serve different populations." On page 8 of Dr. Mackay's testimony, he says: VA and DOD beneficiaries share many similarities. "VA and DOD care for the same individuals at different points in their lives."

These comments suggest to me that there is a cultural disagreement that is taking place here. The question I have is how can we share records, how can we have what has been referred to as a seamless transition from Active Duty to veteran status if, in fact, we do believe that they are different missions, and if, in fact, our IT systems don't talk to each other?

Let me conclude my question by making this comment: I joined the Army in July of 1965, and for my whole Active Duty period, when I would go from station to station, I would carry my records sealed with me. When I went into the Reserves in December of 1968, again, the records would be transferred to units of my assignment. I retired in February of 2003. Do either one of you know where my medical records are? Because I don't.

Mr. CHU. You are sure, sir—but we will be glad to check—to be in the set of records that I have described that we have transmitted to VA electronically.

Let me emphasize that in saying we have different missions, I don't want in any way to undercut the commitment we share to the seamless transition to which you alluded. And it is our objective to produce by the deadline that the task force set the interoperable electronic systems that I think you believe, correctly, we should have.

Back to the mission differences. That is intended to underscore the fact that we deal with a generally younger population. We also are geographically off in very different places because of the structure of the United States military bases, as opposed to the VA which tends to follow national population concentrations. And I just think we have to be realistic about that.

It underscores the point I was trying to make regarding the task force recommendation on a single formulary. We have got different instruction by the Congress on how to proceed there. I don't think the Congress really wants us to cut off DOD beneficiaries from current drug benefits. That is not really, I presume, your intent. At the same time, I don't think Congress wants to undercut VA's efforts to manage the formulary. Where we think we can agree is there is an important intersection in the set of drugs that we require every MTF to have, that is on—there are a couple minor exceptions—but that is on the VA list. And we are going to use that as our way forward in terms of the task force recommendation.

So, there are differences between the two institutions, but in no way should they stand in the way of providing a seamless transition of the individual's records. That is our standard. We are starting to meet that standard electronically. In no way should it stand in the way of the kind of collaboration that Congressman Buyer

pointed to. That is our objective in every place where it makes sense from the perspective of the veteran, of the military member, and of the taxpayer.

Dr. MACKAY. Congressman, there are, as Dr. Chu pointed out, some very seminal differences, and they suggest that there are limits to the amount of collaboration and cooperation that are possible. We are not close to that.

One of the things that is most astounding about this line of work is that servicemembers and Guardsmen and Reservists have been becoming veterans for well over 300 years in these United States, and the process, as I found it at the beginning of this administration was almost as if that is a surprise, even at this late date. We are working towards some things that are straightforward, an electronic DD–214, the record that testifies that a veteran is honorably discharged. That is not available to be transferred to us electronically, and it needs to be.

The service records that you talked about, we are in a process where we are moving those inside DOD to electronic records, and they will certainly facilitate moving those records from DOD to VA in an electronic and interchangeable, interoperable format. That is something that we look forward to.

Other sort of people processes, like why isn't it the case that as you transition out of service that you take a single examination that provides both a discharge physical and a compensation and pension physical for a discharging servicemember who becomes a veteran. We are now pioneering that over at the DiLorenzo TRICARE Health Clinic at the Pentagon.

Those are the kind of common sense things that with the leadership of Congress and with the gentle and not-so-gentle prodding of leaders on both the Armed Services and the Veterans Affairs Committees, we are beginning to take some of those steps.

We cannot fuse, it is my view, the two systems. There are pediatrics and neonatal, those are the differences in this formulary. We have 91 percent men, and the average age is already over 60. So there are some limits, and their readiness mission of course is a big limiting factor in how closely we can align the two systems.

But in places like north Chicago, where they have a recruit training depot and we have a VA clinic, and Albuquerque and out in Hawaii, where we both face the challenges of distance, and with telemedicine, we can collaborate. We can cooperate. We can save money for the taxpayers, and we are beginning to do that.

And I would help search for your records, but I believe they are over in DOD.

Mr. SIMMONS. If I could conclude, Mr. Chairman. I have a piece of paper for the two of you. It has got my name, rank, serial number, and home of record, and I will give it to you and you give me a call when you find the records.

The CHAIRMAN. Mr. Michaud.

OPENING STATEMENT OF HON. MICHAEL H. MICHAUD

Mr. MICHAUD. Thank you very much, Mr. Chairman. I would like to thank both you and Ranking Member Evans for having this hearing. In my short 5 months here, I am really impressed, Mr.

Chairman, with the way that you have been running the committee in a bipartisan manner. I really appreciate that.

Reading the testimony, Dr. Mackay, I am disappointed where you strongly oppose mandatory funding. And I can appreciate the talk about the increase over previous fiscal year budgets, however, if a budget is inadequate to start with, just because there is an increase does not mean that it is going to take care of the problem, and it is a problem that Congress should have to deal with.

I think over a number of years businesses in this country have helped with the health care for veterans, keeping veterans out of the VA system, saving the VA money because where they were able to offer veterans that worked for them the health care coverage.

With the economy the way it is today, and the high unemployment, and in some areas, I know in the State of Maine, with unemployment as high as 32 percent, and many other labor market areas in double digit numbers as well, these are people who no longer have health care coverage. A lot of them are veterans.

And that is why I think it is really important that we make sure that VA is funded appropriately. When members sign up for the service, they have certain criteria. Party affiliation is not one of them. There are many members out there who are Republicans, Democrats, Independents. I think that Congress has an obligation, I feel strongly that there is a separation of power between the executive branch and the legislative branch. There are certain times when we as Members of Congress, particularly members of the majority party, you have to support the executive branch. I do not believe that this is one of those times where you should support the executive branch.

I think we got to do what is right and make sure that veterans are taken care of with the health care that they thought they would receive when they enrolled and enlisted in the military.

I guess two questions, Dr. Mackay. The first question is: Who would you hold at a higher esteem? Someone who has been incarcerated for murder or rape or someone who is a veteran that just came back from war?

That is not a trick question. I assume it would be the veteran that you would hold at a higher esteem?

Dr. MACKAY. With the information you supply, that is a safe assumption.

Mr. MICHAUD. My next question then, Dr. Mackay, is: Why? Why should people who are incarcerated for whatever reason, whether it is murder or rape, be guaranteed health care coverage and veterans of this country who put their lives on the line for the freedom are not guaranteed health care coverage?

Dr. MACKAY. Well, Congressman, it is a matter of statute who health care coverage is extended to. I would point out that all service-connected injury or illness, that care is provided without charge to veterans in the VA system if you served this country.

If you don the cloth of our country, as so many of us have, if you are diminished mentally or physically, then we have an ironclad obligation, and we meet that obligation to provide those with service-connected injury and illness of that care without charge to the veteran.

The issue, and the way the statute resolves it with regard to non-service-connected care, provides for other means and methodologies of funding.

With regard to the overall budget, there is some real virtue, I believe, to having both the President's Office of Management and Budget, which has purview over all of the many issues that come before the President for inclusion in the budget, and the Appropriations Committee and the process in Congress, where the representatives of the people decide what the priorities are, and the funding levels will be, for the many, many competing issues that come before this House and the Senate.

I think that is the ordained process of the founders to resolve very, very complex issues like this, where you trade off the rights of those who have been incarcerated. They are incarcerated. They are paying their debt to society, but they are still human beings, and there is a humanitarian interest in their well being.

How that stacks up against the interests of veterans is to be resolved in statute by this House, this Senate, and by our political processes. That system has worked, and that system is flexible. That system is able to respond, as I had pointed out, in fiscal year 2001, since that time in the last 3 years we have moved to meet the needs of veterans.

With regard to Priority 7 and 8 veterans, when eligibility was reformed, it was always the case that those Priority 7 and 8 veterans, because they have no service-connected injury or illness, would have to help defray the costs of being in the system. That is the system as it has come down to us in the last 6 or 7 years.

We can argue about it. We do argue about the level of copays and fees and other things and what exactly their burdens should be. But that is the system. And when I say that the system fully funds our core veterans, those Priority 1 through 6s, that is a true statement.

When I say that it allows for Priority 7 enrollment to continue, that is also a true statement. When I say that it maintains all Priority 8s that have come to us, and there are now over a million 7 and 8s in our system, that is also a true statement.

But in the balancing under the statute by which the Secretary has abide, by law according to the priority system and the eligibility decision that he has to make every fall, he has to match those with demands and make a decision. And he made the decision he made in January.

I mean, that is the system. It has its virtues and overall I would defend the system, because it has the flexibility and it has the decision making occurring in the right place. Those that are responsible to the people, our political process works.

I am a fan of the founders is how I would respond to that, to your question or to your statement, sir.

The CHAIRMAN. Chairman Brown.

OPENING STATEMENT OF HENRY E. BROWN, CHAIRMAN, SUBCOMMITTEE ON BENEFITS

Mr. BROWN of South Carolina. Thank you, Mr. Chairman.

Dr. Mackay, I was listening to the exchange with my good friend, Chairman Buyer, about the situation in Charleston. I certainly ap-

preciate Chairman Buyer coming down to actually view the site. So he now has a good knowledge of what we are talking about.

We have a 33-year-old Navy hospital, and we have a 37-year-old VA hospital. We have a State University replacing it, because of the medical school, and all of those facilities have been a model or two of each other. I am surprised when you say that the VA is taking a pass on the sharing opportunity in Phase 1. Isn't this a great opportunity to have a good intergovernmental model?

Dr. MACKAY. Yes, sir. The issue is not an issue of overall commitment to MUSC or our partnership; it is an issue of the phasing and what exactly MUSC needs to do and the timetable they need to do it on.

As you know, we are in the middle of our CARES program, our capital asset realignment program. We are balancing systemwide what our needs are for new construction with a mind toward the first two decades of this new century.

So there was a mismatch in terms of phasing. There is a partnership. It is strong and it is ongoing. And in successive phases, and I understand that there will be at least three in the construction at MUSC, we will continue to evaluate what is best for our system and what is best for our partnership, Mr. Brown. You have that firm commitment.

Mr. BROWN of South Carolina. Okay. I noticed, Dr. Chu, you said you were very excited about the Denver project. We would like to get you just as excited about the Charleston project. Can I hear anything from you on this?

Mr. CHU. Thank you, sir.

Mr. BROWN of South Carolina. Thank you.

The CHAIRMAN. Mr. Beauprez.

OPENING STATEMENT OF HON. BOB BEAUPREZ

Mr. BEAUPREZ. Thank you, Mr. Chairman. Well, let's stay on the Denver project for just a minute, since the chairman has brought it up.

It is no secret to this committee I am committed about that for very parochial reasons, with full disclosure. But there has been some very legitimate concerns raised, and frankly I share them. I have run businesses before, not something in the nature of either one of you gentlemen, not quite that complex. But I have looked for efficiency opportunities.

I was in the banking business, branches, added departments. But the concern that has been raised that I think is a fair one, if I can characterize it this way, is that you both head agencies that by their very nature are fairly competitive, staffed with competitive people, people typically used to winning. And I am not suggesting that there is necessarily winners and losers, but there has been some concern raised about who is on first.

And for my purposes in this committee, I am very concerned that if we go into this sharing relationship in Denver or elsewhere, the Charleston situation or future opportunities, that we can be very assured that our veterans not only receive the quality of health care on day 1, but for years and years and years forever down the road, and the same for our active duty military, that this can really be a quality joint effort.

Tell me, if you can briefly—because I would like to ask another question—how can we assure that?

Mr. CHU. I think the—first of all, sir, I would take issue with your presumption that on this question of collaboration, that there is necessarily competition between the two institutions. What Dr. Mackay and I have tried to set out as our guiding principle is this shared interest by the two institutions. This is to our mutual benefit. And most important, as you suggest, sir, it is to the benefit of the people we serve.

We think in the Denver case, as far as the military population is concerned, we can do a better job of meeting their needs through the collaborative arrangement that we are in the process of entering into with the university, taking space on their new campus. This will help support Buckley and will help rationalize the entire corridor south all of the way down the interstate below Ft. Carson.

So we have two in-house facilities, Ft. Carson's hospital, the Air Force hospital. We will be using basically space at the university, the new university center for the Denver region, rather than constructing our own stand-alone, ill-sized facility with all of the diseconomies of scale that I think your question pointed to.

So we are committed, and I think the institutions are committed, to taking a very thoughtful view, just as you suggest, of what is best for the people we serve, what is best for the taxpayer in terms of how we use the taxpayers' money to achieve good results. We think the Denver project has that promise.

Our challenge, of course, is to realize it on the ground, to make it work just as well as the plans suggest it can.

Dr. MACKAY. In the interest of time, if we can take your second question.

Mr. BEAUPREZ. Let me follow up, because it is my nature to see all of the glories that could come from this project. But I have to temper that, having been a manager myself of businesses again of what are the risks. I will highlight again a concern of one of the entities, perhaps the university hospital, perhaps either one of your agencies, certainly not under current management, but in years to come, that someone seizes power—that is a concern I have—at someone else's expense.

And then, secondly, if I might incorporate in the question, we certainly would like to think that there are efficiencies, financial efficiencies to be gained. I think some of those are obvious. But in our rush to collaborate, is there also perhaps a possibility that we might rush for opportunities to spend where otherwise we might not have? Is there any of that reservation from either of you?

Dr. MACKAY. I think we are very careful, and this has been a consideration in the Denver negotiations and discussions for us. Veterans seek and want a veterans health care system. It is very important to us. And we will insist, just as good neighbors—good fences make good neighbors—we are going to insist on a deal that preserves our identity, that gives us the kind of flexibility and governance that allows us to control the health care that veterans receive.

The efficiencies and collaboration that we are looking for are through collocation and through sharing of certain back office and clinical and other overheads that can be shared with the Depart-

ment of Defense and with the University of Colorado, so that we lower costs, we are more efficient, we don't have three separate complexes of operating rooms or radiology clinics or other things.

But it is going to be very important for us to have an identifiable presence and to have the kind of governance mechanisms that allow us to deliver veterans health care.

Mr. BEAUPREZ. Governance will be key. My time goes quickly. But your two agencies, the size and magnitude that they are, Federal Government, do you have the flexibility to do a joint collaborative process with Denver, with Charleston, with wherever, given that each one of those is going to be somewhat unique and somewhat different?

Mr. CHU. We think that we do, sir. Indeed we are changing the governance of our system within the DOD military health system to reflect the reality that you have suggested. And that is to say, each of those that we are calling major market areas is a little bit different. And so in each major market area, and there will be 10 to 15 of these for the bulk of our population across the United States, we will have—we will appoint someone as the manager for that market area on a cross-service basis.

We are in the process of setting up that mechanism now in the Department. We think it will advantage us in areas like Denver, for example, and other major areas where we have significant concentrations of military personnel and military families.

Dr. MACKAY. I think also very importantly, we have opportunities because of our size, and I use the business term, to make the market, particularly with health informatics. As DOD, VA and HHS, if that much of the Federal health care system moves to health*e* people, which is the objective sort of third phase of our health informatics collaboration and cooperation, then we are a significant market leader.

And if we can—I won't say impose, but you know lead to standards that allow health informatics to be more easily disseminated, and so the same sort of exchange that we look forward to where VA and DOD can exchange medical records interoperably between our two systems, if that can be extended to the private sector, then that will certainly facilitate these kind of tripartite arrangements where in Denver we have the University of Colorado as a third partner.

So there is some ability for us to set the stage and to move in certain very critical markets like health informatics.

Mr. BEAUPREZ. Thank you.

The CHAIRMAN. Mr. Renzi.

Mr. RENZI. Thank you, Mr. Chairman. It is good to see you, Doctor. I sense there is a good debate going on on this issue of whether or not the system was changed significantly. As a new person trying to learn this, and honestly looking for you to teach a little bit here, was the system changed significantly or not? Is there an ability to go back? Would you want to go back? What are your thoughts on this debate on the issue whether or not the—what is described as the original mission?

Dr. MACKAY. Well, I think that the original mission from the founding of the veterans health care system has been to take care of disabled vets. That has been the core. And on a space available

we would take care of indigent vets, of those that had no other alternatives. Until, that is, the Eligibility Reform of 1996, which was implemented in 1998, and we opened up the system to all 25 and a half million veterans.

Now, as long as we understand sort of the original understanding of that major reform, that those veterans who are not wounded or injured or have illnesses that are by virtue of their service to the country, that they would have access to our system, as our system was available to give them care, that there would be certain copays and fees and other things that would balance resources and demand, then that eligibility reform was a good thing.

What we are arguing about now, or where we have some difference of opinion about, is what is the proper funding mechanism in order to ensure that that system——

Mr. RENZI. So there is no going back?

Dr. MACKAY. No, I don't think so.

Mr. RENZI. Okay. I am going switch gears on you. It is good to see the new DOD-VA love fest with the coordination and all, and particularly of the university collaboration.

I want to share with you that within the United States of America there is a sovereign nation, the Navajo Nation, the largest Native American tribe in America. It takes up part of Arizona, New Mexico, Utah, I think even Colorado. Some of my guys are hitchhiking 4 hours to get VA health care.

And I have talked about the idea, we have got to put a VA clinic—it would be historic under your watch, sir, to put a VA clinic on a sovereign nation. Now, right now you have got Native American IHS, Indian Health Service, hospitals that are operating up there, and are serving non-natives, non-Indians. Okay, Caucasians like me.

So there is no impediment to access for other veterans who are not Indians, not Native Americans. And right now the idea is that we may not be able to do that, because non-Native Americans wouldn't be able to access that. Which is, I don't know who is coming up with it, but I need you to get behind it and champion this. Okay?

Particularly in an area where you have got guys and veterans, and ladies, and particularly female soldiers, because Native American women are fierce warrior fighters. So I need you, please, as you look at collaboration and DOD sharing and university sharing, that we look at IHS, Indian Health Services.

Go ahead, sir.

Dr. MACKAY. I have some good news to report. About 4 months ago we signed an MOU between the Departments of Veterans' Affairs and Health and Human Services, with my colleague and counterpart, Deputy Secretary Claude Allen over at HHS. And last week, as a matter of fact last Friday, I was on the Pine Ridge Reservation in South Dakota to officiate at the dedication of a PTS clinic that was opened up on the reservation about a stone's throw from the IHS hospital.

It is an in-residence program. We have six beds. The Native American Indians that are suffering from PTSD can come there, they have compensated work therapy in cooperation with the In-

dian Health Service. That is the first one, is my understanding, on Native——

Mr. RENZI. That is historic, sir. I commend you for it.

Dr. MACKAY. So that means it can be done elsewhere.

Mr. RENZI. On Navajo Nation.

Dr. MACKAY. We are also, pursuant to that memorandum of understanding, looking at access to CMOP operation, our Consolidated Mail Order Pharmacy, to help solve that same access issue, if you can get your meds and your prescriptions by mail, it certainly is more convenient than having to go down to the pharmacy.

And also with respect to computerized patient records, again, and health informatics, we have the ability to share that technology in our system with Indian Health Service and we are looking to do that as well. So it certainly can happen in the Navajo Nation, because it has happened for the Sioux.

Mr. RENZI. That is fantastic.

The CHAIRMAN. Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman. I have a couple of questions about the statement you made, sir, which we have already talked about. But you say we would strongly oppose—and I suppose you are assuming to speak for the administration here—any form of mandatory funding, including formulas set in statute and independent bodies directing budget levels.

Am I accurate in assuming that you would oppose the bill that was introduced recently by Ranking Minority Member Lane Evans as well as the bill that has been introduced by Chairman Smith regarding funding?

Dr. MACKAY. Mr. Strickland, as I understand them, they have those provisions, so we would oppose them.

Mr. STRICKLAND. Okay. And I think that puts you in conflict with every major veterans organization that exists in this country, and I just think it is important that we understand that there is this great divide between your position or the position of the administration and the position of the two leaders of this committee as well as all of the veterans service organizations, and that is a huge chasm, I would think.

If I can just follow up in regard to this year's funding. You say that this year's budget request is the largest medical care increase ever. Is that increase based upon the assumption that certain things will occur, an increase in the cost of medication, the imposition of an enrollment fee for certain veterans, the understanding that certain veterans will likely drop out of the system and not come to the system for care as a result of these increased costs? So is the increase in the budget—does it take into account the savings to the VA from these increased costs as well as those who may drop out of the system as a result of them?

Dr. MACKAY. Well, the statement about the $2.1 billion, 8.1 percent, those are hard dollars. And the statement was that the appropriation is the largest ever requested in history, and that is true.

There are some of the other provisions that you named. And to go back to your first statement, you described it as a chasm. I would not describe it as such. I don't think there is any disagreement about the desire for a robustly funded, well functioning veterans health care system that serves the very worthy heroes of this

Nation, our veterans. There is a disagreement or a difference in opinion about the proper methodology by which we arrive at a budget.

Mr. STRICKLAND. But it is a basic difference of opinion, and the difference is whether or not there has got to be yearly battles to try to secure adequate funding, or whether or not there will be put in place a system of mandatory funding that will bring predictability, assurance to the VA system.

And, I mean, I think that is different than just a difference of small levels.

Dr. MACKAY. If I may, though. This is a system of health care provision. It takes active management. You were here last week when we were talking about some of the things that we are trying to do to improve the efficiencies and the management of this system. It takes active involvement of the people who oversee it and the people that manage it.

And every year in the appointed political process that comes to us from the founders, people that are elected and are held responsible by voters, not formulas, not groups of experts, not demographers, but people who are elected by real voters, get together, and we decide, with all of the other competing pressures, what we going to do for our veterans.

Mr. STRICKLAND. I understand that happens. It can change, and it can, depending on who is here and who is on this committee, who is the President and all of that kind of stuff. We want to get away from that.

Dr. MACKAY. It can also change according to what the needs of the system are. When we moved from inpatient care to outpatient care, we had a change in the way we managed the system and the way we funded it. The need is for funding changes when different things happen. When we do the CARES program, and the capital asset realignment, we are going to have a different need for funding than we do now.

Mr. STRICKLAND. All of those things can happen with mandatory funding. Mandatory funding does not freeze in place a certain method of health care delivery. All of those efficiencies and changes that you described are possible with mandatory funding, and so I think we should have both. I think we should have a system that is sensitive to the changing needs certainly of the population. But I believe what most of us want on this committee and in this country and certainly among the veterans is a system of predictable mandatory funding, and I think that is a fundamental disagreement. But my time is up, and I thank you, sir.

The CHAIRMAN. Mr. Bradley.

OPENING STATEMENT OF HON. JEB BRADLEY

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

And thank you both, gentlemen, for being here this morning. And, Dr. Mackay, I appreciate especially that you would quote Robert Frost. I had to memorize that poem in seventh grade, something there is that doesn't love a wall, mending wall.

I would like to, instead of focusing on some of the more contentious issues which have already been the subject of a lot of the questions this morning, focus on some of the other recommenda-

tions that are in the report of the President's Task Force, and in particular two: How to better create a seamless transition for the veterans as they leave active duty and become veteran status, and then also how you better integrate information technology between both of your Departments.

And so if you could just elaborate a little bit on that, and where you are going and where you have come. Thank you.

Mr. CHU. I would be pleased to begin, sir. We have ongoing this Federal health information exchange, as I described in my testimony. It has already made significant progress in transmitting electronically to the Veterans' Administration the heart of the medical record for a million and a half veterans, about 4 million records all together.

As we go forward, we would like to be able to have two-way, as close to real time as possible, transmission of medical information. That is not there now. That is going to take significant effort, investment. We think we are on a path to achieve that goal.

Likewise, when a member of the Armed Services separates, it should be the situation that the DD Form 214, which indicates service and will summarize many of these points, can be sent electronically to VA. I think there is an issue with the task force about when we get there.

The Department of Defense, as you probably are aware, sir, is in the process of moving toward what we call an integrated military human resource system, which will merge the pay and personnel records and improve the accuracy and responsiveness of both. That we hope will be fielded between 2005 and 2007.

We would like to make the DD Form 214 and other transmissions like that happen as that occurs, rather than try to write stand-alone software with all the costs and complications that will apply.

So whether we can—whether we meet the task force's deadline on that particular aspect or not, I want to emphasize the commitment to that outcome. I think we are all agreed on where we need to be. I think the issue is going to be over means of getting there and timing of when it can be achieved.

Dr. MACKAY. I thank Dr. Chu. You did a wonderful job of talking about the information technology. There are several other programs and softer "people things" on the seamless transition front. I mentioned our benefits delivery at discharge. That program has several dozen outlets and continues to expand. We also have the TAP and DTAP program, which is transition assistance. It has been going on for 12 or 13 years, since 1990. And we are also doing the best job we can to integrate with regard to things like clinical practice guidelines or information brochures.

We just let one for Guard members and Reservists to ensure that people understand their benefits and know that this sort of transition is owed to them, and these sort of briefings and other processes. Again, I will mention over at the DiLorenzo TRICARE Health Care Clinic at the Pentagon, where we are pioneering something that will be signally important, along with that electronic DD–214, and that is a single discharge physical/comp and pen physical that will satisfy both of our requirements.

We have made the decision at the Department to standardize on the core of the DEERS enrollment system that DOD has, to come as close as possible to a common system. So instead sort of enrolling in DOD for benefits and then reenrolling in VA we can meet to the extent possible all of our data needs, both in the Defense Department and in VA, with a single enrollment system, a single enrollment form with data shared between the two Departments.

So in health informatics, but also in the processes and other things, with regard to seamless transition, we have in prospect for the first time, of going back to colonial times. I think the Federal Government will be in readiness to really do a seamless transition, both in terms of data and in terms of the experience that a veteran has in moving from servicemember status to veteran status with their comp and pen figured out, that they are fully briefed about what their transition assistance and other veterans programs are and with the data coming along simultaneously.

Mr. BRADLEY. Great. Thank you very much.

The CHAIRMAN. Mr. Boozman.

Mr. BOOZMAN. I would like to follow up on the seamless transition. I guess, you know the report that came out, certainly you can tell that all of us are very interested in this cooperation happening. But the reality is that unless you have the infrastructure, whatever, behind it so that the records can go back and forth and that that process is done, it doesn't matter if you want to cooperate or not. You can't, because you don't have the background to do it.

So here you mention that you would like to have electronic medical records that are interoperable, bidirectional, whatever, by the end of 2005. I guess really what I would like to see at some point is kind of really where we are at on this core infrastructure, so that right now, you know, if you said, hey, we are going to do this totally, we are in total agreement of everything, where are we at on that?

Again, I would like to see, maybe, Mr. Chairman, periodically or, Mr. Ranking Member, periodically kind of an update on what is going on with that. You know, maybe every 6 months somebody can come in and say we have made some headway in doing that, because, again, I think that, you know, unless there is some accountability behind that it is not just going to happen. It will happen, but I think it will happen faster if we do hold you accountable.

Dr. MACKAY. I would agree, and we would be happy to supply any sort of update that the committee would like.

Those words are chosen very carefully about bidirectional, interoperable. We are not attempting, and this is a great thing that encapsulates some of the limits of how far we can go to being joint, but how much we can do in collaboration. We are not trying to have the same sort of system for computerized patient records for both DOD and VA. DOD has embarked on a very ambitious upgrade of its CHCS program to go to CHCS 2. They have a readiness mission. They have some very stressing missions with regard to generating data in the field, making sure it follows the servicemember until they are repatriated back to CONUS. That is something that we don't do.

We have what we like to think is one of the best—the best computerized patient record system in the world. It was made by our

own clinicians. It was not a billing system masquerading as a patient record system, it is a clinical-driven computerized patient record system that we are very proud of.

What we are doing is we are moving to a data repository, as is DOD. Ours is a health data repository. Theirs, I believe, is called a clinical data repository. And what we are doing, is making those two data repositories interoperable. Each Department will be able to pull data from the respective data repositories. So we have two separate systems that meet the needs of both the Department of Defense and the Department of Veterans Affairs that accomodate the different needs, different patient populations, and different practices of medicine, while maintaining high standards in both.

But the system must allow us to talk back and forth to one another with regard to electronic medical records, which is very critical.

Mr. BOOZMAN. Thank you.

The CHAIRMAN. Ms. Brown-Waite.

OPENING STATEMENT OF HON. GINNY BROWN-WAITE

Ms. BROWN-WAITE of Florida. Thank you very much, Mr. Chairman. Dr. Mackay, I know how much has been done by the administration and by last year's Congress and certainly this Congress to increase funding for veterans care.

When I read through your testimony, let me just pull one line out that says: The administration's record in this area is unprecedented. And on that we totally agree, and we would strongly oppose any form of mandatory funding, including formulas set in statute and independent bodies directing budget levels.

If the VA has a 30-day self-imposed goal, does the VA support legislation that actually puts that language on the books that says either supply it and appoint within 30 days or the veteran is entitled to health care elsewhere?

Dr. MACKAY. I think that there is one very dangerous unintended consequence that could result from a step such as that, and that would be what is called mainstreaming, which is that, as we know, if there is an inability to meet access standards more and more care is purchased. Over time there is a potential that the system could become much more of a purchaser of health care than a provider of health care.

And that is important because the veterans health care system operates synergistically to deliver things like blind rehabilitation, brain trauma rehabilitation, spinal cord injury and other specialized care. We have to have an interoperable system, a total system in order to deliver the specialized care in prosthetics and other areas of care that veterans need and deserve.

Ms. BROWN-WAITE of Florida. But if you are meeting the goal, and it is your goal, your Department's goal, what is wrong with putting it in statute?

Dr. MACKAY. What exactly are you saying that we should put in statute?

Ms. BROWN-WAITE of Florida. The Department has a goal of veterans being able to be seen by a physician in a clinic within 30 days. Is that correct?

Dr. MACKAY. That is our goal.

Ms. BROWN-WAITE of Florida. That is your self-imposed goal, which obviously is not being met in some geographic areas of the United States. Do we agree on that?

Dr. MACKAY. That is true.

Ms. BROWN-WAITE of Florida. What is wrong with putting it into statute, to kind of hold your feet to the fire to that 30 day requirement?

Dr. MACKAY. Well——

Mr. BROWN. And then I have two other questions.

Dr. MACKAY. I would really have to see language, because the interplay of any sort of access standard or guarantee and other things would have to be examined. I am sorry, but I would have to see it.

Mr. BROWN. Well, I will be happy to send you over a copy of the bill. Two other questions. Recently I was informed by a veterans service officer that a clinic was being shut down in my area. I didn't believe it. It is not being shut down, it is being transferred from a contract, I understand, to total VA personnel.

Is that correct? It happens to be the Leesburg Clinic.

Dr. MACKAY. I am familiar with that. My understanding is it is under consideration. Under no circumstances is the CBOC going to be closed. But there is an internal examination being done, about whether the services will continue to be under contract or whether we should bring it in-house. That is being looked at.

Mr. BROWN. If I may make a suggestion, it sure would be nice to hear from you all first instead of our veterans service officers, who don't have accurate information, who are concerned about the delivery of health care to veterans. It really would be much better if you had a whole lot better communication with the Congressional offices, ours, our office, I am sure the members of the committee. They are the ones who hear the cries from the veterans of what is happening to my clinic?

If we had the information, we can help to better educate both the veterans service officers and the veterans. When the word starts spreading in a community that the clinic is going to close, that can cause absolute chaos, despair and unnecessary concern for veterans.

So I would again plead, please have better communications with every single Member, not just of this committee but also every single Member of Congress.

Dr. MACKAY. Congresswoman, I agree with you. While we cannot combat every rumor, we certainly have an obligation to get you the best information and the true story first, and I apologize if that has not been the case over the recent weeks.

The CHAIRMAN. Thank you very much. Before going to a second panel, in hearing your testimony, Dr. Mackay, it prompted a question or two.

Earlier in the year, I had asked Secretary Principi for the demand model for the information, and as a matter of fact we got back a note, a comparison of demand projection and resource availability, which suggested that in 2003 there is a $1.9 billion shortfall and a $4 billion shortfall in 2004.

The Presidential Task Force calls it significant core underfunding and in fact, in response to Mr. Buyer, who suggested that the

panel was hijacked, I would respectfully submit, having read this report very carefully and having talked to some of the commissioners in response to our hearing we had the other day, if anything, they found with regard to the mismatch, as they called it. They couldn't work with the DOD/VA sharing, and they couldn't talk about veterans health care without addressing the core threshold problem, that there is a mismatch.

You said in your testimony that the PTF agreed that in fiscal year 2004, the President's budget fully funds enrolled veterans in Priorities 1 through 7. Our budget also fully funds those Priority 8 veterans already in the system, ensuring that no veteran currently in the system will be denied care.

I read that report. I don't know where that is found, perhaps it is here somewhere, and stealthily written, but I don't see it. Perhaps you can shed some light on that, especially in light of the other data that we have gotten from VA itself, this briefing note, which was in response to a question I had raised.

It shows a significant shortfall in funding. I would submit respectfully that OMB is a major problem here. The VA gets it right as to what is needed. I believe a panel of experts would also get it right.

But once it goes through that filter, what comes out has been shredded, and unfortunately it leads to fewer dollars available to provide this vital health care network with the money it needs. And we starve it. Long-term health care bed shortages, as we discussed last week in our hearing, and a whole host of other anticipated problems and consequences then indeed do occur.

But where is that found, that 1 through 7s and 8s are funded in the President's budget? I haven't been able to find it. Bottom line question to you, Dr. Mackay: Is there a funding mismatch? The core of this entire report, when you strip it of everything, is that there is a fundamental mismatch between veterans health care and funding.

Is it your testimony that there is a mismatch or not?

Dr. MACKAY. It is our position that looking at the core, the historic core of those that are highest priority for us, the Priority 1 through 6——

The CHAIRMAN. It says 1 through 7 in your testimony.

Dr. MACKAY. I am going to extend to cover that, Mr. Chairman. Those are fully funded. With regard to the nonservice-connected for Priority 7, in the President's budget in fiscal year 2004, provision is made for Priority 7s to continue to enroll for all Priority 7s that we have. The million or so Priority 7s and 8s that are already enrolled in our system, will stay enrolled in our system.

That is the genesis of my statement that Priority 1 to 7 is funded in the President's budget. I go on further to make an observation about the desirability of changing the methodology of funding. It is our position that the current system is flexible and responsive. It is messy. It does provide for the participation of OMB, which is the President's agency that looks after balancing all of the priorities and all of the spending across government.

It does provide for the inclusion of the appropriations committee in that process. That is the current process. We think that it has the necessary flexibility and it can work and does work. We would

point to the preceeding 3 years, from fiscal year 2001 to 2004, where there is a good solid track record of increased expenditures with regard to veterans health care and overall to the veterans budget.

The CHAIRMAN. In response, for the last 5 years Congress has added an average of $671 million to the President's budget, and it has been bipartisan. We did it under President Clinton, we are doing it now under President Bush. It just begs the question whether or not this demand model that we have is of any validity. Is it fiction or is it real? I say that with all due respect. The numbers that we have been tendered in response to questions that I and others have raised, say that we have missed the mark by a mile.

So, I remain baffled. I deeply respect President Bush. I am sure he doesn't know, how would he, being so preoccupied, the details of what OMB has done to the budget, to the VA and the recommendations the VA made to do its work. That is why the bill I have introduced, maybe it is not the best, or maybe it is the best—hearings and a process will determine that. But what is unacceptable to us, and I say this is in a bipartisan way, is the status quo. The flexibility you talk about usually leads to a downward revision of numbers coming out of VA once they go through the filter called OMB.

And I am very concerned. I would hope the administration would rethink its current opposition, as was relayed in the testimony and in response to Mr. Strickland's questions to either of these bills. The PTF did a magnificent job. This isn't fun, as was suggested by Mr. Buyer. I don't think anyone can say with honesty that the PTF board, made up of distinguished Americans, hijacked a mandate.

I read the mandate. At the end of the PTF's work on DOD/VA sharing they say, that sharing alone isn't going to do it. It seems to me that you as responsible people given, in this case a 2-year look at VA health care, need to come back and say, what will fix it?

And I am grateful that they felt it within their purview to make this bold but needed recommendation, or series of recommendations. And so I do thank you for your testimony. Look forward to working with you. But again, this demand model, and I know I am repeating myself, but I think it needs to be stressed with exclamation points, says that we have missed it by a lot. We in Congress have missed it as well. We are still not getting and ponying up sufficient moneys to meet the demand.

But having said that, we are getting closer. I think putting a process in place that cuts out the middleman; that is, the one with the knife cutting out necessary veterans funding, is one viable means of doing it.

I thank you for your testimony and look forward to working with you.

Dr. MACKAY. Mr. Chairman, thank you for your leadership. And you know that the Secretary and I have the highest esteem for the work of this committee, for your leadership, for the participation of the ranking member and all Democrats and Republicans. This is a good body, and we are privileged to have the leadership of this committee.

I testified today to a disagreement that we have about the merits of a proposed methodology. I don't think anybody doubts that underneath it all, actually above it all, that there is unanimity of agreement about the desirability of robust funding for a very high quality veterans health care system that serves the veterans of this country.

Thank you, sir.

The CHAIRMAN. Thank you. I would like to ask—unless Dr. Chu, do you have anything to add?

Mr. CHU. No, sir. Thank you for the chance to appear.

The CHAIRMAN. I would like to now ask our second panel to make their way to the witness table. It consists of many distinguished members of the President's Task Force to Improve Health Care Delivery for our Nation's Veterans.

Dr. C. Ross Anthony is a senior economist at RAND and Director of the Center for Military Health Policy Research, which is a joint program of RAND and NFFRDC's end health program.

Dr. Anthony is also the Associate Director for Global Health of RAND's new Health Center for Domestic and International Health Security. Dr. Anthony has over 20 years of experience and leadership in the health care field, including a unique combination of work at all levels of government.

Next, we will be hearing from Mr. Mack Fleming, who is the former Chief Counsel and Staff Director of the House Committee on Veterans' Affairs under previous Chairman Sonny Montgomery, a position that he held for 21 years.

An Army veteran, Mack was the Special Assistant for Congressional Affairs to the Administrator of the VA during the Johnson administration, and he subsequently practiced law for 5 years in DC before beginning his time on Capitol Hill.

I would just say as a personal footnote, having served with Mack for a number of years, he did an outstanding job and like Pat Ryan, who continues in that legacy, strove to make sure that this committee was bipartisan and did the best possible work on behalf of veterans.

And, Mack, it is nice to see you back here again.

Next we hear from Ms. Susan Schwartz, who is Deputy Director of Government Relations, Health Affairs at the Military Officers Association of America, where she follows health care reform legislation and its potential impact on the military health services and serves as co-chair of the Military Coalition's Health Care Committee.

Dr. Schwartz has over 19 years experience as a registered nurse in a variety of health care settings, holding positions of staff nurse, operating room educator, operating room post anesthesia care unit director, and quality improvement director.

Next we will hear from Mr. Robert Spanogle, who is the National Adjutant of The American Legion, and has been in this position since July of 1981.

Prior to his appointment as National Adjutant, he served as Executive Director with The American Legion's Washington, DC Headquarters and as Director of Internal Affairs at the Legion's National Headquarters in Indianapolis, Indiana.

Mr. Spanogle is an Army veteran with service during the Vietnam War, has been honored with a life membership in the Oldsmobile Post 237, The American Legion, Lansing, Michigan. He is past member, president and a member of the board of directors of The Veterans Day Council of Indianapolis, and a former member of the National Advisory Council to the Consumer Electronics Manufacturers Association.

Mr. Harry Walters is a principal in a general partnership of the Lafayette Equity Fund in Washington, DC, a venture capital fund. Prior to this he was Chief Executive Officer of DHC Holdings Corp. He was also President and Chief Executive Officer of Great Lakes Carbon Corporation.

What we know him most as was the Administrator of the Veterans' Administration, reporting to President Ronald Reagan. He is a graduate of the U.S. Military Academy at West Point and a former Army Ranger.

If you could begin, and all of you please take 5 minutes or so, perhaps a little longer if necessary, to make your presentations. And then we will go to questions. Dr. Anthony.

STATEMENTS OF CHARLES R. ANTHONY, Ph.D., COMMISSIONER, PRESIDENT'S TASK FORCE TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATION'S VETERANS; MACK G. FLEMING, COMMISSIONER, PRESIDENT'S TASK FORCE TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATION'S VETERANS; SUSAN M. SCHWARTZ, COMMISSIONER, PRESIDENT'S TASK FORCE TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATION'S VETERANS; ROBERT W. SPANOGLE, COMMISSIONER, PRESIDENT'S TASK FORCE TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATION'S VETERANS; AND HARRY N. WALTERS, COMMISSIONER, PRESIDENT'S TASK FORCE TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATION'S VETERANS

STATEMENT OF CHARLES R. ANTHONY, Ph.D.

Dr. ANTHONY. Thank you. Mr. Chairman and distinguished members of the subcommittee, I want to thank you for the opportunity to share my views on the final report of the Presidential Task Force to Improve Health Care Delivery to Our Nation's Veterans. I would ask that my statement be included for the record, so I can summarize a few points here, and we don't actually end with breakfast as Dr. Snyder suggested.

First, I would like to say that it has been a distinct privilege to serve as a commissioner on this Presidential task force and in some small way have the opportunity to honor those among us who have or are serving our country.

Although I serve as the Director of the RAND Center for Military Health Policy Research, the views I express here today are my own and do not represent the opinions of RAND.

Although the PTF commissioners come from diverse backgrounds, we all share a deep commitment to veterans. We worked together, learned from each other, and fashioned what I believe is an outstanding report that calls for bold action on the part of the Department of Defense and the Department of Veterans Affairs,

the Congress, and the administration to improve the quality and delivery and efficiency of health care to veterans.

It is true that some commissioners wished to go farther on the issue of funding for Category 8s. But I urge you to realize that what you have before you, as far as it goes, is a very strong statement for action fully endorsed by all commissioners, and I ask you to help implement those findings.

I believe the report speaks for itself, and what I would like to do this morning is highlight a couple of recommendations that touch on a few issues dealing with the implementation and oversight.

Although we found that direct sharing of facilities such as one finds at Nellis Air Force Base in Las Vegas, although laudable, are the exception rather than the rule. We also concluded that there are many areas where VA and DOD could cooperate with each other that would ease the transition from active duty, increase the quality of care, and improve efficiency, that would benefit both agencies and provide a better, more seamless benefit to veterans.

In general the areas ripe for action are business processes that would enable real cooperation to take place. Key among these is the need to synchronize information technologies that have been discussed here already in some detail.

Recommendation 3.1 calls for the Department of Veterans Affairs and the Department of Defense to develop and deploy interoperable, bidirectional and standards based electronic medical records by fiscal 2005. If the VA and the DOD are to cooperate effectively and implement many of the other recommendations of this report, progress on information synchronization is essential. Success depends on a coordinated business planning process at all levels that is sustained over time, not just a purchase of a particular piece of hardware-software.

This will require sustained leadership commitment that has not always been the case in the past. We see no reason why this key objective cannot be achieved by fiscal 2005.

Second, I would like to draw your attention to recommendations 3.5 through 3.7. These recommendations deal with the need to better track and understand the exposures that Military personnel experience during deployments such as Operations Desert Storm and Desert Shield or Iraqi Freedom, an area of particular concern to veterans.

I had occasion to lead an extensive research effort at RAND on Gulf War illnesses which highlighted how little information existed to understand the illnesses veterans were experiencing after the first Gulf War. These three recommendations called for both DOD and the VA to identify, collect, maintain data needed by both Departments to recognize, treat and prevent illnesses and injury resulting from occupational exposures, and will require routine pre and post deployment physicals, collection of appropriate data, troop location data and innovative data collection analysis.

This will not be an easy task. It is easy to say but it is absolutely essential that it be achieved.

Finally, let me address the idea of funding mismatch. We concluded that it would be almost impossible for there to be effective collaboration between the two systems if one was well funded and the other was not.

While not always the case, DOD presently appears to have adequate funding to fulfill its health care responsibilities. As this committee is well aware, and our report details, the same is not true for the Department of Veterans Affairs. As an economist, I feel it is important to fashion good policy and then finance it adequately, hopefully in a manner that creates incentives for efficiency.

Historically, the country has committed itself to being sure that veterans who had service-connected disabilities and/or are indigent are well cared for. It is a national commitment that I share.

That said, the demand for services has been growing beyond the capacity of the system to provide or the Congress to fund them. In theory, the Secretary of the Department of Veterans Affairs has the authority to limit care to match budget appropriations, but we all know that this is politically very difficult.

In short, I believe this is a process and a situation that is neither wise nor good public policy. Our report calls for guaranteed funding for categories 1 through 7, as we discussed already here today, so that there is certainty in the system for veterans and managers alike.

I also would like to say that I concur with the report's recommendation 5.3 which deals with the funding for Priority 8. I believe that the present situation is unacceptable because it subjects veterans to uncertainty and makes it very difficult for them to plan properly for their health care needs. It is difficult for the VA to plan and manage the provision of care. Veterans deserve better treatment.

That said, I believe the report's recommendation that the Congress and the President work closely together to solve this problem is the right one. As a commissioner, I did not feel that we had sufficient information or analysis or the time necessary to fully investigate and fashion good policy, nor do I believe that the issue was within the scope of the task force charter.

Finally, just let me conclude by saying I hope that you will help us implement what I believe is the 90 percent of the report that is the glass full and not concentrate on the 10 percent that is not yet fully achieved. There is clearly work that needs to be done. There is a lot that is good in this report that I hope you will help us implement.

The CHAIRMAN. Thank you very much.

[The prepared statement of Dr. Anthony appears on p. 150.]

The CHAIRMAN. In alphabetical order, Mack Fleming.

STATEMENT OF MACK G. FLEMING

Mr. FLEMING. Mr. Chairman, Ranking Member Evans, and members of the committee, I am grateful for the opportunity to appear before the committee to discuss some of the recommendations submitted to the President by our Task Force on May 26, 2003.

In order to provide prompt and efficient access to consistently high-quality health care for veterans, on May 28, 2001, President Bush issued Executive Order 13214, establishing a Task Force comprised of 15 members to report findings and recommendations to him. I shall not dwell on most of the recommendations contained in the Report. All members of the Task Force agreed to those pertaining to improved cooperation between the Department of Veter-

ans Affairs and the Department of Defense . Of course as some of you know, notwithstanding the recommendations, nothing will be accomplished without strong leadership from the top down. Sharing authority for the two Departments was enacted in 1982, and Congress has continued to encourage and support the concept. However, over the last 20 years, the extent of sharing and collaboration between the two Departments has been disappointing.

Therefore I will focus on what I think is the most important part of the Report—timely access to health services and the mismatch between demand and funding. It is well documented that due to severe budget shortfalls, thousands of veterans are not receiving their health care on a timely basis. The mismatch affects the delivery of timely and quality health care to veterans. This past January Secretary Anthony Principi for the first time acknowledged the budget shortfall and made the decision to cease enrollment of the newly created Priority Group 8 veterans. Why did he do it? He had no other choice. Funds were inadequate to take care of the demand. The shortage was so severe last year that VA had to stop encouraging veterans to come to the VA for their care. As of January this year, at least 236,000 veterans were on a waiting list of 6 months or more for a first appointment or an initial follow-up. So the Secretary decided it was best to reduce the waiting time for care by not enrolling many veterans. Timely access—I think not for many deserving veterans. Many of them are combat veterans.

In 1996, Congress passed legislation requiring the VA to enroll all veterans into the system. In addition this Committee and the Congress established eligibility for health care for Priority 8 veterans. One critical thing was missing—the funds required to provide the care. Establishing eligibility means little if the level of funds is not made available. I believe Pete Wheeler, Georgia's Commissioner of Veterans Affairs, said it best when he responded to an inquiry as to why Secretary Principi made his decision to scale back VA's outreach program last year. He said: "The VA budget is the problem that must be solved first. The VA budget as been neglected for many years. Congress hasn't done it's job. If they want the VA to treat more veterans, it will only be done if the money is made available. The VA has to live with the budget given it by the Administration and Congress."

Commissioner Wheeler described the adverse impact of anything less than full funding as follows. "Failing to adequately fund VA health care is like telling veterans they are invited to a dinner party but they will have to stand in the back of the line; and if there is not enough food, they will not get to eat." I'm certain many Category 8 veterans feel that way. This group of veterans has not known from year to year whether they will be granted access to VA care. So although Category 8 veterans were made eligible, funding was not made available to grant them health care that Congress had authorized for them. Is this fair—of course not. Why are these veterans being treated differently? Is it because they make a few dollars more than $24,000 a year? What is the "concern" that we can't do what is right for all veterans who have earned it? Under Title 38, USC, the term "veteran" means a person who served on active duty and who was discharged from service under conditions other than dishonorable. All veterans should be treated fairly.

We must be willing to provide full funding for all veterans. To address the mismatch between funding for the VA and the demand for services, the Interim Report released to the President on July 31,2002 said: "The PTF believes the Federal Government should provide sufficient funding to allow timely access to VA health care for all enrolled veterans." Current service members, veterans, retirees, and family members of active or retired service members—should have full and timely access to the health care services that Congress has authorized for them.

I am concerned that we appear to be moving toward the creation of two classes of veterans—those who retire from the military and the "citizen soldier" who make up most of the military services during wartime. Why do I say this? We are saying the Priority 8 veteran cannot receive his or her health care for these reasons. First, the budget submitted by the Office of Management and Budget and passed by Congress is inadequate. And most of the time the Appropriations Committee will not add much to what the President requests. In addition, some will say those "citizen soldiers" making a few dollars more than $24,000 a year is a "higher income" veteran.

Now let's compare that with the retired generals, colonels and other top officers and non-commissioned officers. Under Tri-Care for life, at age 65 those retirees will be entitled to free health care, even though some have incomes of $100,000 per year or more. In addition his widow will also be entitled to free health care. Is this also a "higher income" veteran? Some will say it is a retirement benefit. If so, why did it not come about until 2 or 3 years ago?

So to me discretionary funding is not going to solve current budgetary problems. Current problems will only be solved when the Congress decides to provide veterans' health care through mandatory funding. As to Priority 8 veterans, our Report states: "The present uncertain access status and funding of Priority Group 8 veterans is unacceptable. Individual veterans have not known from year to year if they will be granted access to VA care. The President and Congress should work together to solve this problem." I can tell you that no satisfactory answer was provided as to why they should be treated differently from others. For those who "think it may be too expensive", I would suggest we look at the total cost of a war. Aren't veterans benefits and services a cost of war? What will be the final cost of the war in Iraq? It will be far more than the costs of sustaining the active duty force.

One of the drafts of our Final Report expresses the strong feelings of our citizens for those who have defended our country—all of them. It said:

"VA's mission is to deliver the finest health care to those who served in the Nation's Armed Forces. Many of to day's service members are now in harm's way in defense of our country. This country should honor their courage and sacrifice when they need access to high-quality health care, both while in military service and as veterans. However, the combination of the evolving nature of the VA mission, changing veteran enrollment patterns, and an increasingly complex national health care landscape has produced an untenable situation. Today, the fact that enrolled veterans face long waiting times for appointments in unacceptable because of its

implication for veterans' health care and its derogation of our national obligation to those who serve."

I urge the committee to move legislation without delay to implement mandatory funding for all veterans. One thing is certain. If Priority 8 veterans are not included, veterans throughout the country will raise serious questions as to why veterans are not treated equally.

Again I thank the committee for allowing me to present my views on the recommendations of the Final Report.

The CHAIRMAN. Thank you very much, Mr. Fleming. And, without objection, your full statement will be made a part of the record.

[The prepared statement of Mr. Fleming appears on p. 157.]

The CHAIRMAN. Ms. Schwartz, if you would proceed.

STATEMENT OF SUSAN M. SCHWARTZ

Ms. SCHWARTZ. Good afternoon. Mr. Chairman and distinguished members of the subcommittee, thank you for the opportunity to share my views as a commissioner on the PTF's final report. I am grateful for the opportunity to have assisted in honoring our Nation's obligation to those who currently serve and those who have served our Nation in uniform. I ask that my written statement be included in the record.

I am here today to highlight some of our recommendations and to ask the subcommittee's help in implementation. Other commissions have tackled many of these same issues only to have their recommendations sit on the shelf. Successful implementation will rely upon congressional authority and additional funding. What distinguishes our effort from its predecessors is the focus on leadership commitment as the key to collaboration. The newly energized Joint Executive Council, JEC, has laid groundwork to institutionalize collaborative and joint venture efforts. However, as the report says, what is needed is the will to change. Continued congressional oversight will keep both agencies focused, making sure that the will does not wane.

In my visits to several joint ventures, it is easy to see the need for leadership at the top and empowerment on the ground. The staff's aim to overcome obstacles and their commitment to success is impressive. Unfortunately, the result is reliance on personal commitment rather than guidance from above. Without support at the top or empowerment, enhanced collaboration will never be realized.

Providing a seamless transition to veteran status relies heavily upon enhanced collaboration. A better job must be done to collect, track, and analyze occupational exposure data. Without this information, benefits determinations cannot be adjudicated fairly nor can the cause of service-related disorders be understood. For this to work, health status information must be shared electronically between both agencies.

I am pleased to learn this morning from the previous panel that the VA and DOD do estimate by 2005 there will be an interoperable, bidirectional, electronic medical record, EMR. Just as leadership is the key to successive overall collaboration, the EMR is the linchpin to a seamless transition. Once again, the technology exists, but the will must be found and sustained.

One-stop shopping at the time of separation or retirement is another recommendation relying on collaboration. Not only is it more cost-effective in terms of capital and human resources, it is the right thing to do to ensure that servicemembers receive the benefits they have earned and deserve.

It is now 2003. When will the DD214 be in an electronic format? Certainly the start-up costs could be paid back many times over in efficiencies gained. Again, this is not just about conserving resources; it is the right thing to do, to remove barriers that hamper a veteran's ability to complete the benefits determination process.

I am pleased that the PTF supported greater collaboration and sharing, not the integration of two health systems with unique missions and varied populations. Collaboration must enhance and maintain access to quality health care earned by each category of beneficiary and not be undertaken based solely on gaining government efficiencies at beneficiary expense. Not an easy task, as it must accommodate serious differences in cultures, missions, beneficiary populations, and benefit structures.

In our deliberations on collaboration and joint ventures, we asked is the juice worth the squeeze? Collaboration and the delivery of clinical services is certainly a worthy goal and would make those with green eye shades happy. But is it a worthy enough goal to invest the time and energy it will take to change the management structures of these two agencies to deliver health care to these two populations?

I would also suggest that each agency has its own work to do first. There are no short-term fixes to collaboration. We soon learned that collaboration between the two agencies is severely hampered because of the VA shortfalls in funding. As long as veterans are waiting lengthy periods for care, meaningful collaboration will never be realized. We did not come to a firm recommendation for care for the Category 8s. This was a consensus-driven report. We could not all agree on the level of service for the 8s. I hope this controversy does not overshadow our unanimous recommendation that those enrolled in categories 1 through 7 should be fully funded through either mandatory spending or some other modification to the current process.

The consensus of the commissioners is that first priority must be given to making things right for the veterans for whom the VA has traditionally provided care: those with service-connected disabilities and indigents.

Again, Mr. Chairman and members of the subcommittee, thank you for the opportunity to share these thoughts with you. We look to the subcommittee for your leadership to help in the implementation of these recommendations.

The CHAIRMAN. Ms. Schwartz, thank you very much for your testimony.

[The prepared statement of Ms. Schwartz appears on p. 160.]

The CHAIRMAN. I would like to ask Mr. Spanogle to proceed.

STATEMENT OF ROBERT W. SPANOGLE

Mr. SPANOGLE. Chairman Smith and members of the subcommittee, I appreciate the opportunity to appear today to offer this com-

missioner's views on the final report on the Presidential Task Force to Improve Health Care Delivery for our Nation's Veterans.

I was honored to be asked by the President to serve as a commissioner on this task force. I am equally honored to appear before this bipartisan committee on veterans' advocates. I say bipartisan, because taking care of America's veterans is a national mandate. About the only question not asked of an enlistee is, What is your political affiliation? Because it really doesn't matter. Once you raise your hand and take the oath of enlistment, everything that really matters will be taught to you by your drill sergeant and your fellow servicemembers. I have never met a veteran that said, The military did not change me as a person. Some of the changes were more dramatic than others; some of the changes left scars, both physical and mental. Nonetheless, every veteran paid a part of the price of freedom. Granted, some of their contributions were minimal, while others paid the ultimate sacrifice. Freedom was obtained, is sustained, and will continue to be secured by military veterans.

I understood the mission of this task force was to help this Nation meet its obligations to the men and women of the Armed Forces, past, present, and future.

As a veterans' advocate, I would commend to you and your colleagues a book entitled "The Wages of War—When America's Soldiers Came Home—From Valley Forge to Vietnam." the authors present an accurate account of the treatment of America's veterans throughout history. Tragically, it is not a very proud record. Words used too often in this city, such as "to care for him who shall have borne the battle," and the "thanks of a grateful nation" are lacking in action and filled with broken promises. The one point that was clearly obvious is that all veterans are not treated equally. Nothing supports that statement more than does recommendation 5.3 in this newest report.

Contrary to comments made during the Commission meetings, there are no core veterans. A veteran is a veteran. The traditional veterans treated in the VA medical facilities are any veterans needing medical care. In the 1980s, budget constraints created distinctions through means testing. Before then, any veteran was welcome in a medical facility. Just like the other barriers to collaboration identified in this final report, removal will require a degree of leadership and personal commitment by you and your colleagues. Nearly every barrier identified by this task force was identified by previous commissions in 1991 and 1998 and some of the recommendations in the PTF task force are similar. However, the very best recommendations are meaningless without the necessary actions to bring about change.

On June 3, Dr. Wilensky testified as the task force co-chair and concentrated her remarks on the areas of consensus among the commissioners. I welcome the opportunity today to specifically discuss the only portion of the PTF report that failed to muster consensus of all commissioners, recommendation 5.3 addressing Priority 8 veterans. Personally, I believe this is the most critical issue in the entire report because it deals with the greatest portion of the veterans' population, the average GI Joe and GI Jane. Needless to say, I am less than pleased with the final recommendation.

This task force was asked to offer recommendations, not to draft legislation. Every other recommendation in this report will require a paradigm shift, either administratively or legislatively. Recommendation 5.3 provides little guidance other than "good luck." however, the dissenting recommendation, provided as a footnote in the full report on page 80, offered concrete achievable actions. The title of the task force contains the phrase, "improve health care delivery to our Nation's veterans," not just core veterans or traditional veterans, but all American veterans.

The leadership of the PTF, in my opinion, did not make health care delivery and funding for all veterans the primary concern of the Commission. Some commissioners came to the PTF with experience and knowledge of the VA health care delivery system. They had an understanding of the VA health care funding. They were consistent in asking that health care funding be the primary goal on the PTF agenda. That, however, did not happen. The issue of funding was relegated to the fourth or fifth item on the agenda. The Commission was still trying to reach consensus on a funding recommendation at its meetings of March and April of 2003, and funding was still being discussed during the final Commission meeting April 25th, 2003.

Though funding the veterans' health care system was discussed throughout the life of the Commission, it was never the first topic of discussion. On more than one occasion when commissioners asked about funding, they were reminded that, in the opinion of the chair, the primary PTF mission was first and foremost to make recommendations on VA and DOD collaboration.

In the PTF's early meetings, stakeholder panels of VSOs, veterans' service organizations, and military associations were invited to offer their views. Their views were consistent: Funding the VA health care system was their first priority. They encouraged the Commission to make its funding first priority. I also note that none of the testimony received from the veterans' community was listed in the bibliography in the final report.

There are some organizations that would say the PTF majority recommendation on full funding for Priority 1 through 7 veterans was a landmark. I do not share that opinion. You are certainly familiar with recommendation 5.1, full funding 1 through 7, new, by full funding or a mandatory mechanism. I do not believe it is landmark because it fails to address the funding needs of an entire class of eligible veterans, Priority 8. The majority, of course, will tell you otherwise. However, in examining their recommendation on Priority Group 8 veterans, I think you will find it does not rise to the level of recommendation but is merely a statement, and you have that in the report.

And they talk about the present status being unacceptable. Well, certainly it is unacceptable. It is a startling discovery of the obvious.

Is the PTF majority saying, Priority Group 8 veterans, you are really not enough of a concern for us to make a concrete recommendation concerning your health care?

Is this a subliminal message they are sending to the President, the Congress, and to the veterans of this Nation?

Are they suggesting the repeal of Title 1 of the Veterans' Health Care Eligibility Reform Act of 1996 as it amended section 1710 of Title 38, United States Code, establishing eligibility of Priority Group 8 veterans for health care?

Certainly, the PTF majority making this recommendation were familiar with the Veterans Health Care Eligibility Act of 1996.

They were certainly aware of Title 38, which by that act amended Title 38.

And the PTF majority was further aware that there are certainly Priority Group 8 veterans who served two combat tours in Vietnam or who may have flown 30 combat missions in World War II, but, by the grace of God, do not qualify as Priority 1 through 7.

And they were certainly aware that that Priority Group 8 veterans enrolled in the VA make payments for heir health care under third-party reimbursement authority when treated at VA medical facilities.

They were certainly aware that these veterans pay the required copayments and their insurance is billed. And they were aware that the cost of VA medical care for Priority Group 8 veterans is not borne entirely by the Federal Government.

However, the PTF majority continued to cite the so-called "core mission" of the VA. There are PTF commissioners who are on record as defining these so-called core-mission veterans as only those who are service connected and have incomes below the threshold. On more than one occasion they refer to this as the "historical mission." even when confronted with the indisputable fact that no such core mission exists in Title 38 USC now or before 1996, they remain steadfast in their view and remain unpersuaded.

Finally, Mr. Chairman, three PTF Commissioners—Harry Walters, former administrator, Veterans Administration, Mack Fleming, former director and general counsel to this committee, and I—filed and circulated a dissent that offered an alternative to the PTF majority opinion on the funding of Priority Group 8 veterans. This recommendation would expand the strength of third-party reimbursement.

The alternative we submitted was as follows: Title 38, U.S. Code, defines a veteran as a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

Eligibility for veterans' health care is defined in the Veterans' Health Care Eligibility Reform Act of 1996 Public Law 104–262: Veterans eligible and enrolled are currently placed in one of 8 categories, although only 7 existed at the time of the passage.

The PTF did reach consensus on a strong recommendation for Priority 1 through 7, new, but failed to do so for Priority 8 veterans. Of course, VA enrolled Priority Group 8 veterans until January 17 when new enrollments were suspended because of the budget.

Therefore, we recommend that all enrolled Priority 8 veterans would be required to identify their public or private insurance. This is only for Priority 8. VA would be authorized as a Medicare provider for Priority Group 8 veterans and be permitted to bill, collect, and retain all or some defined portion of their third-party reimbursements from CMS for the treatment of nonservice-connected

medical conditions, and we would go for fee-for-service just like that provided that authority provided the Indian health.

VA should be authorized to offer premium-based health insurance policy to any enrolled Priority Group 8 veterans with no public or private health insurance. All enrolled Priority 8 veterans would be required to make copayments for treatment of nonservice-connected medical conditions and prescriptions. All enrolled Priority 8 group veterans with no public or private health insurance would agree to make copayments and pay reasonable charges for treatment of nonservice-connected medical conditions.

Why not a "pay as you go" system for Priority 8 veterans? Unfortunately, our dissent wasn't in the brief guide, and I have written both the co-chairmen to try to include that.

Finally, Mr. Chairman, I want to thank you for allowing me the privilege of appearing before you today. In one of the final Commission meetings, Harry, Mack, and I were warned by a colleague not to wear our veterans' advocacy on our sleeves. Mr. Chairman, I will readily admit to this committee that I am proud to be a veterans' advocate, and I consider fighting for the rights of every American veteran a badge of honor.

That concludes my testimony, and I would ask that my full statement go in the record. Thank you.

The CHAIRMAN. Without objection, Mr. Spanogle, yours and everyone's full statement will be made a part of the record.

[The prepared statement of Mr. Spanogle appears on p. 164.]

The CHAIRMAN. I would now ask, Mr. Walters, if you would present your testimony.

STATEMENT OF HARRY N. WALTERS

Mr. WALTERS. Thank you, Mr. Chairman, Ranking Minority Member Evans, and members of the committee.

I would rather be in front of The American Legion than instead of behind them, but this feels better. But I welcome the opportunity to appear today to offer my own views on the final report of the President's Task Force on Improving Health Care for our Nation's Veterans. I was honored to be asked by President Bush to serve on this task force, and I am indeed honored to be here this morning in front of this prestigious committee of the Congress of the United States.

The President's Task Force had its start with Gerald Solomon as one of its Co-Chairs. Gerry was your colleague. He served on the Veterans' Affairs Committee, The Armed Services Committee and The Rules Committee where he served as Chairman. Following the very first meeting of the Task Force, we lost Gerry after a bout with cancer ended his life. For me, Gerry was a first class Congressman in every way. I miss him and I hope all of you will join me in a tribute to his work for America's Veterans.

When I last appeared before this committee in 1985—and that will date me accordingly—the veterans' community could not begin to discuss some of the issues we are discussing today. Since 1985, the VA has developed a contemporary, modern medical care system, second to none in our country, and the veterans' service organizations are now more open to discuss methods in which to expand quality health care to more veterans.

In that spirit, it seems to me that Congress passed legislation in 1996 allowing Category 7—then Category 7 veterans access to the VA system. By utilizing third-party reimbursement to pay for their care, the Congress was obviously requiring the VA to act like a private sector hospital in that regard. While the VA medical centers had had some difficulty in developing private-sector billing and coding expertise, I was pleased to see that over the last year there has been significant improvement in collections. I am confident that improvement will continue. It is not easy to implement private sector procedures in a public environment, but it is entirely accomplishable.

I have been and will be a proponent of policy changes that require the VA to compete for additional patients. Eighteen years ago, I would not have dared to utter those words.

My opening statement, Mr. Chairman, are given so that you and the committee may better understand my views on the task force final report.

I believe the task force has put forth some good ideas in finding ways and methods for which the DOD and DVA may collaborate and share resources. The recommendations in chapter 3 dealing with providing a seamless transition to veterans' status are especially pivotal in setting the groundwork for better cooperation in the future. Without a good start in this area, the prospects for future sharing are diluted. And in the course of all of our discussions about sharing, this issue had the strongest consensus amongst the the commissioners.

We also addressed the need for leadership and the elimination of barriers to collaboration. My own personal experience in attempting to start an informal partnership with the Department of Defense in 1983 was not only brief but was extremely nonproductive. Strong leadership from DOD and VA will be necessary to implement our recommendations on sharing. Our discussions on barriers and leadership, however, soon revealed the most obvious barrier to sharing and collaboration: the VA's inability to meet the requirements for their own veteran patient load and the growing mismatch between funding and demand and the VA medical system. This issue led the task force to devote an entire chapter, chapter 5, to this matter.

The commissioners all agreed with recommendation 5.1 dealing with Category 1 through 7 veterans. It should be noted, however, that the task force did not come to closure on the funding mechanisms for this recommendation. Two alternative approaches were discussed. The commissioners did not recommend either of them. We simply did not discuss them in enough detail to provide a recommendation. In my view, the alternative to suggest an outside board of experts has not been properly vetted with the veteran community. They have a stake in the VA and their views, to my knowledge, have not been heard, and they should be heard.

Recommendation 5.2 also adds strong consensus among the commissioners. Twenty years ago, the outsourcing of VA health care would have been contentious. Now, it seems the veteran community favors it. What a difference 20 years can make.

Category 8 veterans were the last issue on the table for discussion. Perhaps it should have been the first issue on the table. An

issue of this magnitude certainly deserved more time. Recommendation 5.3 is really not a recommended solution for Category 8 veterans. It only calls for the Congress and the President to solve the problem, while stating that the present situation is unacceptable.

The footnote or dissent to recommendation 5.3 outlines five specific recommendations for solving the problem for the Category 8 veterans. Recommendations, not legislation. I hope that the committee will take these recommendations under serious consideration. The opportunity to create new revenue streams for the VA is discussed in this dissent. It features a pay-as-you-go methodology, and, for the older veterans, the use of their Medicare benefits in a VA hospital. The Medicare reimbursement issue was supported by all of the veterans' service organizations that testified in our public hearings.

I think that PFC Jessica Lynch will be a Category 3 veteran following her discharge from the active force. She deserves that priority, and the country is proud of her service. The 100 or so members of our Armed Forces who risked their lives to bring her to safety will most likely be Category 8 veterans. While most Category 8 veterans will not seek care in a VA hospital, those who choose to come to the VA presently do not have that choice.

In closing my remarks, I am reminded how important the VA is to our country. While we have a large contingent of our Armed Forces in harm's way, we should be especially diligent in ensuring the continued success of the Veterans' Administration.

Mr. Chairman, thank you for the invitation to testify in front of your committee.

[The prepared statement of Mr. Walters appears on p. 170.]

The CHAIRMAN. Mr. Walters, thank you very much not only for your past service but your present service, and to all of you for providing this very valuable guide and blueprint for Congress, the Executive Branch, and the American people, as to how we deal with the challenge of fully funding our veterans, and also all of the other chapters dealing with a seamless transition to DOD/VA sharing. As you pointed out, it is better to glean information now, so that we don't have another Agent Orange debacle as we had in the 1980s.

I would just point out for the committee and for our panelists, and Mack remembers this, that we worked very hard to try to determine, where the veterans were during the spraying of the herbicide Agent Orange, and the information was very difficult to come by. Records weren't kept. And then we almost saw, but not quite, a deja vu with the Persian Gulf mystery illnesses. So hopefully this will finally encourage that we get it right. So I do thank you.

Just a couple of questions, because your work is really in your magnificent product that you have produced and your testimonies amplify it a bit and underscore it as well.

As you know, last year I introduced H.R. 5250, along with my good friend and colleague, Mr. Evans. We had in that bill a formula that suggested 120 percent of the 2002 number, with other documentation or other criteria as well, inflation, for example. This year the bill has been introduced by my friend and colleague Mr. Evans and has 130 percent. We had worked up a draft, and it was right along those lines as well. We have real difficulty as to knowing

what the true number should be. If it is going to be formula driven, it seems to me getting that number right is absolutely essential.

I have introduced a bill that has perhaps more flexibility to it in that the panel of experts, and it was pulled right out from your two alternative recommendations, would empower a three-member panel to determine, based on the demand model, with OMB data and everything they can get their hands on. There certainly would be a list of information they would be required to get their hands on, and then they would make a recommendation that would become the President's number. The last look would be probably May 1, and then we would go forward with that, and that would be the President's number.

My hope would be that if it became law, we would get it right. If we didn't, we would get it right the next year. And my good friend and colleague from Connecticut and I have introduced a bill, along with close to 40 cosponsors.

If the panelists could give us some insight, what do you think is the right number, formula-wise, if we went with Mr. Evans' bill? Is it 120? Is it 140? Is it 125? It is a vexing problem. If we get it wrong, we could grossly underfund or we could provide a surplus. And, believe me, trying to fix the formula via a new statute would be difficult. It doesn't lend itself, as we all know, and Mack, you remember how hard it is to get any bill passed through the House and Senate and down to the President. Fixing that formula might be very difficult if we don't get it right.

Secondly, I would like to ask Mr. Walters in particular what your experience was with OMB, because obviously you had budget recommendations that had to go through OMB when you were Administrator. If you could speak to that as well.

I would like to yield to the panelists for an answer. Mr. Walters, you might want to start.

Mr. WALTERS. Well, I had the good fortune of having David Stockman as my OMB director, and who seemed to enjoy being a lightning rod for the veteran service organizations. So my task was somewhat easier than some. But I will say this—and I have testified at public hearings of the task force on this issue—that the discretionary budget is an enormous effort. The effort begins anew every year and is a burden on management.

And when you are competing by line item with other agencies in the government, it seems to me that the move to mandate the funding for care is appropriate. I am not taking exception with what Deputy Secretary Mackay said today, because he is on top of all the detail. But from my experience, if a mandated care budget were to become a reality, it would take a load off the VA and allow the agency to focus on what it does best, and that is the care of America's veterans.

The CHAIRMAN. Mr. Spanogle.

Mr. SPANOGLE. I had the pleasure of attending Michigan State University with David Stockman, but I will leave that story for another time. That was at the height of the Vietnam War. But I was coming back as a veteran, he was kind of on the other side. But, anyway.

I agree with Harry. I have not had the opportunity to look at the independent panel bill yet, but I was certainly in support of the bill

last year on full funding. In my experience—and that has been about 30 years, and I served with the Legion when Harry was the administrator. I think the VA does a good job on forecasting the needs. The demand models are pretty good. And I happen to believe that this committee can assist in that. I have never been disappointed by this committee in forecasts, or the VA. So I think—that is my thoughts on it.

The CHAIRMAN. Dr. Anthony.

Dr. ANTHONY. I haven't had a chance to look at the numbers in great detail, but I will say that more information is always better. And if you could have a panel, even if they didn't have the legislative authority to ultimately set the rate, a group that looked at all the information, provided this committee and the public with real live data that was analyzed, that got as close to the number as possible, I think would be a useful thing to have achieved.

I would secondly say that I think that any system that you put into place ultimately should be cognizant of and flexible enough to include in it incentives for efficiency. You know, I used to help run the Medicare, Medicaid program at HCFA when it was called HCFA, and I did a lot of battling with OMB too. And actually I was an intern with Stockman, which was at OMB, a long time ago.

But we do need systems. And if you look at the Medicare, when we paid on a fee-for-service basis, it got out of control. Certainly we need to be cognizant of good public accountability. And in my experience, the more data, the more information, the more accurate it is, the more that people and the Congress can make decisions within parameters that are responsible and in the public best interest.

Ms. SCHWARTZ. Mr. Chairman, I would also urge—I had a brief chance to look at your bill, and at first glance I thank you for your leadership in this area.

One of the things that your bill does do is it ties it to access standards. It does no good to fund a benefit and not tie it to access standards, as what I would call my area of expertise is the TRICARE benefit. And I think the VA access standards are very loose. And I know that this is a long-term goal, but those goals, those access standards need to be tightened as well. But I would urge you to always tie it to access standards. And as Dr. Anthony said, also efficiencies.

As I looked at the legislation, you do a good job providing the funds, but I think there is also accountability on the VA side. If you know the money is coming all the time, where are the efficiencies that could be tied to that? So that would be my only other suggestion.

The CHAIRMAN. Mack.

Mr. FLEMING. Let us talk efficiencies. How long have we been dealing with that? OMB will put something like that in their budget each time. I don't believe that a private sector hospital or medical system could be nearly as competitive as VA has been over the years, given the budgets that it has had. And so I am not here suggesting, like in the 2004 budget, that you are going to save $900 million through efficiencies or waste, fraud, and abuse.

I will just simply leave this. I mean, I used to have my differences with OMB, too, in dealing with staff. But no OMB is going

to let VA come in with a budget that it needs to take care of it. I don't care whether it is Republican or Democrat, it is not going to happen. And so what you have to do is do the best you can with what you get. And the issue here, though, is not which one are we going to have to deal with. The issue here is mandatory funding. Discretionary funding is not going to do it, and it never has. Even the years that I was here, sure.

But mandatory spending. I mean, that is where it should focus on. And while I made my presentation before the task force—yes, I used the Chris Smith-Lane Evans bill that you introduced last session. I mean, that was something that would do the job. Now, would you make a mistake in whether or not you estimated the number of people? Maybe. But in the end, if I were the Secretary of the Department of Veterans Affairs, I want to be the one to determine what the level should be rather than some group.

But the two alternatives that were set out in our task force report, it wasn't recommending one or the other, just like Harry said, but it was just two alternative ways of getting there. But I and the veterans' organizations were very enthusiastic last time with the bill that you two had put in. But as long as we come down with mandatory funding, maybe there is a different way to go.

The CHAIRMAN. Mr. Evans.

Mr. EVANS. I am not sure that the resolution you would like us to offer is in question. We appreciate it, though.

Mack, I have known you now for 20 years, and I get nostalgic about some of those good old days. And I appreciate everything you have done. Twenty years, I don't know where it has gone. And that is as long as I have known Bob Spanogle, for that matter. I will never forget my trip to Indianapolis to your national headquarters. I wish every member of this committee could have a chance to go there and see it.

Dr. Anthony, the report does not take a position on what Congress and the administration should do about meeting the needs of Priority 8. As you indicated, the more information, the better. Why was it your view that the Commission is able to speak to the needs of Priority 1 through 7 but not Priority 8 veterans? In your view, what more information do we need to make this decision?

Dr. ANTHONY. Well, in my view, the issue is really very complex. That is not an excuse for not dealing with it. This committee has dealt with the issue for many years. We on the Task Force did not have either the staff, the data, or the information to really look into the policies as I think we needed to.

I mentioned I used to work at the Health Care Financing Administration, and at those times implementing regulations that—as a result of laws that Congress would pass, we very quickly found that every single area had implications and feed-over effect on all other parts of the program. That is going to be true here. You presently in the Congress are considering legislation to provide Medicare—pharmacy benefits for Medicare beneficiaries. The way you structure that program has real implications for what happens with Priority 8s in the VA. Personally, I think you need to look at both in conjunction with each other and think about some way of synchronizing the two benefits.

As was mentioned earlier by Dr. Mackay, there are really significant changes that would take place if all of a sudden you made funding available. Depending on how you made it available has real implications for the demand on the system. If, for instance, we doubled the number of users—we all know that the real issue here is the woodwork effect: that is how many veterans are eligible but are not using the systems—and have a tremendous increase in demand on the system, then it changes the VA drastically. Instead of a system that is providing care in VA facilities, now you are going to have to have a system that purchases care outside of the VA system some way to accommodate the demand.

I don't know what the answers to all these questions are. They are important questions to get right, and I didn't feel that we had the time, the staff expertise, or even the right commissioners—in spite of the very distinguished panel we had. These are issues of how you design a financing a provision-of-care system that I think could have benefited from greater expertise than we had even on the Commission. So, in my opinion, versus getting it wrong, that it was better to make the recommendation we did.

And you may note in my testimony, I actually think that this is an extremely important issue. It is probably worthy of another task force that concentrates only on that issue or perhaps, at the very least, a report to Congress that helps to inform you on the alternatives open to you.

I know that the opinion is not held by some of my colleagues here. I respect their views. And I wish that we had had the time and, in my opinion, the expertise to analyze all these issues. I think they are important, and they need to be addressed.

Mr. EVANS. Thank you.

Director Walters, You developed the America is number one "Thanks to our Veterans" T-shirt. I still have mine down in the wall locker. We appreciate that. It is a big morale booster and it is still holding up pretty well.

Dr. Schwartz, My late mother was a nurse. She worked in the country. I saw the practicality of inpatient care through inpatient care through her work and through many other things that she did. We want you to know that we strongly support getting more women involved in the processing, and women's Committees that help women have and a little more protection.

So, Mr. Chairman, thank you. This has been a very interesting panel, and I will yield back my time.

The CHAIRMAN. Chairman Simmons.

Mr. SIMMONS. Thank you, Mr. Chairman.

I serve on the House Armed Services Committee, and in the last session of Congress we were involved in the oversight of the TRICARE for Life program, where military retirees would no longer be shifted into Social Security or Medicare, but would receive TRICARE for Life. One of the big questions that came up in the context of that process was, would the information technology systems be brought online in a timely fashion? Would it work, or would we actually be creating a monster that we couldn't manage?

Well, the way it has worked out is—it has worked out. The Armed Services Committee put a lot of pressure on the Defense De-

partment and, to the best of my knowledge, the system seems to be working.

Now we are confronted with the situation where we are trying to create a seamless system between DOD and VA. "Seamless" is a term we hear a lot. In Dr. Anthony's testimony, he talks about a system that is interoperable, bidirectional, and standards-based, and that we would like to see this by fiscal year 2005.

There is also a reference in Ms. Schwartz's testimony to the development of an electronic DD214.

I served for many years in the Reserves, and we had systems—shells, if you will, for literally hundreds of forms. If you do an OER or if you do a logistics request or a request for orders, you just point and click and the shell comes up and you fill in the blanks and you print it out or you e-mail it. You know, the idea that we don't have an electronic DD214, which is basically a one-page document, that we don't have that up and running is just astounding to me. I can't understand why not.

I am not a high-tech guy. I mean, I majored in English literature in college. I don't know anything about how these systems work. All I know is that as a military commander in the Army Reserves, we used hundreds of these electronic forms in the 1990s, and they were up and running.

So we talk about seamlessness and we talk about interoperability and we talk about bidirectional and standards-based and all this kind of stuff. What is the problem? Why don't we have a DD214 up and running, and why don't we have medical forms that are generated by the military that can be e-mailed to VA and received and processed anywhere, in any VA facility around the country?

Ms. SCHWARTZ. Sir, we probably should have asked Dr. Chu that.

Mr. SIMMONS. Where did he go?

Ms. SCHWARTZ. Maybe next year in the Armed Services Committee hearings, we will be having that discussion.

Mr. WALTERS. I will take a crack at that, since I have no political gain or loss in these matters anymore.

The fact is that being a retiree or a veteran of the DOD is different than being just a regular veteran. Over the years, the DOD has built themselves a culture of retirees that have been taken care of by the Department of Defense. In the mid-1980s or so, that began to change. Hospitals were closed, TRICARE was put into place. They have been separated from the DOD to the extent that they are not really a core—they are not really a core mission for the DOD any longer. And I believe that. I do not believe that retirees are treated appropriately at the DOD, but I understand why they are not. The primary mission at the DOD, since I served there for 2 years as Assistant Secretary of the Army, is to fight our wars. And veterans are the last war, not the new one.

And this has been a huge issue. I tried in 1983 to—since my close association with Cap Weinberger, I went over there thinking I would have a wonderful reception. I mean, after all, he used to work there. And they literally booted me out of the Pentagon. I mean, they weren't interested, period.

I think that notion is still the same. I think that is the basic notion, that they have two different missions, is why they don't share very well, for sure. And you may be trying to force an apple and

an orange, you know, to make another orange. I don't think it is going to happen that way. I have never been very optimistic about the DOD and the VA coming together so closely, because their missions are so diametrically opposed and the cultures are entirely different.

Dr. ANTHONY. First of all, I don't claim that I am a techie, either. Every time I have a problem, actually, I rely on my 18-year-old son Michael to straighten it out for me.

But having said that, what happens when you have two different groups head off and invest huge, huge amounts of money—and we are not talking small dollars when you start talking about the DOD and the VA system, is a situation were two groups have a tremendous amount invested in each of their systems, and it is a complicated expensive technical problem to bring them together. My view is that we need a black box between the two so they can talk to each other.

But, if you asked the questions you are asking to the techies, they will tell you there is no reason why it can't be done; it is really a matter of commitment and a matter of resources.

It is absolutely essential to have information synchronization or talking back and forth if almost any kind of real sharing is to happen between the DOD and the VA. So I think we, all of us, and you and this Committee through your oversight authority, need to really be sure that this issue is tracked and it happens; because if it doesn't happen, I don't think many of the other recommendations can effectively be achieved.

Mr. SPANOGLE. Mr. Simmons, if I could, I didn't have the time to address that part of the report, but I am very high and would give it an A-plus as far as the interoperability and the seamless and DD214 and the life medical record of the veteran or the military as he transitions—he or she transitions.

Dr. Paul Tibbetts worked with the task force. He was a staffer, consultant to the PTF, and he had people working on his staff that were lent to him by DOD and VA; techies, if you will. And I remember him saying one thing very, very straightforward. He said: We can do this. If the Secretary of DOD and the Secretary of the VA say this is what I want done, it will get done, because the software and the hardware is there.

Mr. SIMMONS. If I could just comment, Mr. Chairman. There is another word that appears in the report repeatedly; it is leadership. Leadership. Maybe the appropriate subcommittee of the Armed Services Committee and this committee should have a joint meeting and bring in the leaders.

The CHAIRMAN. I fully agree. I would just remind my good friend and colleague, last year I was the lead witness at least one such a hearing that we put together. And there was some real reluctance on the part of a number of people to move ahead with what was a modest implementation of the old sharing agreement, and to promote more of it because we have seen so little over the two decades. But I think the time is ripe to do it again, and I commend the Chairman and I think we should do it as soon as possible. And the leadership obviously should also come from VA and DOD, but our committees need to do their part.

Dr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman. I think just a comment. This has been a helpful panel, and I have read I think all but one of your written statements, since I didn't have the other one before I got here.

But, Dr. Anthony, you had a statement, one sentence in your written statement in which you talk about this funding issue. And you say, "Decisions of this nature will involve hundreds of billions of dollars over many years, interactions between other major programs such as Medicare, and difficult public trade-offs that need to be properly considered by the President and Congress.".

I think this issue of the difficult public trade-off in my view, I mean, we have missed that mark in my view for the last couple of years. I mean, this is not a question. But we are going to have one this week, you know, we are going to talk about permanent repeal of estate taxes worth hundreds of millions. It is the only time in our history as a government we are going to give a tax break worth tens of millions of dollars to a few individuals—a few individuals in Arkansas versus what we are talking about here, a few thousand per individual would just do wonders for their lifestyle.

But I think we have got, as you said, some difficult public trade-offs that, in my view, have not been going—the public is not getting the money for their trade here in the last couple of years.

Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Snyder, thank you very much.

I would like to thank our panel again for the enormous work and the great recommendations you have made. I would like to point out that Everett Alvarez is here, and thank him for his good work. He is also working as Chairman of the CARES committee, so he certainly has an enormous amount of work ahead of him. I also would like to thank some of the staff who are here today including Catherine Swartsell, who is the acting Executive Director; Karen Heath, Senior Consultant; William Brew, Counselor; Dan Amon, who we have known from this committee as the Communications Director; Daniel Blum, who worked on the resource budget process; and Dr. Paul Tibbetts. I hope I didn't miss anybody who is here, that was just from eyeballing the audience. I want to thank you again and I look forward to working with you as we go forward.

I would like to welcome our third panel, beginning first with Dennis Cullinan, who is the National Legislative Director of the Veterans of Foreign Wars; Mr. Richard Fuller, National Legislative Director of the Paralyzed Veterans of America; Mr. Richard Jones, the National Legislative Director of AMVETS; Colonel Robert Norton, who is the Deputy Director of Government Relations for the Military Officers Association of America; Mr. Steve Robertson, who is Director of the National Legislative Commission of The American Legion; and Mr. Joe Violante, who is the National Legislative Director of the Disabled American Veterans.

And, without objection, your full statements will be made a part of the record, but I do hope you will proceed as you see fit. And I thank you for your patience in waiting until Panel 3. But your recommendations, as always, will be taken very, very seriously by this committee and we save the best for last.

STATEMENTS OF DENNIS M. CULLINAN, NATIONAL LEGISLATIVE DIRECTOR, VETERANS OF FOREIGN WARS; RICHARD FULLER, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS; COLONEL ROBERT F. NORTON, USA (RET.), DEPUTY DIRECTOR, GOVERNMENT RELATIONS, MILITARY OFFICERS ASSOCIATION OF AMERICA; STEVE ROBERTSON, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION; AND JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

STATEMENT OF DENNIS M. CULLINAN

Mr. CULLINAN. Thank you very much, Mr. Chairman. On behalf of the 2.6 million men and women of the Veterans of Foreign Wars and our Ladies Auxiliary, I wish to thank you for including us in today's most important hearing.

The VFW views the PTF report as being a major milestone with respect to devising the means to improve access, enhance services, and generally enhance the quality and timeliness of the health care provided by the Departments of Defense and Veterans' Affairs to their respective beneficiaries.

The task force places special emphasize on the need for senior and sustained leadership on the parts of DOD and VA with respect to enhanced collaboration as well as the general provision of health care. The VFW places special emphasis on the PTF finding that, even if VA were operating at maximum efficiency, it would be unable to properly meet its obligations to enroll veterans at the current funding level.

The growing mismatch between funding and demand must be addressed. The VFW has historically and continues to support providing all veterans seeking such timely access to VA health care. We do, however, acknowledge and applaud the PTF recommendation that the Federal Government provide full funding to ensure that enrolled veterans in Priority Groups 1 through 7 are provided the current comprehensive benefit in accordance with VA's established access standards. We concur that full funding should occur through modifications to the current budget and appropriations process by using a mandatory funding mechanism or by some other changes in the process that achieve the desired result.

The VFW has long insisted that VA facilities be held accountable in meeting the Department's own access standards for enrolled veterans. In this we support the PTF recommendation that this standard apply for Priority Groups 1 through 7. In instances where an appointment cannot be offered within the access standard, the VA should be required to arrange for care with a non VA provider unless the veteran elects to wait for an available appointment within VA.

The VFW also strongly agrees that the present uncertain access status and funding of Priority Group 8 veterans is unacceptable. Individual veterans have not known from year to year if they will be granted access to VA care. The situation is grossly unfair, amounting to outright denial of care to countless veterans in need, and we insist that it be rectified.

The VFW is also very encouraged by the recommendation of the task force to continue discussions to clarify Medicare reimbursement for eligible veterans. It is the VFW's contention that the veteran, VA, and the Medicare Trust Fund, due to the lower VA medical costs, will all benefit under such an arrangement.

While the precise health care funding methodology remains to be devised and implemented, there may be no doubt that a budgetary solution must be quickly forthcoming or countless deserving veterans in need will suffer as a consequence. We as a Nation must not allow this to happen.

Another area addressed by the PTF that the VFW views as being of critical importance is providing for a seamless transition from military service to veteran status. The VFW strongly supports the task force's assertion that lines limiting organizational jurisdiction and authority should be invisible to the servicemember or veteran crossing them.

A key element in this regard is the PTF recommendation that VA and DOD should develop and deploy by fiscal year 2005 electronic medical records. The establishment and utilization of fully compatible EMRs is critical in this regard.

The VFW also supports the PTF recommendation that the Departments implement a mandatory, single separation physical as a prerequisite for promptly completing the military separation process. Upon separation, DOD should transmit an electronic DD214 to VA.

Further, we agree that VA and DOD should expand their collaboration in order to identify, collect, and maintain the specific data needed by both Departments to recognize, treat, and prevent illnesses and injury resulting from occupational exposures and hazards experienced while serving in the Armed Forces, and to conduct epidemiological studies to understand the consequences of such events.

Mr. Chairman, for the sake of timeliness, I will discontinue commenting on the rest of the PTF areas of interest to the VFW. We find this to be an outstanding document, a terrific blueprint to be pursued in providing better health care services for America's veterans.

Thank you.

The CHAIRMAN. Mr. Cullinan, thank you very much for your testimony.

[The prepared statement of Mr. Cullinan appears on p. 173.]

The CHAIRMAN. Mr. Fuller.

STATEMENT OF RICHARD FULLER

Mr. FULLER. Thank you, Mr. Chairman, Mr. Simmons. Thank you for the opportunity to let me present the views of PVA on the Presidential Task Force Report.

In summary, PVA is pleased that the PTF recognized the unique missions of both the DOD and VA in recommending ways in which the two systems can work together to improve services for both patient populations. We were also pleased that the PTF highlighted patient access as the biggest problem facing the VA health care system today.

Indeed, PVA views chapter 5 of the final report, "Timely Access to Health Services," and the mismatch between demand and funding as the crux of the PTF recommendations. We are pleased to see the PTF attempt to tackle these vital issues. But we think that they did not go far enough. Access standards without sufficient funding are standards in name only.

In addition, although we applaud the PTF for bringing up the importance of access standards, we have concerns over the recommended enforcement method; namely, arranging for care to be provided by nonVA providers when these standards are not met. The VA is a national asset. Steps taken to shift patients to nonVA providers can set a very dangerous precedent, encouraging those who would like to see the VA privatized, and the Federal Government turning its back on its promises to the men and women who have served. We do think that access centers are important, but we believe that the answer is in providing sufficient funding in the first place in order to negate the impetus to drive health care into the private sector. Indeed, as the PTF recognized, providing adequate health care funding is the key to shoring up and improving VA health care. Many of the recommendations in the report will ultimately have very little effect, if any, if the VA funding structure is not reformed.

Although the PTF must be commended for attempting to grapple with this issue, we are disappointed with the extent and scope of the recommendations in recommendation 5.1.

First, the PTF recommended that the Federal Government should provide full funding to assure that only veterans enrolled in Priority Groups 1 through 7 received care. And, second, the PTF was quite vague, as people have testified before, as to exactly how full funding should be achieved.

Let me address the Priority 8 issue first.

PVA strongly agrees with the position advocated by task force members Alvarez and Wallace which called for guaranteed access and funding for Priority 8 veterans. The PTF in their recommendation 5.3 merely called the uncertainty facing Priority 8 veterans unacceptable, and urged the President and the Congress to work together to solve the problem, while excluding this from recommendation 5.1. We also note that task force members Spanogle, Walters, and Fleming also urged continued access and health care for Priority Group 8 veterans, and PVA believes that Priority 8 veterans must be included in any guaranteed funding mechanism developed for Priority 1 through 7.

Secondly, in addressing the funding issue, as stated before, the PTF called for full funding by using a mandatory funding mechanism or by some other changes in the process that achieve the desired goal. One of the two alternative mechanisms suggested by PTF in regards to recommendation 5.1 calls for the creation of "an impartial board of experts, actuaries, and others from outside VA to identify the funding required for veterans' health care that must be included in the discretionary budget request." This approach, while different from the mandatory funding mechanism we have become familiar with, is well worth investigation and full consideration. The panel of actuaries approach may be a valid solution to this longstanding funding problem. No well-intended concept

should be disqualified out of hand if it is designed to produce the end result, and the end results are the dollars needed to maintain the quality and quantity of veterans' health care.

We congratulate Chairman Smith for his advocacy and leadership on this issue in introducing legislation bringing this new funding concept to the table.

Mr. Chairman, there is certainly no mystery concerning the amount of funding needed by the VA health care system. PVA and AMVETS and DAV and VFW published The Independent Budget, now for the 17th year, which provides, we believe, a true assessment of VA's true resource requirements. Indeed, even the VA comes somewhat close at times, if you ask them behind the scenes, and if you strip away OMB's artificial budget caps and all the far-fetched policy initiatives and the wildly overstated numbers regarding third-party collections and such things as the perennially popular management efficiencies.

For this reason, PVA must again restate our support for guaranteed mandatory funding. This was the second of the two alternative approaches identified by the PTF, and we strongly believe that some form of mandatory funding system is the only realistic solution to the VA's budget woes.

We would also commend Ranking Democratic Member Lane Evans for introducing H.R. 2318, calling for mandatory funding for health care for all currently eligible veterans. Guaranteed mandatory funding is an approach recommended by veterans' groups and supported by many members on this committee. We urge the committee and this Congress to adopt a guaranteed funding approach for VA health care.

That concludes my testimony.

The CHAIRMAN. Thank you very much, Mr. Fuller.

[The prepared statement of Mr. Fuller appears on p. 176.]

The CHAIRMAN. Mr. Jones.

STATEMENT OF RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Mr. JONES. Mr. Chairman, on behalf of National Commander Bill Kilgore and the nationwide members of AMVETS, it is an honor to appear before you to discuss the report of the President's Task Force to Improve Health Care Delivery for our Nation's Veterans. AMVETS deeply appreciates the President's decision to establish this task force to improve health care delivery. If for no other reason, the President's directive has brought into focus the fact of an enormous continuing gap between resources and capacity of the system to deliver timely quality care to our Nation's veterans.

As directed under the Executive order, the task force was created in large part to recommend specific reforms to better coordinate the activities, benefits, and services of VA and DOD. In review of the report, AMVETS finds the task force recommendations are fine as far as they go but, frankly, they do not go far enough.

While the task force call for full funding of the seven groups of priority veterans is certainly commendable, AMVETS is extremely disappointed that a majority of the panel members would present a document that excludes a broad category of veterans from access to health care. In looking at Title 38, United States Code, the defi-

nition of the word "veteran" is a person who served in the active military, navy, or air service, and who was discharged or released therefrom under conditions other than honorable. Moreover, in chapter 17, it clearly indicates that all veterans are eligible for VA health care, including Priority 1 through 8.

Mr. Chairman, there is not one member of AMVETS who would refuse to give up their position in VA's waiting line to allow a service-connected veteran medical services for a service-connected condition. Yes, the task force highlights the obvious mismatch in demand for services and resources necessary to provide health care. Over the years, we have testified to that. Vital VA health care programs, key to assisting veterans, have seen unceasing underfunding. These trends deeply trouble AMVETS because we believe, like you, that there exists a sacred commitment to those current, past, and present who wear this Nation's military uniform.

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

In reviewing task force documents, AMVETS would like to point out an observation made previously by former Administrator Harry Walters. He made this in testimony a moment ago and he made this during task force debate when he commented about the task force and its members' misdirected concerns with the economics of health care rather than the delivery of health care to veterans. He told about the then-recent repatriation of PFC Jessica Lynch. He said, "Broken legs and all, she is home. And she will be a Category 3 veteran. She will have access to the VA medical care system." However, "the 100 or so brave people that rescued her and dug up the six bodies of her comrades with their own bare hands will also come home, and a good deal of those veterans will be Category 8 veterans, some of whom may not have insurance when they return and may elect not to have insurance because it is too costly for them to have insurance and support their family. And the VA will not be there for them; will not be there for them."

Again, AMVETS supports a policy aimed to ensure that severely disabled veterans receive prompt care. With tens of thousands of veterans waiting for an appointment, granting priority and scheduling health care appointments for severely disabled veterans is the right thing to do. But the task force failure to make a specific recommendation on veterans already eligible for care is troubling.

In reading task force transcripts, it seemed that some members of the panel wanted to disregard the enactment of the Veterans' Health Care Eligibility Reform of 1996. They spoke of traditional and historical users of VA, then aimed to blame a category of eligible, legitimate users of VA saying, "but what has happened has been the worst of all worlds; the traditional users are getting the short end of the stick."

The task force, instead of looking to improve health care delivery for the Nation's veterans, looked with green eye shades to change eligibility for enrollment, and they carried that failure over to their final report.

Today as we discuss the task force report, the condition of the VA health care system remains troubled. Each year the accumulated shortfall is built into the budget process. In past years, VA has responded by delaying equipment replacement, postponing maintenance, cutting information resources, and other related activities. More recently, VA has decided to ration veterans' care, first by delaying elective procedures and medical appointments, and, more recently, by barring access to the system.

Mr. Chairman, the members of AMVETS believe mandatory funding of VA health care would provide a comprehensive solution to the current funding problem. Once health care funding matches the actual average cost of care for the veterans enrolled in the system, the VA can fulfill its mission.

As the war on terrorism continues, we are reminded daily of the sacrifice and invaluable service given by those who wear the military uniform. For the benefit of the soldiers, sailors, airmen, and marines past, present, and future, AMVETS stands ready to work with you to express our gratitude and our obligation to them as a Nation. We call on the administration and Congress to provide the resources necessary to care for America's veterans.

This concludes my testimony. Thank you very much.

The CHAIRMAN. Mr. Jones, thank you very much for your testimony.

[The prepared statement of Mr. Jones appears on p. 183.]

The CHAIRMAN. Colonel Norton.

STATEMENT OF ROBERT F. NORTON

Colonel NORTON. Thank you, Mr. Chairman and distinguished members of the committee, for the opportunity to testify today on behalf of the 380,000 members of the Military Officers Association of America.

From the start, MOAA actively contributed to the work of the Presidential Task Force, and we commend Dr. Wilensky, Congressman Hammerschmidt, the commissioners and staff for their hard work and commitment to our Nation's servicemembers and veterans.

I believe it is fair to say that all of us had in mind that the task force should focus on what is best for military servicemembers and veterans as they looked at ways to improve collaboration between the Defense Department and VA health care systems. We believe that has largely been done, and we applaud their efforts. Obviously, a lot of attention has been placed on the funding issue, and rightly so. I will return to that subject in a moment.

First, however, I want to speak to a few of the recommendations in the report that we believe are crucial to implementing the mandate of the President in establishing this task force.

First, MOAA strongly supports continued leadership involvement in the collaboration between DOD and the VA. To focus this strategic planning process, we recommend that the Interagency Leadership Council publish a national strategy on DOD and VA collaboration every year or so, and we recommend that the Veterans' Affairs and the Armed Services Committees hold joint hearings from time to time to assess the progress of collaboration efforts. If this activ-

ity is left to one committee alone to oversee, we believe that the interest and effort over time could wane.

Second, the recommendations of the task force on seamless transition in chapter 3 of the report are extremely important to the men and women who serve in uniform today and are tomorrow's veterans.

The veterans of previous wars have not always been well-served because of missing or incomplete medical records, scant attention to operational exposures, and separation physicals performed under inconsistent standards, if they were performed at all. Today, there are still hundreds of thousands of claims from veterans and survivors that await action in the system. Going back decades to World War II and before, many of the problems veterans have encountered in dealing with the VA arise from the poor hand-off of essential medical and other information between the military services and the VA. Without complete, accurate medical documentation and the ability to seamlessly transfer information between the two Departments, the problems veterans have dealt with for years and years will go on and on. MOAA strongly endorses aggressive implementation of a common electronic medical record and a single separation physical that will help veterans get prompt, accurate disability ratings and improve the quality of care. This should be a major area of emphasis for DOD and the VA going forward. I can't emphasize enough how important this joint activity will be to the veterans of the the 21st century.

The third area I want to address is the funding mismatch. Everyone in this room knows the reason for the mismatch: annual budget submissions that do not take into account the actual demand on the system. The solution can be found in first accepting the fact that veterans are being shortchanged. The problem can be solved either by fixing the annual appropriations process or by enacting mandatory funding legislation. The current system, discretionary spending, has failed because the annual budgets understate the true cost of fully funding the care of enrolled veterans.

But mandatory funding is not necessarily a panacea. A flawed funding model could shortchange the system and veterans over time. That has happened to other mandatory programs like Medicare. Whether the committee recommends to modify the current appropriations process or pass mandatory funding legislation, MOAA supports the task force recommendation for establishment of an outside panel of experts to estimate the annual cost of fully funding the VA in accordance with its own access standards. A formula that does not include a mechanism to estimate the cost for the VA to meet its own standard of care for a routine appointment within 30 days is not, quote, "fully funding the VA." That will mean hiring enough qualified physicians, nurses, technicians and administrative capacity to assure consistent adherence to the VA standards.

The real challenge is to face the hard reality that fully funding the VA won't come on the cheap. What is needed is an absolute commitment by Congress and the administration to stop playing with the numbers and get the job done. At the end of the day, MOAA supports any legislative solution that will provide for timely quality access to all veterans the VA has agreed to treat.

Thank you again, Mr. Chairman, for the opportunity to testify on behalf of MOAA. I look forward to your questions.

The CHAIRMAN. Colonel, thank you very much.

[The prepared statement of Colonel Norton appears on p. 190.]

The CHAIRMAN. Mr. Robertson.

STATEMENT OF STEVE ROBERTSON

Mr. ROBERTSON. Thank you, Mr. Chairman. Mr. Chairman and members of the committee, The American Legion would like to take this opportunity to publicly thank the Commission members of the President's Task Force for their time, energy, and effort and cooperation throughout this process. I would be remiss if I failed to applaud the PTF professional staff for an exceptional performance. From the very first day, the professional staff established an unprecedented working relationship with the entire veterans' community.

The PTF's challenge was very clear from the very beginning. Although VA and DOD are committed to the timely delivery of quality health care, each health care network is truly distinctive in its leadership structure, operational mandates, information technologies, procurement systems, and are equally committed to meeting their unique missions. The American Legion strongly agrees with the Presidential Task Force observation concerning the key role of leadership in each agency, especially the armed services.

When the general or admiral provides guidance or marching orders, the troops tend to fall into step. Every veteran in The American Legion faced the transition challenges of putting away the uniform and reentering the civilian workforce. For some, this was relatively smooth but, unfortunately for others, their transition was overpowering. Nearly every veterans' and military service organization is committed to helping ensure as smooth a transition as possible. The PTF recommendations, if implemented, concerning transition should go a long way to removing certain barriers.

Speaking of barriers, The American Legion agreed with the PTF in that many of the current barriers to collaboration are removable with dynamic leadership from all parties concerned. The American Legion believes that timely access to health care services and the mismatch between demand and funding chapter is the most important issue addressed in the entire PTF report. Clearly, American Legion strongly believes timely access to quality health care is a moral, ethical, and legal obligation of any health care delivery system. Preventive medicine has demonstrated its lifesaving benefits, not to mention the economic impact as well.

For years, The American Legion watched the national rationing of VA health care through a complex and complicated maze of rules, regulations, and policies governing who would receive health care, in what setting, under what conditions.

The American Legion advocated a dramatic shift from the hospital-based system to a managed-care health care delivery system. Finally, Congress stopped the madness with the enactment of the Veterans' Health Care Eligibility Reform Act of 1996, Public Law 104–262.

The vision called for opening enrollment in VHA to any eligible veterans seeking access to quality health care within existing ap-

propriations. The idea was to receive copayments and third-party reimbursements for the treatment of nonservice-connected medical conditions to help supplement the VA discretionary appropriations. Unfortunately, the largest single identified health care insurance program, Medicare, was exempt from reimbursing VA for the treatment of Medicare-eligible veterans' nonservice-connected medical conditions.

Although VA medical care receives discretionary appropriations, those appropriations are offset by the amount of third-party collections Congress determined achievable. VA's billing and collection process has improved dramatically in recent years, however, it will never realize its true potential until it can collect from CMS.

Medicare eligibility is not a factor in determining eligibility to enroll in VA, Indian Health Services or DOD's TRICARE, yet TRICARE providers may receive Medicare reimbursements. Indian Health Services is authorized to bill and collect from CMS for the treatment of both Medicare-eligible and Medicaid-eligible beneficiaries. Both health care systems receive annual discretionary appropriations just like VA.

Yet, it is ironic that both DOD and IHS each had demand and funding mismatch problems that they successfully overcame through generating new revenue streams involving third-party reimbursements, copayments and offering a premium-based health insurance.

DOD insists its own obligation to guaranteed health care is for active-duty servicemembers and their eligible family members. However, through TRICARE and TRICARE for Life, it is meeting the current health care needs of the military beneficiary through a combination of discretionary funding, mandatory funding, copayments and premiums.

The American Legion adamantly opposes Recommendation 5.3. The dissenting commission members to this recommendation, the only dissent in the entire report, offered suggestions based on allowing Priority Group 8 veterans to enroll and to receive timely access to quality health care.

Mr. Chairman and members of the committee, the vast majority of the veterans' population falls into Priority Group 8, yet the majority of PTF voted against providing a substantive recommendation regarding Priority Group 8 veterans' eligibility for VA health care. They even described the Priority Group 8 veterans as those veterans without compensable service-connected conditions whose incomes are above the geographically adjusted means test—as though that makes a difference—makes them different from any other veterans. In reality, the only difference between some Priority Group 7 veterans and Priority Group 8 veterans is their ZIP Code.

A veteran is a veteran. There are Priority Group 1 veterans that never left the shores of the United States, yet there were Priority Group 8 veterans that served in the theater of operations.

Honorable military service made us veterans. It was Congress and VA that put us into categories.

These are veterans—there are veterans of the Armed Forces being denied enrollment and timely access to health care in the VA Integrated Health Care System, even if they have the means to pay

for their medical care. Somehow, The American Legion does not believe this represents the thanks of a grateful Nation.

Thank you for the opportunity to participate in this hearing. This concludes my testimony. And I look forward to the discussions.

The CHAIRMAN. Mr. Robertson, thank you for your testimony.

[The prepared statement of Mr. Robertson, with attachments, appears on p. 194.]

The CHAIRMAN. Mr. Violante.

STATEMENT OF JOSEPH A. VIOLANTE

Mr. VIOLANTE. Mr. Chairman, members of the committee, thank you for the opportunity to present the views of the Disabled American Veterans on the final report of the President's Task Force to Improve Health Care Delivery for our Nation's veterans. As an organization of more than 1 million service-connected disabled veterans, DAV is concerned about the government's commitment to meet the health care needs of sick and disabled veterans through access to timely top quality medical care.

Mr. Chairman, I am going to dispense with my written remarks. I sat here this morning and this afternoon thinking that this is worse than preaching to the choir. This is preaching to the preacher. You know the problems. You are fully aware of it. Your strong leadership and strong advocacy, as well as that of ranking member Evans and most of the members of this committee, make this part of our job very easy because you fully appreciate the situation and you express those concerns openly. We appreciate that candor.

We also are pleased to see that you have introduced your legislation based on one of the recommendations of this Task Force in Chapter 5, and Mr. Evans has introduced another version, one that was introduced by you and him last Congress. We fully look forward to debate on this issue and moving forward with the resolution of this situation. This crisis situation cannot continue to go on much longer because service-connected disabled veterans, as well as other sick veterans, are not getting the health care that they have earned.

You know, we sit here today and we talk about who should be receiving this health care and no one questions the fact that certainly service-connected disabled veterans and the poor and those with special needs should be receiving VA health care. The question comes to the other veterans in Category 8, and I think Mr. Robertson hit the nail on the head. There are some veterans who never left these shores that are Priority Group 1 and others that fought alongside with us, fought from the beaches of Normandy to the soil of Germany without being wounded. They helped us off of the battlefields and some of those are in Priority Group 8. The question isn't who we should care for now. The question is if we limit who we care for now, will we be able as a Nation to take care of those service-connected disabled veterans who are now fighting in Iraq and Afghanistan and around the world in our battle against terrorism 20, 30, 40 years from now? I don't think we can if we limit who we care for now.

I mean, VA has stated that if they care for only Priority Groups 1 through 6, they can sustain the system for the next 10 to 15 years. We have heard a lot about Private Jessica Lynch, 19 years

old, who was held as a prisoner of war for several weeks and has disabilities. Where will this system be when she needs it 35 to 40 to 50 years from now? Where will it be when some of our Vietnam veterans need it in 20, 30 years? I think the question is let's move forward, let's consider all enrolled veterans in whatever plan we come up with; and again, I would encourage this committee to move quickly to resolve this, because these sick and disabled veterans cannot wait much longer for a resolution of this problem.

Again, I want to thank you for your strong leadership and your strong advocacy. I have seen a drastic change in the attitude of this committee, and the bipartisanism that I have seen here has made me feel good. And again, thank you all for all that you do for our Nation's veterans.

[The prepared statement of Mr. Violante appears on p. 257.]

The CHAIRMAN. Mr. Violante, thank you very much for those words. And all of you for your ongoing, courageous and indefatigable advocacy for veterans. This committee and I think the whole Congress, and by extension the American people and every veteran are well-served by your leadership here in Washington, whether it be the Independent Budget, or the recommendations that you made when your commanders make their presentations every year. As you know, sometimes everyone isn't here to receive that testimony, but we pull apart your recommendations and somehow one way or the other so many of those ideas end up in legislation.

And we are grateful for those recommendations because you are out in the field, you hear back from the veterans every day of the week, and it is very, very helpful to us.

I do think, like you, that this blueprint provides us a catalyst for action. It has put the imprimatur on some very serious recommendations that we will carry forward with. I share your concern that with respect to Category 8s the PTF punted. They did not give a solid recommendation as to what to do. So, we are left to grapple with that, and we will.

My concern is that we do get there, that is, to full funding. I do not think anyone has the wisdom to know what is the absolute best way to get there, but Colonel Norton, I do share your concerns about a capitated, or at least you gave some thought to a concern that if we go with a formula and the formula is wrong. And, again, I put the formula in my legislation last year, 120. This year we are looking at 130. We are not sure. We know that Medicare+Choice had some problems with HMOs getting out of it because the rate of reimbursement was so deficient and inadequate that they ended up opting out of that kind of coverage. So getting it right is the key here.

Maybe we will end up with a hybrid. But I do think the panel gives us the flexibility. And, as we all have observed, VA, if it follows its demand model, gets it right. They basically know what is needed. The problem is OMB. And earlier we heard what Mr. Walters had to deal with, although he did not get into great detail when David Stockman was at the helm over there. I will never forget asking a question when I was ranking member about the loan origination fee hike that was in one of the early budgets recommended by OMB under Stockman. They were talking about a loan origination fee for the VA Home Loan Program that would be

five points. I asked the Assistant Secretary when he testified, what would that do to the program? After he gave me the official version he said, I said in your opinion, and he said: "It would kill it." We are still dealing with that OMB mentality.

So an independent board, fully empowered, would set a mark. And TRICARE, I think gives us at least some trailblazing hope that they are doing it. They have a panel. They seem to be getting it right, and, hopefully, we can do so if, again, the Congress were to adopt that approach.

I would be interested, because your testimonies were very comprehensive, what you thought of the earlier comment about the VSO's hijacking the Task Force. You might want to give some feedback on that. Frankly, I find it offensive. I do believe that when you get 15 people, and these are distinguished Americans, who make a recommendation; 2 years of their lives and a very professional staff that has worked very hard; and they come to a resolution and get to the point where they say DOD-VA sharing is not going to provide us the kind of resources to do the job. Our mandate really was Executive Order 13214, and sufficiently expansive. I believe that you make recommendations where they are merited and required. What is your sense on that kind of mentality?

Mr. ROBERTSON. Mr. Chairman, I took it as a compliment because to hijack any commission in this town would be a major coup. I wish that Mr. Buyer had had the opportunity to attend all of the meetings of the PTF that I had the pleasure of sitting through, along with many of my staff. And it was a very well-discussed issue.

I guess the most important part that I think came out of it was until this problem is solved, the rest of it is stymied. And as I commented in my testimony, when CHAMPUS was in existence, that was the classic example of demand exceeding resources. And you gentlemen gave DOD the mandate to fix it. And ironically, they fixed it by purchasing health care. Exactly what Dr. Mackay said that you would have to do. VA would have to become a purchaser of health care. What we are recommending is to allow the veterans, right now that are being left out of the system, to buy their way back in with the health care coverage that they have access to. Generate their health care dollars back to the system.

Every month I pay Medicare benefits, and I am not 65 yet. So I am prepaying my health care benefit. Why can't, in God's name, I use it at facility that I choose to use? One that I have faith in, one that I think provides quality care, and I hope that the system is still around when I get there.

Mr. CULLINAN. Mr. Chairman, all I have to say it was a pretty outrageous statement. The other thing as far as the PTF, what happened there was evolutionary, not revolutionary. One of their first findings was that even under ideal situations with respect to collaboration, cooperation, efficiencies and all of that, there wasn't enough money to do the job. So naturally it would turn to funding.

Mr. JONES. Mr. Chairman, what I thought was most severe was the lack of understanding as who a Priority 8 veteran might be. There is one individual that AMVETS prays will one day be a Category 8. He is walking a dusty Iraqi street replacing a soldier who walked that street the day before but that fellow was shot in the

back, killed. We pray that this individual who stepped forward in military uniform will some day be a Priority 8 veteran, and we ask that you think about this, as I know you do. That you think about this and recall what Abraham Lincoln once said: That a Nation that does not honor its heroes will not long endure. We consider these men heroes. We consider them eligible for VA under the 1996 Reform Act.

And I find troubling that we seem to overload that fact in our discussions about the run-up in costs and the surge in demand. Who care these people? We need to remember that these people are the ones defending the cause of freedom.

Colonel NORTON. Mr. Chairman, last summer in the heat of the deliberations that the task force was looking at in its public hearings, the VA was running up waiting lists of 315,000 veterans waiting 6 months to a year or longer. And the obvious conclusion that the Task Force came to, and many of us testified before the Task Force, was that if the VA was going to meet access standards, that it needed to look at the fully-funded access standards that TRICARE provided.

So before you could have any sort of meaningful sharing or collaboration, "cross-border" sharing, if you will, you needed to fix the long waiting list problems, the access problems of the VA. So funding had to be fixed. That is not hijacking the system. That is recognizing a chronic problem that needed to be addressed on behalf of America's servicemembers and veterans. To the contrary, this Task Force was not hijacked. They did the right thing. The report is sound. The recommendations are strong, and we fully support them.

Mr. FULLER. Mr. Chairman, I think this is indicative of a situation which occurs often in certain quarters. When someone jumps up like a Jack-in-the-box and says, "VA health care is out of control." We have got to do something to crank it back down again, because there are a lot of people who really are not deserving who are getting benefits. This is expensive, and we need to spend our money elsewhere.

I have concern about that. I have concern about the fact that the Congress becomes the whipping boy and this committee becomes the whipping boy for having thrown wide the gates of VA health care eligibility and created this monster that is going to consume us all down the line, when we very well know that is not the case at all. Anybody who was here in 1996 knows exactly what we were doing with eligibility reform. We were fixing a corrupt, inequitable eligibility system. The old system was not only bad government, it was bad medicine. Subsequent to eligibility reform, there was a cost analysis of how many veterans were going to come to the VA. The analysis showed that you had a VA hospital sitting here with its own market share and it would absorb that market share and people were not going to come from miles and miles around.

What happened, aside from what this committee did, the VA on its own, and with the imprimatur of the Appropriations Committee, opened up 800 outpatient clinics. When you open up 800 McDonald's restaurants, you are going to sell a lot more hamburgers than you did when you only had five. And that is what created the prob-

lem. It was not eligibility reform, it was the change in where VA health care was provided that created the problem.

So thank you for the opportunity for letting me say that.

Mr. VIOLANTE. Mr. Chairman, while I was outraged, I certainly wasn't surprised with the comments made by Mr. Buyer. Certainly, I think anyone who is willing to take their blinders off would reach the same conclusions this Task Force reached when looking at how to improve delivery to our Nation's veterans, that the funding problem would just totally encompass anything else they were trying to do.

The CHAIRMAN. Thank you all. Chairman Simmons.

Mr. SIMMONS. Briefly, we have, I think, covered most of the territory. I just wanted to note for the record that The American Legion is doing a survey, it is called, "I Am Not a Number Survey." They are surveying veterans in different States, and I thank them for this program. I certainly enjoyed reading what some of my veterans had to say about these services that they have received in the State of Connecticut. I have basically two questions.

When you look at the Presidential Task Force Report and the summary on Page 76, there is the question should Congress provide an entitlement to care for all veterans, regardless of priority, and then Recommendation 5.1 refers to full-funding or mandatory-funding mechanism. The summary uses a lot of the same language.

Is there anyone at the table this afternoon who believes that we can solve these problems without mandatory or full funding or an entitlement? Please raise your hand.

Let the record show that no hands went up.

Second question, we refer repeatedly to seamlessness. Seamless systems. It is one of those terms that cropped up years ago, and we just continue to be confronted with seamless transition. In this case, from military service to veteran status. Fiscal year 2005 we are looking for the electronic medical records system, we are looking at the DD–21 form. Is there anyone at the table who feels that the technology of transferring records electronically from DOD to VA is an overwhelming challenge, that it is going to take maybe 2 or 3 years? Does anyone feel that?

Mr. ROBERTSON. I am in a very unique situation, not only was I in the active duty in the United States Air Force, but when I went into the civilian world, I was married—I am still married, to an officer in the United States Air Force. So, therefore, I am a dependent. When I moved to Washington, DC, I joined the Army National Guard. I have an Air Force medical record, I have a dependent medical record, a National Guard medical record, and my private health care medical record and my VA medical record. You think you are going to have a challenge rounding up all of your records, I would be more than happy to provide all the information to you and have my name added to the list, because I don't think that I am a unique animal anymore because of the number of Guard and Reserve people who have been called up who have spouses that are also on active duty.

So it is a major challenge. Is it achievable? I think absolutely it is. But I think that there is a lot of wickets that are going to have to be orchestrated to make sure that the data is all in one location.

Mr. SIMMONS. If it is recorded electronically, does that facilitate or interfere with the problem of finding your records?

Mr. ROBERTSON. If it was all connected electronically, it seemed it would be zapping it to one location, i.e. the VA.

Mr. SIMMONS. In your judgment, is that outside our capacity as Americans?

Mr. ROBERTSON. Absolutely not, sir. It is a responsibility. It is amazing how it all winds up at the IRS.

Mr. SIMMONS. Even the IRS destroys hard copies after 7 years, I have learned through painful experience. I keep my copies for over 20 years. Let me just say, Mr. Chairman, that this has been a very useful hearing today. I have certainly learned a lot, and a lot of the things I already know have been reinforced. But I think that the record will show very clearly that there are a couple of things that this committee has to do, and one of those is to get deep into mandatory funding. And point two, get deep into IT between the DOD and the VA. Our failure to do so is simply to be irresponsible.

The CHAIRMAN. I thank the Chairman. I think, unless you want to add anything further, we will end the hearing.

Mr. JONES. Mr. Chairman, I would like to add one thing about collaboration, how difficult clearly it is. You had an example a year ago last April, where you sent a staff delegation down to Charleston, SC. They visited where there is a naval facility and a veterans hospital facility. And your staff was engaged in a conversation—you had this in the statement last year when you worked on your sharing, DOD-VA—a conversation between your staff and individuals in the pharmacy at the naval facility who indicated they had a very severe problem hiring and retaining pharmacists to get the mailing of pharmaceuticals out to nearly 500 individuals on a daily basis. It was brought to their attention that across the street was a VA pharmacy mailing operations. They visited. Conversation was held. The VA pharmacy mailing operation said this represents less than one percent of what we do on a daily basis, and we could handle it easily. A year passed. Nothing was done. You had some conversations with those people. They do not even recall the visit.

Talk about collaboration problems. I wish you luck.

The CHAIRMAN. On that happy note, thank you so much, again, for your great work. The hearing is adjourned.

[Whereupon, at 1:47 p.m., the committee was adjourned.]

APPENDIX

Honorable Rob Simmons
Committee on Veterans' Affairs
Opening Statement

Full Committee Hearing to receive the report of the President's Task Force to Improve Health Care Delivery for our Nation's Veterans
June 3, 2003

Thank you Mr. Chairman.

Thank you, Dr. Wilensky [**"Will-END-ski"**] for appearing before the Committee today on behalf of the President's Task Force. I also thank the President, George W. Bush, for creating this Task Force.

- One of the most difficult duties of a Member of this Body is to send young people off to war -- which we have done lately -- and then to see them repatriated home afterward. Both are frankly wrenching experiences.
- Serving on both the Armed Services and Veterans Affairs Committees is a great opportunity to gain additional insights on VA-DOD sharing, because the one that creates them, and the one that oversees services to them after they have served, have much in common.

So, I have been following activities of the Task Force with great interest, anticipating this keystone report, and am eager to hear your comments today.

For the past twenty years while Congress encouraged VA and DOD to enhance their degrees of health sharing, a chasm between the two departments has developed, or perhaps has even grown wider.

The hope of this Committee was that this task force would simply identify the reasons for missed opportunities between VA and DOD, and encourage they come together. <u>But ironically</u>, one of the most significant conclusions of this report is that the key factor frustrating true, optimal sharing between the two departments <u>is the huge mismatch between demand for health care and available funding at VA.</u>

This is a surprise, yet perhaps should really not be one. The conclusion drawn by this distinguished panel will help both Congress and the Administration essentially kill two birds with one stone:

- The PTF's recommendation is that we ***remedy the funding calamity in VA's health care system, and as a result, we enhance sharing opportunities for VA and DOD.***

Completing both of these goals would be beneficial to veterans and military families across the nation, and might even save the taxpayers a dollar or two. This would be a win-win situation. Once adequate funding is provided to VA, many other inefficiencies that VA faces will be more easily remedied.

Mr. Chairman, as a Committee we have been admonished by the House leadership to ferret out fraud, waste and abuse – so I put these reforms that might spur new sharing into that category of endeavor worth pursuing.

I also want the record to show that Chris Smith meets my definition of a hero to America's veterans, and needs to be recognized as one. He is showing the courage of his convictions, and says that veterans come first with him. The Chairman has led us to an important juncture in the history of Veterans Affairs with vigor and wisdom. As a veteran of the U.S. military with 37 years of active and reserve service, I salute you, Mr. Chairman.

Statement of Congressman John Paul Hammerschmidt (Ret.)

June 17, 2003

Chairman Smith, Ranking Member Evans, and Members of the Committee:

I appreciate the opportunity to submit remarks to the House Veterans' Affairs Committee, where I was privileged to serve for 26 years. It was an equal privilege to succeed our late former colleague, Jerry Solomon, in serving with Dr. Gail R. Wilensky and 13 other distinguished commissioners of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans.

Two weeks after the first Task Force meeting, this nation lost one of the best friends veterans ever had. It was with a great sense of sadness and respect that I accepted the appointment to succeed Jerry Solomon as co-chair. Everyone who knew him and worked with him misses him. He was respected on both sides of the aisle for his fairness, his integrity, and his tenacity for the principles dear to him -- traditional values, a strong national defense, and fiscal responsibility. His wife, Freda, was gracious as ever to welcome me at my first hearing. The Task Force Final Report is dedicated to his memory.

As current House Members I'm certain you could appreciate any body that can produce unanimity on 22 or 23 recommendations. It was almost as if the spirit of Jerry Solomon guided the Task Force throughout its existence, the spirit of compromise which characterizes the art of policy recommendations as well as the art of legislation. President Bush is to be commended for assembling a Task Force with such a diversity of talents and perspectives, all directed toward the goal of improving the health care delivery for our veterans and military retirees. Dr. Wilensky is Washington's most recognized expert on the economics of health care. The other 13 Task Force commissioners, the staff, subject matter experts, and consultants included experts in every field related to the mission given us by the President.

The mission reflected the President's management agenda:

- Identify ways to improve benefits and services for Department of Veterans Affairs beneficiaries and Department of Defense military retirees who are also eligible for benefits from the Department of Veterans Affairs through better coordination of the activities of the two departments;
- Review barriers and challenges that impede Department of Veterans Affairs and Department of Defense coordination. Identify opportunities to improve business practices to ensure high quality and cost effective health care;
- Identify opportunities for improved resource utilization through partnership between the Department of Veterans Affairs and the Department of Defense.

The barriers included the different corporate cultures of the VA and DOD, and even differences among the military branches themselves. The most daunting challenge was the charge that the Task Force would produce nothing more than another glossy report to gather dust on bookshelves. After all, it had been nearly 20 years since Congress first enacted legislation calling for greater collaboration and sharing between the two departments.

The Task Force answer to that challenge is before you, a number of recommendations, which, if implemented, will mark a historic advance in the delivery of health care for veterans and military retirees. The benefit would not stop there. As you all know, the VA and DOD, because of their unique missions, have often been innovative health care pioneers. If we can improve the delivery of health care to veterans and military retirees, the models and business practices of that delivery will serve as an inspiration for health care in general, a topic that is likely to dominate public policy in this new century.

Before I comment on the specific recommendations, I'd address a challenge to the Veteran's Affairs Committee. The Task Force has completed its mission, and closed its doors on May 28, 2003. Even if the Task Force were still active, it would have no power to enforce or implement its recommendations. That power resides with the executive authority of the President and the legislative authority of the Congress. The spotlight has shifted from the Arlington office of the Task Force to

both ends of Pennsylvania Avenue. With that in mind, I would respectfully point out key recommendations or themes that might serve as the inspiration for legislation.

I fully associate myself with Dr. Wilensky's assertion during her June 3 testimony that leadership is central to the success of VA/DOD collaboration. Unless future presidents are as committed as the incumbent, unless present and future VA and DOD secretaries are determined to collaborate on every possible level, unless that determination is communicated down the VA and DOD chains of command, Task Force commissioners and staff will have wasted their time and efforts. I am encouraged by the signs of activity generated by the very creation of the Task Force. But since the enactment of the original sharing legislation, an effort in which I was intimately involved, there has been little sustained leadership on the national level. Such success as we have seen has been more the result of excellent relationships among local VA hospital directors and military commanders. Too often, however, when military commanders are reassigned, the relationships that drive collaboration leave with them.

Dr. Wilensky and I were quite pleased with the current commitment of both VA and DOD toward collaboration. The cooperation of both Secretary Principi and Secretary Rumsfeld bodes well for the future of collaboration between the VA and DOD. I would add, however, the warning that future collaboration should not be dependent on the presence of two such committed and dynamic secretaries, any more than they should depend on the relationship of a particular VA hospital director and military hospital commander. Reforms should be institutionalized so that collaboration becomes part of the corporate culture and the norm for the two departments everywhere and at all times. Performance ratings and promotions should be dependent on proven track records in collaboration. As the committee with oversight jurisdiction over one of the departments, the Veterans' Affairs Committee is well-equipped to demand that level of leadership commitment and accountability.

One of the things that leadership should be directed at is a seamless transition for the veteran or military retiree entering civilian status. It was a top priority for the Task Force, and I would be pleased to see the Committee embrace it as a top legislative priority as well. Before the transition from military to VA health care can become seamless, the electronic patient records of the DOD and VA must become interoperable. The VA and DOD must be committed to maintaining health care records of individuals from the moment they enter military service. The two computer

systems must be able to communicate and share patient information quickly and effortlessly. The technology exists, and awaits only the leadership commitment to sharing information relevant to deployments, occupational hazards, and health conditions.

The process for separating from military service should be especially seamless to the individual service member. A mandatory DOD separation physical should determine eligibility for benefits and health care, and the DD214 should be transferred immediately to the VA.

The importance of information sharing was confirmed for Task Force commissioners during visits to joint venture sites and co-located VA and DOD facilities. Doctors and other clinicians at joint venture sites were quick to mention the frustrations of transferring data between VA and DOD medical record systems. Task Force commissioners were impressed and inspired by the local efforts to share information at those joint venture sites. Those efforts are good first steps, but they are not enough. I would urge the Committee to examine joint ventures closely. Joint ventures in Alaska and other sites are virtual laboratories in collaboration and sharing, and should serve as models for programs applied on a national level. Task Force commissioners concuded that joint ventures should be central to the operations of both departments, and that VA and DOD facility construction should be planned as joint ventures whenever and wherever possible. On this the Task Force consensus was clear, as it was on nearly everything else.

One area where we could reach no consensus was the status of Category 8 veterans.

As Dr. Wilensky noted in her June 3rd testimony, the Task Force constantly encountered concerns over the mismatch between the demand for VA health care and the available resources. Commissioners believed the mismatch adversely affected both access to VA health care and full collaboration with DOD. There was no disagreement among commissioners about our recommendations for veterans in Categories 1 through 7, those veterans with service-connected conditions or incomes below the threshold. Recommendation 5.1 calls for full funding to provide veterans in Categories 1 through 7 the current comprehensive benefit within VA's established access standards. Recommendation 5.2 calls for the VA to provide for outside care when it cannot meet its own access standards for veterans in Categories 1 through 7.

Mr. Chairman, I do not hesitate to call PTF Recommendations 5.1 and 5.2 historic breakthroughs. If they were to become the law of the land and official VA policy, they would change the way the federal government responds to the needs of veterans. I invite the House Veterans' Affairs Committee to review those two recommendations thoroughly and consider the appropriate legislative vehicles for them.

The closest PTF commissioners got to a consensus on Category 8 veterans, however, was a rejection of the status quo.

Should Category 8 veterans be treated the same as veterans in Categories 1 through 7? Should they have access to VA health care on a pay-as-you-go basis? These are policy questions, and Task Force commissioners believed that ultimately the Congress must answer them. That is why I urge this Committee to take up the debate begun by the Task Force, and to turn the blueprint provided by the Task Force into a structure of reforms Congress will pass, the President will sign, and the leadership of both departments will execute for the benefit of men and women who have served their country and defended our freedoms.

To summarize, Mr. Chairman, if you would like key themes or bullet points to guide the Committee's response to the PTF Final Report, I would offer the following:

- Committed leadership;
- A seamless transition from military service to civilian status;
- Full funding for Category 1 through 7 veterans;
- Resolving the status of Category 8 veterans; and
- Encouraging joint ventures.

I have a long-standing affection for this Committee, and for the constituency it serves. In the spirit of that affection, and in honor of the memory of Jerry Solomon, I ask Committee Members to remember that collaboration and sharing should not be pursued as ends in themselves, but as the means for serving the most deserving citizens in America.

Mr. Chairman, this concludes my statement for the record. I would gladly make myself available for any question you or other Members might have, or for any assistance I might render in implementing the recommendations of this Final Report.

Statement of

Gail Wilensky, PhD

Co-Chair, President's Task Force

to

Improve Health Care Delivery For Our Nation's Veterans

Before the

Committee on Veterans' Affairs

U. S. House of Representatives

June 3, 2003

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the Final Report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. Along with your former colleague, John Paul Hammerschmidt, I was honored to co-chair this Task Force. Copies of the Final Report, along with a Brief Guide to the Report, have been delivered to the Committee, and I ask that they be made a part of the record of today's hearing.

At the outset, I note that this Final Report is indeed the work of a task force, not of any individual member or members. While John Paul and I were privileged to chair the Task Force, the final product is the work of the overall body and speaks for itself.

I also note that all of the work of the Task Force was carried out in a very open, very public manner. Anyone with an interest in what we were doing -- and I know that included staff of the Committee -- could attend our public meetings or, shortly after each meeting, find both all the briefing slides and a verbatim transcript of the meeting on the Task Force's web site. Now that the Final Report has been issued, it, along with last summer's Interim Report, is available on the Task Force web site which will be maintained as a stand-alone site though the summer and then will be placed on the VA web site.

As you know, the Task Force was established pursuant to Executive Order 13214 issued in May 2001. Along with the two co-chairs – originally former Congressman Gerry Solomon was the other co-chair until his untimely death in October 2001 – the President appointed thirteen other members. We were a diverse group, with backgrounds in medicine, VA and DOD affairs, information management, health policy, and various other disciplines and life experiences. Some knew VA or DOD well, while, for others, Federal medicine was a new enterprise. Over time, I think we worked together very effectively. One demonstration of our effort to forge consensus is that, of our 23 numbered recommendations which, with sub-elements,

comprise 35 specific recommendations – all but one was supported by the full Task Force.

The President identified improved cooperation between VA and DOD in delivering health care to those who served in the Armed Forces as one of his Administration's ten management improvements, and he established the Task Force to assist in that effort. The Task Force was given three specific missions:

- to identify ways to improve benefits and services for VA and DOD beneficiaries through better coordination of the activities of the two Departments;
- to review barriers and challenges that impede that cooperation and to identify opportunities to improve VA and DOD business practices so as to ensure high-quality and cost-effective health care; and
- to identify opportunities for improved resource allocation between VA and DOD so as to maximize the use of their resources.

As I will discuss later, as the Task Force carried out its focused work on collaboration matters, we realized that there were other issues, most notably those associated with the mismatch in VA between demand and available funding, that had to be addressed if we were to successfully deal with the primary mission of identifying ways to improve VA-DOD collaboration.

In the end, I believe that the PTF's work, as exemplified in our Final Report, adds important insights and direction on the collaboration issue. This issue is one that will continue; I do not believe that any of us on the Task Force supposed that we would have the final word, but I do believe that we have helped further the process. Our goal, from the outset, was to forge a set of recommendations that would be implemented.

Few are more aware than my co-chair, John Paul Hammerschmidt, of the challenges associated with fostering greater cooperation between VA and DOD. John Paul was the Ranking Member of this Committee when the original sharing legislation was enacted in the early 1980s and he worked on the issue until he left the Congress in 1993. The Task Force benefited greatly by his insights and perspective gained through his experience in the Congress and specifically on this Committee.

Since the Final Report speaks for itself and our work, I will not go into any detailed discussion of the specifics although, of course, I am very happy to attempt to answer any questions you may have. Instead, I will just highlight some of the more significant themes from the report.

As the Members of this Committee are only too aware, the history of VA-DOD collaboration is one of fits and starts. In the early days, after the enactment of the original Sharing Act, Public Law 97-174, back in 1982, there was a flurry of activity. However, that activity was focused almost exclusively at the local level and seemed to flourish in those locations where it was in the mutual interest of the local facilities involved.

Early in our deliberations, the Task Force identified senior leadership commitment as the linchpin of any sustained collaborative effort between VA and DOD. It was not until the mid-1990s that there was any focused leadership at the

national level and that interest was not sustained. Indeed, it has only been in the last two years or so that there has been a renewed attention at the national level on increased cooperation between the Departments, interest that I believe reflects the President's attention to the issue and the creation of the Task Force.

The Task Force found that the current leadership focus within the two Departments to VA-DOD collaboration is very effective. We heard from and met with some of the key VA and DOD officials on a number of occasions. The Task Force was pleased with the activity of the Joint Executive Committee, chaired by VA Deputy Secretary Dr. Leo Mackay and DOD Under Secretary Dr. David Chu, as well as with the Health Executive Committee, chaired by Dr. Roswell and Dr. Winkenwerder. This level of leadership commitment must be sustained.

The effort of the Congress to solidify the statutory underpinning for this effort, most recently in H.R. 1911 as passed by the House in late May, is an important element in seeking to institutionalize the needed leadership but, frankly, it cannot be seen as enough by itself. I strongly urge your Committee and the other committees and subcommittees that deal with VA and DOD to maintain vigilant oversight of the two Departments and insist that they continue the current level of attention to VA-DOD collaboration.

It is also vital that the field-level managers of the two Departments come to understand the commitment of the top leadership to improved collaborative efforts between VA and DOD. Once field managers begin to see that increased success in undertakings between the Departments is recognized and rewarded, it is likely that there will be a much more sustained and consistent effort throughout the Departments.

Before I turn to some of our specific recommendations on collaboration issues, I stress one key, underlying principle of our work: the goal of improved collaboration between VA and DOD is not collaboration for the sake of collaboration, but rather that, through such activity, VA and DOD can improve timely access to quality health care and reduce the overall costs of furnishing services.

As directed in the Executive Order, the Task Force identified a number of process, institutional, and organizational barriers to improved collaboration, and our report provides specific recommendations to address these barriers. In addition to these departmental process issues, the Task Force members quickly focused on what their work would mean to the individual veteran. Specifically, they asked what should the Task Force recommend to make the transition from military service to veteran status seamless to the individual.

Early on, we decided it was important to get input from the field - from the VA medical center directors and military treatment facility commanders and their staffs engaged in the day-to-day challenge of delivering quality health care to their beneficiaries. As delineated in Appendix E of the Final Report, Task Force members and staff made a concerted effort to visit both joint venture sites and a number of co-located VA and DOD facilities.

We rapidly came to the conclusion that providing timely, high-quality health care requires effective information sharing. When you talk with clinicians at joint venture sites, you are quickly struck by the inability of the VA and DOD electronic

medical record systems to readily share data. The frustration of providers is often palpable. I well remember at one of the joint venture sites I visited how delighted the staffs were that their IT experts had developed a way to display both the VistA and CHCS medical records on the same desktop so the provider could at least have access to the full medical record on one computer. This was important enough to the local leadership that they invested scarce facility resources that were intended to fund other activities to accomplish this IT collaboration. And, while this was an important step, it was clearly only a first step. The Task Force quickly identified the electronic medical record as one of our focus areas.

As we researched the electronic medical record issue further, we found that the issue was not technology – the technology exists today -- but rather the will and the leadership commitment to overcome institutional "rice bowls" and make it happen. The development and use of electronic medical records that can share data would not only foster collaboration in the delivery of health care services but also reduce medical errors and attendant costs.

As a result, development and deployment in real time of interoperable, bi-directional, standards-based electronic medical records is the centerpiece of the PTF's seamless transition recommendations. VA and DOD responsibility for an individual's health begins when the service member enters the Armed Forces. It is important to gather baseline medical information in an electronic medical record that DOD can later use to exchange appropriate information with VA in mutually understood and usable formats. Subsequently, information relevant to deployments, occupational exposures, and health conditions should follow the service member throughout the military career. As discussed in greater detail in the report, DOD's personnel tracking systems are also a vital component in correlating subsequent health problems to exposure to occupational hazards during military service and need to be adequately resourced.

Upon separation from military service, the process for determining eligibility for veterans' benefits, reviewing health status, and receiving VA health care should be timely, accurate, and seamless to the individual service member. A mandatory separation physical from DOD should set the stage, where appropriate, for a compensation and pension examination to determine the level of VA disability. When the individual separates, the DD214 should be immediately transmitted electronically to VA, not take weeks or months. The current transition process is often cumbersome, slow, and overly bureaucratic. The technology exists to make it reasonably seamless to the individual, and the Task Force felt strongly that, with continued leadership commitment, this was an achievable goal.

Earlier in my statement, I mentioned that many Task Force members and staff visited a number of joint ventures. The individual effort expended by local medical center directors and military treatment facility commanders and their staffs at these joint ventures is extraordinary, and they are clearly committed to overcoming a variety of obstacles. I also learned early on that, when you've seen one joint venture site, you've seen one joint venture site. They are all very different and, in many ways, still viewed as pilots. In addition, the separate strategic planning and management practices, personnel assignment processes, and standard IT capital investment programs of each Department generally have disregarded the needs of joint venture sites. The Task Force believed that VA and DOD should declare joint ventures to be integral to the standard operations of both Departments and made specific recommendations for action by the Joint Executive Committee,

including that all proposed VA and DOD facility construction within a geographic area be evaluated as a potential joint venture.

As I noted earlier, as the Task Force addressed issues set out directly in our charge, we invariably kept coming up against concerns relating to the current situation in VA in which there is such a mismatch between the demand for VA services and the funding available to meet that demand. It was clear to us that, although there has been a historical gap between demand for VA care and the funding available in any given year to meet that demand, the current mismatch is far greater, for a variety of reasons, and its impact potentially far more detrimental, both to VA's ability to furnish high quality care and to the support that the system needs from those it serves and their elected representatives.

The PTF members were very concerned about this situation, both because of its direct impact on VA care as well on how it impacted overall collaboration. Our discussion on the mismatch issue stretched over many months and, as anyone following the work of the Task Forces already knows, it was the area of the greatest difference of opinion among the members.

Although we did not reach agreement on one issue in the mismatch area – that is, the status of veterans in Category 8, those veterans with no service-connected conditions with incomes above the geographically adjusted means test threshold – we were unanimous as what should be the situation for veterans in Categories 1 through 7, those veterans with service-connected conditions or with incomes below the income threshold.

Our recommendations, if adopted, would represent a very significant change in how the government fulfills its commitment to these veterans who represent VA's historical constituency. Recommendation 5.1 calls on the Federal government to provide full funding so as to ensure that enrolled veterans in Categories 1 through 7 are provided the current comprehensive benefit within VA's established access standards. Recommendation 5.2 provides that, in instances where VA cannot offer an appointment to enrolled Category 1 through 7 veterans within its access standards, VA would be required to arrange for care with a non-VA provider. If these recommendations become law, service-connected and low-income veterans would get needed care from VA in a timely manner, with no use of waiting lists to manage access to care.

As to Category 8 veterans, the Task Force members had legitimate disagreements. Some members believed Category 8 veterans should be treated the same as Category 1 through 7 veterans; others believed that these veterans should have access to VA but on a pay-as-you-go basis; and still others believed that the Task Force had neither the information nor the authority to make such decisions.

While we were not in agreement on the specifics of how the issue of Category 8 veterans' access to the system should be resolved, the Task Force members did agree that the status quo is not acceptable. It is not clear what Congress intended for these veterans with the enactment of the Eligibility Reform legislation or whether VA's response to that legislation has been in keeping with that intent. To the extent there was uncertainly about the impact of providing this category of veterans with access to VA care, that would now seem to be at least partially addressed, as more specific information is becoming available on their demand for service. With such

information, it should be possible to engage in a full and open debate on the appropriate policy, and that was the recommendation of a majority of the members of the Task Force.

Mr. Chairman, that concludes my statement. I am happy to attempt to answer any question that you or the other members of the Committee might have, but note again that the Final Report is indeed the work of the entire Task Force and can and does speak for itself.

Statement of Chairman Chris Smith (NJ)

Hearing on the President's Task Force on Veterans Health Care

June 17, 2003

Good morning. Today's hearing is the second hearing on the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. Two weeks ago we received the Task Force's Final Report from Co-Chair Dr. Gail Wilensky.

Dr. Wilensky, along with Co-Chair John Paul Hammerschmidt, and thirteen other dedicated members of the Task Force, have produced a remarkable document, one that I hope will serve as a blueprint for reforming the VA health care system.

Established two years ago to strengthen and expand resource sharing and collaboration between the Departments of Defense and Veterans Affairs, the Task Force quickly found that a larger obstacle to improving VA health care needed to be resolved first.

Confirming what this Committee and others have found over recent years, the Task Force concluded that optimal collaboration and resource sharing could NOT occur until VA first corrected the funding mismatch between demand for health care services and available resources.

According to the Task Force, this funding mismatch not only prevented VA and DOD from achieving maximum efficiencies in sharing, it also threatened the quality of care for veterans.

The Task Force unanimously recommended that changes be made to VA's funding system in order to achieve full funding, which the Task Force defined as providing timely and comprehensive care to all Priority 1 through 7 veterans, within VA's existing access standards.

It also calls on Congress and the Administration to devise an appropriate response to Priority 8 veterans who desire to use VA for their health care.

The Report identifies two examples of full funding models: one, a formula-based mandatory funding scheme, is based upon legislation—H.R. 5250—I introduced last year, with Rep. Lane Evans as the principal cosponsor; the other is a new approach establishing an outside board of experts to determine funding levels, similar to what is currently used to fund TRICARE for Life.

Yesterday, I introduced H.R. 2475, with Rep. Rob Simmons as the principal cosponsor, which would build upon this recommendation.

Let me briefly summarize our new legislation. H.R. 2475 would establish a three-member Funding Review Board to be appointed by the Secretary of Veterans Affairs for 15-year staggered terms.

The Board would have full access to VA's economic, actuarial and other data relevant to veterans health care funding, as well as the Office of Management and Budget's (OMB) economic and forecasting analysis; but would be completely independent of both OMB and the Secretary.

The Board would produce an annual budget request and a budget forecast for amounts required to provide full health care benefits to all enrolled veterans in Priority Groups 1–7, primarily those injured or disabled while serving their nation, or with low income levels.

The amount calculated by the Board would become the President's budget request submitted to Congress, while its forecast for the following year would be the basis for planning initiatives. From that point forward, the congressional budget and appropriations process would remain unchanged.

To ensure that veterans are receiving timely care, the legislation would require VA to meet demand within its own access standards;
if VA is unable to furnish care to veterans who need it within these reasonable timeframes, it would be obligated to contract for that care with private sector health care providers.

In order to promote fiscal discipline within VA health care, the Board would be required to identify areas where VA program efficiencies and savings can be achieved, as well as consider recommendations from OMB.

While our new approach takes a different course than the legislation I introduced last year, and which Rep. Evans has reintroduced this year, the goal remains unchanged—full funding for veterans health care.

This Committee, veterans service organizations, and now a Presidential Task Force, have all concluded that the VA health care funding system—not VA health care, but the funding system, is broken. We can disagree on the details over how to fix it, but we must fix it—this Congress, this year.

Statement of Congressman Lane Evans, Ranking Democratic Member, Committee on Veterans Affairs

Full Committee hearing to receive the report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans, Part II

June 17,2003

Thank you, Mr. Chairman, for agreeing to this second hearing on the report of the President's Task Force to Improve Health Care Delivery for our Nation's Veterans. This hearing will allow those members of the Task Force with dissenting opinions to be heard, as well as the views of veterans' organizations and the affected agencies.

Reiterating my statement for the June 3rd hearing, I appreciate the Task Force's hard work and generally accept its findings in regard to the considerable mismatch between demands on the VA health care system and its funding and the call for increased VA/DOD sharing. I remain concerned, however, that while the Task Force as a whole felt—and rightfully so—that it could offer recommendations on funding for Priority Groups 1 through 7, it also felt it necessary to abdicate responsibility for Priority Group 8. Our witness on June 3 testified that Priority 8s were "too far beyond the charge and expertise" of the Task Force. Why? And apparently I'm not the only one asking that question. As one organization put it: the conclusions of the report are like a long putt for par that is left hanging on the lip of the cup. I was pleased to see that the dissenting opinions of one-third of the Task Force address guaranteed access to VA care for this equally deserving group of veterans.

Lack of adequate resources led VA to deny enrollment to these veterans earlier I this year—that is, deny access to medical treatment to a group that includes decorated combat veterans whose low incomes might preclude the purchase of private insurance and whose Medicare benefits don't transport to VA. I'm sure I'm not the only one who finds this offensive.

It certainly is no secret to those in this room, and throughout the veterans' community, that VA has been plagued by chronically deficient health care budgets resulting in hundreds of thousands of veterans being forced to wait for care and one group being denied access to VA care altogether. So it came as a surprise that our sole witness on June 3, the chairperson of the PTF, would claim that the current funding process has yielded an adequate budget. That position is considerably out of sync with the language of the PTF report.

VA's budget has not kept pace with either medical costs or the needs of a dramatically increasing patient population that has risen from 2.9 million veterans in 1996 to nearly 5 million veterans expected to use VA health care services this year. As of January 2003, more than 236,000 enrolled veterans were on wait lists of more than 6 months for a first appointment or an initial follow-up for health care. An unknown is how many veterans were (and are) being told they must wait to even schedule an appointment.

Our veterans—those returning from Iraq, those who scaled the cliffs above the beaches of Normandy, those who walked point in the jungles of Vietnam, those who survived the brutality of Korea and other battlefields, all who honorably served—have earned the assurance that VA, their system, will be there when they need it. Under the current funding process, they not only are being told they'll have to stand in line for weeks and even months, many veterans are having the door shut in their faces altogether. That not only is wrong, it is dangerous. What does it say to the next generation of service personnel, and the one after that?

I want to point out that the President's Task Force claims that mandatory funding "would most likely eliminate one of the major impediments to providing access: unpredictable or subjectively developed budget requests."

I look forward to the statements of our witnesses, particularly in regard to the need for mandatory funding of veterans' health care, and guaranteeing access for all veterans who have honorably served their country.

PASSBACK

Statement of

The Honorable Leo S. Mackay Jr., PhD, Deputy Secretary of Veterans Affairs

Before the

Committee on Veterans' Affairs

U. S. House of Representatives

June 17, 2003

Mr. Chairman and Members of the Committee, I am pleased to join you today to discuss the recommendations in the Final Report issued by the "President's Task Force to Improve Health Care Delivery For Our Nation's Veterans". The Department of Veterans Affairs (VA) is committed to President Bush's direction to improve benefits and services for Department of Veterans Affairs (VA) and Department of Defense (DoD) healthcare beneficiaries by removing barriers and overcoming challenges impeding VA and DoD healthcare coordination and improving our business practices to ensure high quality and cost effective health care as well as identifying opportunities for improved resource utilization through partnerships maximizing the use of resources and infrastructure, including: buildings, information technology and data sharing systems, procurement of supplies, equipment and services, and delivery of care.

I speak for the entire VA and America's grateful veterans when I express appreciation for what the Task Force has accomplished on behalf of the President. Even before his Inauguration, the then President-elect directed VA Secretary-Designate Anthony Principi and Defense Secretary-Designate Donald Rumsfeld to work together to improve delivery of benefits to veterans and military retirees. To this end, and as he promised during his campaign, the President established the Task Force and has included VA/DoD collaboration as one of the top management agenda items for his Administration. We are committed to fulfilling the President's mandate.

I commend the Task Force Co-Chairs, Dr. Gail R. Wilensky, and your former colleague, Congressman John Paul Hammerschmidt, for their leadership, and the remaining members for their thoughtful analysis and dedication to resolving the issues before us. They were inspired, I'm sure, by the legacy of the late Congressman Gerald B. Solomon, the original co-chair, a true patriot and one of the best friends America's veterans ever had. How appropriate that the Task Force Final Report is dedicated to his memory.

We were pleased to work closely with the Task Force from the moment it undertook its mission, detailing VA experts it needed to staff its workgroups and meeting regularly with the Co-Chairs to create and maintain an open channel of communication.

Much of what I say today, Mr. Chairman, will be a report on the progress we have made since last summer, when the Task Force published its Interim Report. In conjunction with our DoD partners, we immediately began acting on the PTFs preliminary findings.

The leadership is there. The will is there. But make no mistake about it, Mr. Chairman, we face serious challenges to overcome before these recommendations make a difference in the lives of veterans and DoD healthcare beneficiaries and the practice of our healthcare providers.

VA strongly endorses the report's central principles and resulting primary recommendations to have the Departments work together to provide clearer leadership; create a seamless transition from military to veteran status; and remove barriers to collaboration. We believe that the Task Force Report provides a valuable guide to realizing the President's commitment to enhance the care our veterans deserve.

Provide Clearer Leadership

In our view, the fundamental PTF finding from which everything else flows is the recognition of the importance of leadership commitment to successful collaboration and sharing. We applaud the recommendations to the President to require greater accountability from our departments through joint strategic

planning, development of metrics, and performance standards to insure results rather than rhetoric. Our leadership is committed to work with DoD as partners to improve access to care and reduce the overall cost of furnishing services to both military and veteran beneficiaries. We are renewing our efforts to eliminate the institutional and cultural barriers that have historically inhibited VA and DoD cooperation.

The VA/DOD Joint Executive Council (JEC), which I co-chair with my good friend Dr. David Chu, the Under Secretary of Defense for Personnel and Readiness, comprises senior leaders from each Department. Through the establishment of the JEC, we are working together to institutionalize VA and DoD sharing and collaboration through a joint strategic planning process. After more than a year of discussion and interagency planning, the JEC recently approved a Joint Strategic Plan designed to improve the quality, efficiency and effectiveness of the delivery of benefits and services to our beneficiaries through an enhanced VA and DoD partnership. Three principles guide the Joint Strategic Plan. These principles are closely linked to those outlined by the PTF in its Interim Report issued last year. They are: *Collaboration* – to achieve shared goals through mutual support of both our common and unique mission requirements; *Stewardship* – to provide the best value for our beneficiaries and the taxpayer; and *Leadership* – to establish clear policies and guidelines for VA/DoD partnership, promote active decision-making, and ensure accountability for results.

Based on these guiding principles, the Joint Strategic Plan consists of six strategic goals, which are linked to the PTF Final Report recommendations and specific topics emanating from the initial PTF work groups. These goals are: leadership commitment and accountability; high quality health care; seamless coordination of benefits; integrated information sharing; efficiency of operations; and joint contingency/readiness capabilities. Each of these strategic goals is accompanied by performance expectations, measurements and timelines. Not only do the guiding principles and strategic goals closely mirror the Task Force

Final Report, the development of the Joint Strategic Plan and associated accountability metrics respond to the Final Report leadership recommendations.

To further our implementation of PTF recommendations, we have institutionalized our partnership through other senior level deliberative bodies focused on removing collaboration barriers and creating a seamless transition from military to veteran status. The VA-DoD Health Executive Council (HEC) is responsible for improving coordination between the two health care systems. The VA Under Secretary for Health and Assistant Secretary of Defense for Health Affairs co-chair this body. VA and DoD have institutionalized a forum for senior health care leaders from both departments to identify opportunities for further collaboration and to remove obstacles to our partnership. Over the last two years this group has made progress in aligning both clinical and business practices related to health care delivery – some of which I will highlight later in my testimony.

The Veterans Benefits Administration (VBA) has been working with DoD for a number of years on a number of data sharing projects and programs such as the Benefits Delivery at Discharge initiative to improve transition to veteran status. Under the leadership of the VA Under Secretary for Benefits and the Deputy Under Secretary of Defense for Personnel and Readiness, we are currently developing a charter for a Benefits Executive Council to institutionalize the process, ensure senior management oversight of joint initiatives and expand collaborative activities in information sharing, claims processing and the delivery of benefits to separating service members. We believe this new council will serve as an instrument to implement the PTF call for a single separation physical and transfer of records to achieve a seamless transition from military to civilian status.

Further, in accordance with the President's Management Agenda, OMB has included VA/DoD performance milestones in the Management Scorecard which is monitored quarterly. Within VA, we have also included VA-DoD Sharing in our Monthly Performance Tracking System to measure and identify progress in all areas of collaboration.

Create a Seamless Transition

The PTF recommended that the two departments use standardized information nationwide to create a seamless transition from military to veteran status. Information relevant to a service member's deployment, occupational exposures, and health conditions should follow the service member throughout his or her career. As the Task Force has noted, information systems coordination is the critical link between the two Departments.

DoD and VA are moving forward jointly to improve the efficiency and accuracy of enrollment information through the creation of integration points that will permit VA to access the Defense Enrollment and Eligibility Reporting System (DEERS) in real time by the end of 2005, a key objective in the President's Management Agenda. As a result, we expect that a service member's transition from active duty to veteran status will be simplified significantly while improving the process of accurately informing the veteran of all potential benefits for which they may be eligible.

Another key information technology initiative in the President's Management Agenda addresses the sharing of individual health care information between the two systems. We believe that VA and DoD are making substantial progress towards deployment of electronic medical records that are interoperable, bi-directional, and standards-based by the end of 2005. Our Departments have formed a close collaborative partnership, to include the development of a joint business case for electronic health records, under the Federal Health Information Exchange (FHIE) and Health*e*People (Federal) projects. In addition, we have signed formal Memoranda of Understanding on development of additional joint activities under both FHIE and Health*e*People (Federal).

As a result of the implementation of FHIE, VA clinical staff have access to information that was collected in DoD's Composite Health Care System (CHCS) on veterans who have been discharged since that system was implemented in 1989. Information available up to the time of their separation includes laboratory

results, radiology reports, outpatient pharmacy prescription information, admission/disposition/transfer, discharge summaries, and in the near future allergy information, consult reports, and summary outpatient appointment information. VBA staff will have access to this information to assist them in benefits determination starting next month (July 2003).

The joint VA/DoD Interoperable Electronic Medical Record Plan goes much further by committing our two Departments to implementing compatible IT enterprise architectures and adopting common standards, both of which serve as the essential technical foundation to achieve interoperable electronic health records. The end result will be interoperable electronic health records that will serve the needs of our nation's veterans and service members and that could potentially serve as a model for the U.S.

We are working with DoD to ensure that when we share medical information, we fully protect the privacy of individuals. We intend to be in complete compliance with all applicable confidentiality requirements, including the Standards for the Privacy of Individually-Identifiable Health Information promulgated by the Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996. We will keep the Committee posted as to developments in this area.

While we are committed to interoperability, and have established an interagency oversight and milestone structure, we should be careful not to overstate our current progress. Before we realize a fully electronic, bi-directional patient medical record, significant challenges remain due to the complexities inherent in coordinating multiple layers of activities within two large bureaucracies with extensive and independently developed IT support structures.

Goal 3 of the Joint Strategic Plan mirrors the PTF recommendation to provide for a seamless transition from active duty to veteran status through a streamlined benefits delivery process. This goal includes the PTF recommendation to develop a physical examination protocol that is valid and acceptable for all military service separation requirements. Additionally, the Joint Strategic Plan requires the development of an online benefits application process

that allows service members to submit applications directly to the appropriate federal agency; enhancing collaborative efforts to educate active duty, reserve, and National Guard personnel on VA and DoD benefits programs, eligibility criteria and application processes; and the seamless transfer of beneficiary data between VA and DoD to expedite all benefit and entitlement processes.

To that end, VA and DoD recently cooperated in a pilot expansion of the Benefits Delivery at Discharge program and the development and distribution of a pamphlet that outlines the VA benefits available to National Guard and Reserve personnel. This reference tool provides information on eligibility, a summary of VA benefits and services and contact information to assist with specific inquiries.

The PTF Final Report recommends that VA and DoD expand collaboration to identify, collect, and maintain the specific data needed by both departments to recognize, treat, and prevent illness and injury resulting from occupational exposures and hazards experienced while serving in the armed forces. We agree. For example, Goal 2 of the Joint Strategic Plan contains specific objectives designed to enhance collaborative activities in health research, provider training and information sharing.

The HEC has designated 10 work groups to address specific issues of common interest to the VA and Military Health System. One of these, the Deployment Health Work Group, is charged with examining clinical issues and research related to Deployment Health, and recently worked to enhance the DoD post-deployment assessment tool for troops returning from the combat theater. Additionally, the Clinical Practice Guidelines Work Group has jointly developed clinical practice guidelines for use by clinicians in both Departments, including a focus on Post-Deployment Health. Highlights in this area include guidelines for Screening Health Exams and Medically Unexplained Symptoms: Chronic Fatigue and Pain.

Remove Barriers to Collaboration

As the PTF noted, VA and DoD have a mixed record in carrying out mandates, both statutory and administrative, to improve coordination and

sharing. To improve collaboration, the PTF recommended that VA and DoD review the following areas: organizational structures; business practices; clinical pharmacy initiatives; joint contracting; interoperable IM/IT systems; facility lifecycle management; joint venture sites; and human capital and credentialing systems.

VA and DoD beneficiaries share many similarities. VA and DoD care for the same individuals at different points in their lives. Frequently, these individuals are eligible for services in both Departments when they retire from the military. In spite of this fact, and largely due to the differences in mission, health care delivery policies and structures have historically been organized on a departmental basis to meet specific needs and requirements, with generally very little accommodation given to interests outside the immediate purview of a particular Department. Over the past two decades VA and DoD have made attempts -- with some success – to improve coordination of services between our two departments. But, as the PTF has noted, we can do a better job on behalf of our beneficiaries and our Nation's taxpayers. We agree that there is substantial opportunity for VA and DoD to improve quality, access, and efficiency of health care delivery by pooling resources, eliminating administrative barriers, and implementing change. Not only do we agree, we are committed. Our Secretary has pledged that we will fulfill the President's often-stated goal that the walls will come down between VA and DoD. As part of our joint strategic planning process, we have developed specific goals whose fulfillment is directly designed to overcome institutional barriers through integrated information sharing and efficiency of operations. We have committed to jointly improve management of capital assets, procurement, logistics, financial transactions, and human resources.

The PTF recognizes that the most successful collaborative initiatives are usually those in which each business partner receives a benefit from the arrangement. In reviewing financial barriers to improved coordination through sharing agreements, it became clear that the proliferation of rate setting mechanisms only complicated the billing process and called into question the

financial efficacy of agreements. Facilities focused their attention on the negotiation of rates rather than collaboration. Once the rates were set, they were often not reviewed for several years. To remove this financial barrier, we signed a Memorandum of Agreement to establish and implement a standardized, national billing rate for local sharing agreements. This new rate, commonly referenced as CMAC minus 10%, provides a mechanism to streamline local negotiations and a reliable method for calculating value and financial benefit.

To further address efficiency in financial transactions between the departments, we have begun implementation planning for the DoD-VA Health Care Sharing Incentive Fund, created in the FY 2003 National Defense Authorization Act to provide incentives for creative coordination and sharing initiatives at the facility, intra-regional, and nationwide levels.

In addition to serving as a DoD health care provider through the TRICARE Managed Care Support Contractor, VA supports policies that provide incentives for direct sharing between VA medical facilities and military treatment facilities (MTFs). We negotiated a change in the solicitation for the next generation of TRICARE contracts that allows greater flexibility for military commanders to enter into direct sharing agreements with local VA facilities for care provided to their prime enrollment population. Additionally, earlier this month we encouraged local VA medical centers to become TRICARE providers to expand the set of tools available for VA/DoD collaboration in direct care delivery. VA is revising its policy to provide clear, updated guidance for more interaction between VA medical facilities and MTFs.

VA and DoD continue to experience remarkable success in our joint pharmaceutical related efforts through the HEC Pharmacy Work Group. As the PTF noted, joint contracting for pharmaceuticals has been one of the bright spots in the VA/DoD partnership over the last several years. We are maximizing cost savings through our cooperative pharmaceutical acquisition strategy. As pharmaceuticals become an ever increasing and integral component of health care delivery, both Departments are committed to providing more coordinated clinical care. The bi-directional electronic access to complete pharmaceutical

profiles is an important step towards answering the PTF call for a seamless transition from DoD medical care to VA medical care and improving the continuity of care. We are working together to identify a clinical data-screening tool, which ensures electronic access to complete pharmaceutical profiles.

Both Departments have noted success with the VA/DoD Consolidated Mail Order Pharmacy (CMOP) Pilot Program, designed to test the feasibility and desirability of processing MTF refill prescriptions through the VA CMOP while maintaining high quality service to DoD beneficiaries. The pilot is being conducted through three designated MTFs at Naval Medical Center, San Diego CA; Darnell Army Community Hospital, Fort Hood, TX; the 377th Medical Group, Kirtland Air Force Base, Albuquerque NM; and the VA CMOP in Leavenworth, KS. Although VA and DoD continue to coordinate pharmacy-related issues between the Departments through the Federal Pharmacy Executive Steering Committee, substantial challenges remain.

The PTF recommended that VA and DoD identify opportunities for joint acquisition in all areas of products and services. The JEC has incorporated planning for additional joint procurement in Goal 5 of the Joint Strategic Plan. Since 1999, VA and DoD have been working to combine the purchasing power of the two departments and eliminate redundancies. We have signed two appendices to the Memorandum of Agreement governing pharmaceuticals and medical and surgical supplies. As a result, VA and DoD are working to establish a searchable database through the conversion of DoD's Medical-Surgical Distribution and Pricing Agreements to VA's Federal Supply Schedule Contracts. Approximately 35,000 of 200,000 items have been converted and cooperation is ongoing. Additionally, the HEC is reviewing a third appendix covering high-tech medical equipment that we anticipate will be completed this summer, allowing for increased efficiencies and cost savings in this arena. This, like other areas, will require both committed leadership and due diligence to ensure the desired outcomes.

The PTF recommended that the interagency leadership identify those functional areas where the departments have similar information requirements,

so that they can work together to re-engineer business processes and information technology in order to enhance interoperability and efficiency. Goal 4 of the Joint Strategic Plan provides a framework for the development of an interoperable information technology architecture that will enable the efficient and secure interchange of records and information to support the delivery of benefits and services. As recommended by the PTF, the operational emphasis will be on improved business processes, reduced redundant applications and procedures, and increased access to services and benefits.

As part of the Joint Strategic Plan, VA and DoD have agreed to improve our coordination in planning and managing capital assets in order to enhance long-term partnering and achieve cost savings. This goal is compatible with the PTF intent that VA and DoD implement facility lifecycle management practices. A JEC task force is currently working to develop a Capital Coordination Process that will provide joint policy recommendations and monitor capital asset planning to ensure an integrated approach to capital coordination between VA and DoD, including identifying high-priority sites that represent the best opportunities for potential VA/DoD partnerships in facility sharing.

Additionally, as VA moves through the Capital Asset Realignment for Enhanced Services (CARES) review process, DoD is participating with VA in identifying appropriate sharing opportunities and serves as a member of our clinical advisory team. The DoD Assistant Secretary for Health Affairs, Dr. Winkenwerder, assigned three key members of his staff to coordinate participation by the military health care system, including the military services, in development of CARES options.

VA agrees with the Task Force that support of joint ventures as integral to our collaboration with DoD for health care delivery. Through the HEC Joint Facilities Utilization and Resource Sharing Work Group, VA and DoD are in the process of developing models for joint facilities designed to improve access and quality of care for both VA and DoD beneficiaries. Additionally, we are working with DoD to assess the feasibility of demonstration projects for the joint federal facility concept. We expect to identify pilot sites later this year that will test the

coordination of budget and financial managements systems; staffing and personnel assignment; and medical information and information technology systems. Further, we are in the final stages of identifying pilot sites to evaluate the merits of integrating the VA and DoD healthcare provider credentialing systems.

The National Defense Authorization Act of 2003 requires that VA and DoD better coordinate the benefits and services they provide to our military and their dependents, either while on active duty or after they have served our Nation. In order to accomplish this formidable task, the bill requires that the Departments establish three pilots where services, manpower and facilities will be shared (using common IT systems) to provide seamless care to our veterans and their dependents. We are actively working to identify sites, and developing our approach to accomplish this priority effort and will submit this information to the Congress by September 30, 2003.

These are extremely important initiatives to remove barriers to collaboration. As I discussed earlier, the JEC structure is specifically designed to ensure that senior leadership of both Departments be directly involved in the oversight of joint initiatives and be in a position to respond to any issues impeding successful collaboration. Again, we recognize that while the leadership and commitment are there, we still face significant implementation challenges.

Fully Funding VA Medical Care

The PTF stated that the government should ensure that enrolled veterans in Priority Groups 1 through 7 are provided current comprehensive benefits in accordance with VA's established access standards, and suggested that full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism, or by some other changes in the process that achieve the desired goal. The PTF agreed that the FY 2004 President's Budget fully funds enrolled veterans in Priority Groups 1 through 7. Our budget also fully funds those Priority Group 8 veterans already in the system – ensuring that no veteran currently in the system will be denied care.

In addition, the funding levels in the President's Budget will allow VA to eliminate the waiting lists of veterans seeking medical care by January 2004. With our FY 2004 VA medical care budget request of $27.5 billion, President Bush has requested the largest medical care increase ever - $2.1 billion (8.1%). It is more than 30% greater than the FY 2001 budget which was in effect when the President took office. The Administration's record in this area is unprecedented, and we would strongly oppose any form of mandatory funding – including formulas set in statute and independent bodies directing budget levels.

Conclusion

While I did not specifically address every individual recommendation offered by the Task Force, I believe that VA and DoD are committed to the President's goals and realizing the desired outcome -- improving health care delivery to veterans and military retirees by removing the barriers that exist between our two departments. We fully or conceptually support the actions proposed by the PTF. We are already addressing many of the recommendations either directly or indirectly with our DoD partners.

Remembering that the PTF final report was presented to the President less than three weeks ago, some of the specific recommendations will require additional analysis and we will be working together with our colleagues in the coming days to address each of the recommendations. Over the last several months, DoD and VA have re-emphasized ongoing collaborative efforts to maximize sharing of health resources, to increase efficiency, and to improve access for the beneficiaries of both Departments. The focus of our efforts is moving from a relationship of simply sharing to one of a proactive partnership benefiting veterans, military beneficiaries, and the taxpayer. The President has established the vision for a mutually beneficial partnership that optimizes the use of resources and infrastructures to improve access to quality health care and increase the cost-effectiveness of each department's operations, while at the same time respecting the unique missions of VA and DoD. While the challenges to realizing that vision are great, we are on the threshold of success in many areas and these victories are rewarding.

Mr. Chairman, this completes my testimony. My colleagues and I will now be happy to answer any questions that you or other members of the Committee might have.

STATEMENT OF

DAVID S.C. CHU

UNDER SECRETARY OF DEFENSE

FOR

PERSONNEL AND READINESS

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

U. S. HOUSE OF REPRESENTATIVES

JUNE 17, 2003

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United States House of Representatives

Introduction

Mr. Chairman, I am pleased to be invited here today to discuss with you and the members of the Committee the Department of Defense's views on the report of the President's Task Force to Improve Health Care Delivery for Our Nations Veterans.

First, let me express my deepest appreciation for the impressive work of the President's Task Force. The co-chairs of the Task Force, Dr. Gail Wilensky and John Paul Hammerschmidt, have exemplified public service in their dedication to improving health care for our military and veterans. I commend them for their leadership and their thorough and creative analysis of the issues.

During the 24 months of the deliberations, we have worked closely with the members and staff of the Task Force to provide critical information on key areas of collaboration that have contributed to the recommendations in the Final Report. I have met monthly with Dr. Wilensky to ensure an ongoing dialogue on the findings of the Task Force. Consequently, DoD has been well informed on the direction of the Task Force and has already begun to implement many of the recommendations in the Final Report. We have likewise kept the Task Force informed on major initiatives and policy decisions regarding DoD/VA collaboration that have occurred through our Joint Executive Council.

One of the most important of these initiatives has been the development of a Joint Strategic Plan that identifies goals and objectives for DoD/VA collaboration in the areas of leadership oversight, health care, capital asset planning, contingency planning, information management and information technology, and transition planning. Through

this strategic planning process, we have launched a new era of DoD/VA collaboration, with unprecedented strides toward a new federal partnership that promises to transcend business as usual, and serve as a model for inter-agency cooperation across the federal government.

This Joint Strategic Plan is consistent with the recommendations of the Task Force in that it addresses the same key issues, recognizes both our common and unique mission requirements, and ensures accountability for results. This will become more evident as we review each of the major areas of recommendations outlined in the Final Report.

Leadership

DoD fully concurs with the recommendations regarding the need for leadership, collaboration and oversight. In April 2003, DoD and VA signed a charter that institutionalizes a Joint Executive Council structure. I am pleased that the report of the Task Force saw fit to praise the leadership of our two Departments in setting that Joint Executive Council structure. Through our VA/DoD Joint Executive Council, co-chaired by Dr. Leo Mackay and myself, we have established a forum for senior leaders from both Departments to provide support and oversight of all our collaborative activities between DoD and VA. Our Health Executive Council has been in place for sometime and has had many successes . Through its extensive work group structure, many opportunities for further collaboration have been identified and many obstacles to sharing have been removed. Building on the success of our Health Executive Council, the two Departments have also established a Benefits Executive Council, which is examining ways to improve information sharing, refining the process of records retrieval, and identifying procedures

to improve the benefits claims process.

Seamless Transition

Our concern for the well-being of Servicemembers extends well beyond their time on active duty. DoD supports the recommendations of the Task Force to provide a seamless transition from active duty to veteran status. We have already made significant progress in ensuring pertinent medical data is transferred to the VA on Servicemembers upon their separation from active duty. Through our Federal Health Information Exchange, an exemplary model of collaboration between both Departments, DoD transfers electronic health information on separating Servicemembers to the VA. Currently, DoD sends VA laboratory results, outpatient military treatment facility pharmacy data, radiology results, discharge summaries, demographic information and admission, disposition and transfer information. By the end of this year, DoD will also send allergy information and consult results. To date, DoD has transmitted to VA information from 3.8 million records on 1.5 million discharged or retired Servicemembers. To further strengthen DoD/VA electronic medical information exchange, while leveraging departmental systems investments, we are working with our VA counterparts to ensure the interoperability of our electronic medical records by the end of FY 2005. To achieve this goal, DoD and VA will update our joint business case for an electronic health record with the development of an implementation plan in the last quarter of 2003. In addition, DoD and VA are moving forward jointly to improve the efficiency and accuracy of enrollment information through the creation of integration points that will permit VA to access the Defense Enrollment and Eligibility Reporting System (DEERS) in real time by the end of 2005, a key objective in the President's

Management Agenda. Together, these information technology initiatives will be significant steps to a seamless transition and will markedly enhance the continuity of care for our nation's veterans.

Through our Joint Strategic Plan, we are continuing our emphasis on improving access to benefits, streamlining application processes, eliminating duplicative requirements such as physical exams, and smoothing other business practices that complicate Servicemembers' transition from military to civilian status continuity of care to our nation's veterans.

In addition to enhancing and expanding the technical capability of DoD and VA information systems, an "Information Sharing Task Force" is being established under the VA-DoD Benefits Executive Council to develop a plan to automate the data collection process so necessary information is received in a timely and accurate manner.

In addition to these efforts, DoD and VA are collaborating to ensure that VA has visibility into the future health care needs of military personnel who will be depending on VA for their care in the future. DoD and VA have established a joint Deployment Health Working Group which has already enhanced collaboration and communication on identifying individuals who deploy, locations of deployment, environmental exposures during deployment and illnesses or injuries occurring during deployments. DoD and VA have also initiated a 20 year, prospective study of 140,000 military personnel to determine relationships of health outcomes to their military service. DoD is already providing VA daily information on personnel separating from active duty, which includes the assignment history, location and occupational duties. The DoD TRICARE on Line program has the individual Servicemember's pre- and post-deployment health

assessments and a significant portion of their medical history, including illnesses and injuries. This program is available electronically to DoD providers.

Remove Barriers to Collaboration

DoD and VA have different missions and serve different populations. We have different care delivery strategies and benefits. Despite the differences in the two departments, we are working to remove barriers to collaboration and are confident we can overcome these challenges through our joint strategic planning process. We are actively eliminating policy and program barriers between DoD and VA and institutionalizing processes that promote collaboration and communication. Our success in joint contracting for pharmaceuticals is a model for overcoming barriers to collaboration. In fiscal year 2002, DoD/VA joint pharmaceutical procurement purchases totaled over $230M, and resulted in $379M in cost avoidance.

DoD concurs with the Task Force's recommendation for a single, common clinical screening tool that ensures reliable, electronic access to complete pharmaceutical profiles for VA/DoD dual users across both systems. The Pharmacy Data Transaction Service (PDTS) already allows DoD to build a patient medication profile for all beneficiaries regardless of the point of service. Since implementation in June 2001, over 210 million transactions have been processed and over 75,000 potential Level 1 (life-threatening) drug interactions have been identified involving beneficiaries using more than one pharmacy for prescription services.

Because of our many successes in the pharmaceutical arena, DoD has some concern with the Task Force's recommendation to develop a national core joint

formulary. We believe we are already achieving many of the goals of a national joint formulary through our on-going DoD/VA joint pharmaceutical contracting initiatives I previously highlighted. The primary goal of common formulary selections for both organizations is to leverage the buying power of both Departments to obtain the lowest price possible, where having a drug on both formularies given the differences in their patient population demographics is clinically appropriate. However, there are inherent differences between the two healthcare organizations and their pharmacy benefit programs. The most significant difference is that VA is essentially a closed system where VA patients are seen almost exclusively by VA providers who write prescriptions using only the VA formulary. TRICARE is essentially an open system in which patients may seek care from civilian providers who have no relationship to TRICARE, requiring DoD to have a much broader pharmacy benefit for DoD beneficiaries, including access to almost all FDA approved prescription drugs. The development of a national joint core formulary may result in either greatly expanding the drugs made available to VA beneficiaries or decrease the scope of drugs available to DoD beneficiaries. The FY2000 National Defense Authorization Act mandates many aspects of DoD formulary management, including how drugs will be selected for the DoD's Uniform Formulary, and the associated copays. A decision to establish a joint VA/DoD formulary would not relieve the DoD from complying with these laws. The Department is prepared to implement the DoD Uniform Formulary in conjunction with the new TRICARE Retail Pharmacy contract in FY04, ensuring the optimum combination of best pricing, beneficiary choice, and the tool needed to better manage the pharmacy benefit.

We are focusing more energy in the area of medical supplies and equipment. The Task Force report encourages VA and DoD to work with industry to establish a uniform methodology for medical supplies and equipment identification and standardization and to facilitate additional joint contracting initiatives. The report suggests that VA and DoD identify opportunities for joint acquisitions in all areas of products and services. We fully agree.

The benefits of joint national pharmaceutical contracts are difficult to replicate in the medical surgical supply arena, because there is no industry standard to identify these items. Our Defense Supply Center in Philadelphia has taken the lead in establishing a federal data synchronization workgroup to collaborate with industry in determining the data necessary to identify medical surgical products. A common identifier is essential to ordering, product comparisons, and documenting usage. Valid usage data will facilitate volume discount negotiations for DoD/VA national contract prices.

We are also working to facilitate collaboration in health care delivery. To simplify and standardize the process of encouraging sharing agreements between facilities, DoD and VA have instituted a new reimbursement methodology of a single regionally adjusted rate structure for DoD/VA medical sharing agreements. Using a single—but regionally adjusted--rate simplifies negotiations among facilities, clarifies reimbursement issues, accounts for local differences, and improves data analysis.

The Task Force Report addressed VA/DoD joint ventures, suggesting that they be used as test beds for future initiatives and that all future construction, where there is opportunity, be considered as a potential joint venture. DoD recognizes the value that joint venture facilities provide in increasing access to care and reducing costs. No joint

venture, of course, is completely like its predecessors, either in physical plant, location or patient clientele. Each is designed to meet the needs of the special circumstances that existed where it is built. Thus, there is no standard template to be used for all situations.

We can, however, create the common templates for many of our clinical systems, as is embodied in the test of the provider credentialing systems of DoD and VA. A joint pilot study is being conducted to evaluate the merits of integrating the Department of Defense Centralized Credentials Quality Assurance System (CCQAS) with the Veterans Administration Professional Review Program (VetPro) credentials system.

A current example of an emerging joint health care operation is North Chicago, Illinois. In lieu of a replacement hospital at Naval Hospital Great Lakes, the Navy will construct a Navy Ambulatory Care Center based on a family practice/primary care model. The nearby North Chicago VA Medical Center will provide inpatient services. This will require upgrading its surgical facility. The Navy Clinic will be sized to meet the projected workload, including specialty outpatient services required to support the unique requirements of the Naval Training Command.

Collaboration just between our two Departments will not address all the opportunities to collaborate in solving demand, access and funding issues associated with the delivery of health care. We think its time to discuss a new paradigm in sharing. DoD believes that a multiplicity of opportunities can be found at the local level of health care delivery to leverage DoD, VA and quality civilian health care institutions to provide the best quality and value for our beneficiaries. The University of Colorado project in Denver is one example of how both agencies and the private sector can benefit. DoD, VA and the University Medical Center all need updated health care facilities in the

Denver metropolitan area. As stewards of the federal dollar, we owe it to our taxpayers to aggressively seek out opportunities such as this to provide the highest quality care at less cost.

The National Defense Authorization Act of 2003 requires that VA and DoD better coordinate the benefits and services they provide to our military and their dependents, either while on active duty or after they have served our Nation. In order to accomplish this formidable task, the bill requires that the Departments establish three pilots where services, manpower and facilities will be shared (using common IT systems) to provide seamless care to our veterans and their dependents. We are actively working to identify sites, and developing our approach to accomplish this priority effort and will submit this information to the Congress by September 30, 2003.

Therefore, as part of our strategic planning efforts, we are establishing a Capital Asset Planning and Coordination Steering Committee to provide executive oversight and strategic direction for joint capital asset planning. This committee will provide strategic direction and serve as a clearinghouse for all capital asset planning activities between DoD and VA.

Conclusion

Mr. Chairman, our goal is to build a world-class partnership between DoD and VA, guided by the principles of collaboration, stewardship and leadership. The recommendations of the Presidential Task Force to Improve Health Care Delivery for Our Nation's Veterans will assist us in this accomplishing this goal.

Statement of

C. Ross Anthony, Ph.D.

Commissioner

President's Task Force to

Improve Health Care Delivery For Our Nation's Veterans

Mr. Chairman and distinguished members of the subcommittee, I want to thank you for the opportunity to share my views on the Final Report of the President's Task Force (PTF) to Improve Health Care Delivery for Our Nation's Veterans. It has been a distinct privilege to serve as a Commissioner on this Presidential Task Force and in some small way have the opportunity to honor those among us who have or are serving our country so that the freedom and liberties we enjoy are preserved.

It was also a distinct privilege to serve with 14 distinguished Commissioners ably led by the Co-Chairs the Honorable Gail Wilensky and the Honorable John Hammerschmidt. These 15 commissioners who first gathered shortly after 9-11 came from very diverse backgrounds and professions. Some commissioners represented constituency groups and others, like myself, came as independent voices. Although I serve as the director of RAND's Center for Military Health Policy Research, the views I expressed on the PTF and express here today are my own from the perspective of a commissioner, and do not represent the opinions of RAND.

All commissioners on this task force shared a deep commitment to ensuring that veterans seeking health care are provided timely access to high quality health care delivered efficiently and compassionately. We worked together, learned from each other, and fashioned what I believe is an outstanding consensus report that calls for bold action on the part of the Department of Defense (DoD), the Department of Veterans Affairs (VA), Congress, and the Administration to improve the quality, delivery and efficiency of care to veterans. It is true that some commissioners wished to go further on the issue of funding for category eights, but I urge you to realize that what you have before you is a

very strong statement for action fully endorsed by Commissioners who include veterans' advocates, clinical professionals, policy experts, and business leaders. I urge you to help implement our findings.

I believe that the report speaks for itself and what I would like to do this morning is highlight a couple of recommendations that I think are particularly important and then touch on a few issues dealing with its implementation and oversight.

In forming the task force, President George W. Bush directed us to identify ways to improve benefits and services for VA and DoD beneficiaries through better coordination, to review barriers that impede that cooperation, and to identify opportunities to improve business practices to ensure high quality cost effective care, and to identify opportunities for improved resource allocation between the VA and DoD. In our numerous meetings and field trips we concluded that situations appropriate for direct sharing of facilities such as one finds at Nellis Air Force base in Las Vegas, although impressive examples of what is possible, are the exception rather than the rule. This is true for a number of reasons including the different missions of the Department of Defense and the Department of Veterans Affairs, and the lack of excess capacity at the VA. However, we also concluded there were many areas where the VA and DoD could cooperate with each other that would ease the transition from active duty, increase the quality of care, and improve efficiency that would benefit both agencies and provide a better, more seamless benefit to veterans. In general, the areas ripe for action are business processes that would enable real cooperation to take place. Key among these is the need to synchronize information technologies.

Recommendation 3.1 calls for the Department of Veterans Affairs and the Department of Defense to develop and deploy interoperable, bi-directional, and standards-based electronic medical records by fiscal year 2005. If the VA and DoD are to cooperate effectively and implement other recommendations such as a mandatory single separation physical or to improve care through the implementation of evidence based clinical practice guidelines, synchronizing information systems is essential. As the report makes clear, "effective interoperable or joint IM/IT solutions that significantly improve VA/DoD collaboration depend on senior executive commitment to, and involvement in, planning synchronization between the Departments, and motivation at all levels with accountability for results." In short, success depends on a coordinated business planning process at all levels that is sustained over time, not just the purchase of a particular piece of hardware or software. This will require sustained leadership commitment that has not always been present in the past. We see no reason why this key objective cannot be achieved by fiscal year 2005.

I would now like to draw your attention to Recommendations 3.5-3.7. These recommendations deal with the need to better track and understand the exposures that military personnel experience during deployments such as Operations Desert Storm and Desert Shield or Operation Iraqi Freedom. I had occasion to lead an extensive research effort at RAND in support of the Office of the Special Assistant for Gulf War Illnesses which highlighted how little information existed to understand the illnesses veterans were experiencing after the first Gulf War. These three very important recommendations

address some important concerns of veterans. I would point out that they call for both DoD and the VA to identify, collect, and maintain data needed by both departments to recognize, treat, and prevent illness and injury resulting from occupational exposures and hazards experienced while serving in the Armed Forces. Our recommendation calls for the VA to share information with DoD and vice versa in a process that allows both departments to address these critical issues. This will not be an easy task and will require routine pre and post deployment physicals, collection of appropriate troop location data, and innovative data collection and analysis.

Finally, let me address the issue of the funding mismatch. We concluded that it would be almost impossible for there to be effective collaboration between two systems if one was well funded and the other was not. While not always the case, DoD presently appears to have adequate funding to fulfill its health care responsibilities. As this Committee is well aware and our report details, the same is not true in the case of the Department of Veterans Affairs. As an economist, I feel that it is important to fashion good policy and then finance it adequately—hopefully in a manner that creates incentives for efficiency. Historically the country has committed itself to being sure that veterans who had service-connected disabilities and/or were indigent were well cared for. It is a national commitment I share. The Congress in the Veterans Health Care Eligibility Reform Act of 1966 (PL 104-262) expanded eligibility to include veterans whose incomes were above established VA means test thresholds and who did not have compensable service connected condition. However, the demand for services has been growing beyond the capacity of the system to provide or the Congress to fund them.

Today there are over 250,000 veterans who have been on waiting lists for six months or more waiting to receive care. Growth has been particularly rapid among the over 65 population which has sought ways to pay for prescription drugs, a benefit not presently provided by Medicare. In theory, the Secretary of the Department of Veterans Affairs has the authority to limit care to match budget appropriations, but we all know that this is politically very difficult and a path which the Congress has usually not been willing to accept. In short, I believe this is a process and situation that is neither wise public policy nor fair to veterans. Our report calls for guaranteed funding for categories 1-7 so that there will be certainty in the system for veterans and managers alike.

I concur with the Report's recommendation 5.3, which deals with the funding for priority eights. I believe the "present situation is unacceptable" because it subjects veterans to uncertainty that makes it very difficult for them to plan properly for their health care needs and makes it difficult for the VA to plan and manage the provision of care. Veterans deserve better treatment. That said, I believe the Report's recommendation that the Congress and President should work closely together to solve this problem, is the right one. As a Commissioner, I did not believe that that we had sufficient information and analysis, or the time necessary to fully investigate and fashion good policy, nor did I believe that this issue was within the scope of the Task Force. Further, decisions of this nature, will involve hundreds of billions of dollars over many years, interactions between other major programs such as Medicare, and difficult public trade-offs that need to be properly considered by the President and Congress. Given the magnitude and complexity of these issues, I believe the appointment of another Task

Force to consider just this issue and/or a Congressional Report on the subject should be considered.

I would also urge the Congress to give some thought to the impact of any proposed Medicare prescription drug benefit legislation on the demand for services at the VA. Synchronizing benefits, if properly designed, could help seniors receive care, eliminate perverse incentives, and alleviate the pressures created by Medicare eligible veterans just seeking pharmacy coverage at the VA.

Finally let me turn to an old management adage, "You get what you inspect, not what you expect." Members of the PTF often spoke of wishing to have real impact and not simply to become one more report atop a dusty shelf. Recommendations for action without assigned responsibility and accountability usually fail. The management literature is rich with text emphasizing that once clear objectives are decided upon, that assignment of responsibilities and accountability for performance is essential for success. A number of recommendations in the Report (recommendations 1.1, 2.3, and 4.2) deal with these issues, including those that discuss metrics for success for performance, needs for accountability, and specific mechanisms for tracking and reporting. For example, Recommendation 1.1 calls for the Secretaries of the VA and DoD to annually submit a report to the President detailing their status on implementing sharing and collaboration initiatives and the recommendations of this report. I believe that these are particularly important recommendations to ensure that this report has more effect than its predecessors. Presently, the Department of Veterans Affairs and the Department of Defense are making rapid progress on joint objectives through the Joint Executive

Committee, which we on the PTF have applauded and hope will be sustained. I also urge this Committee to actively use its oversight authority to be sure that progress is sustained towards achieving the Task Force Recommendations.

Thank you again for the opportunity to present my views, and I would be pleased to take any questions you might have.

MACK G. FLEMING

MEMBER, PRESIDENT'S TASK FORCE TO
IMPROVE HEALTH CARE DELIVERY
TO OUR NATION'S VETERANS

Mr. Chairman, Ranking Member Evans, and Members of the Committee, I am grateful for the opportunity to appear before the Committee to discuss some of the recommendations submitted to the President by our Task Force on May 26, 2003.

In order to provide prompt and efficient access to consistently high-quality health care for veterans, on May 28, 2001, President Bush issued Executive Order 13214, establishing a Task Force comprised of 15 members to report findings and recommendations to him. I shall not dwell on most of the recommendations contained in the Report. All members of the Task Force agreed to those pertaining to improved cooperation between the Department of Veterans Affairs and the Department of Defense. Of course as some of you know, notwithstanding the recommendations, nothing will be accomplished without strong leadership from the top down. Sharing authority for the two Departments was enacted in 1982, and Congress has continued to encourage and support the concept. However, over the last twenty years, the extent of sharing and collaboration between the two Departments has been disappointing.

Therefore I will focus on what I think is the most important part of the Report – timely access to health services and the mismatch between demand and funding. It is well documented that due to severe budget shortfalls, thousands of veterans are not receiving their health care on a timely basis. The mismatch affects the delivery of timely and quality health care to veterans. This past January Secretary Anthony Principi for the first time acknowledged the budget shortfall and made the decision to cease enrollment of the newly created Priority Group 8 veterans. Why did he do it? He had no other choice. Funds were inadequate to take care of the demand. The shortage was so severe last year that VA had to stop encouraging veterans to come to the VA for their care. As of January this year, at least 236,000 veterans were on a waiting list of six months or more for a first appointment or an initial follow-up. So the Secretary decided it was best to reduce the waiting time for care by not enrolling many veterans. Timely access - I think not for many deserving veterans. Many of them are combat veterans.

In 1996, Congress passed legislation requiring the VA to enroll all veterans into the system. In addition this Committee and the Congress established eligibility for health care for Priority 8 veterans. One critical thing was missing - the funds required to

provide the care. Establishing eligibility means little if the level of funds is not made available. I believe Pete Wheeler, Georgia's Commissioner of Veterans Affairs, said it best when he responded to an inquiry as to why Secretary Principi made his decision to scale back VA's outreach program last year. He said: "The VA budget is the problem that must be solved first. The VA budget as been neglected for many years. Congress hasn't done it's job. If they want the VA to treat more veterans, it will only be done if the money is made available. The VA has to live with the budget given it by the Administration and Congress."

Commissioner Wheeler described the adverse impact of anything less than full funding as follows. "Failing to adequately fund VA health care is like telling veterans they are invited to a dinner party but they will have to stand in the back of the line; and if there is not enough food, they will not get to eat." I'm certain many Category 8 veterans feel that way. This group of veterans has not known from year to year whether they will be granted access to VA care. So although Category 8 veterans were made eligible, funding was not made available to grant them health care that Congress had authorized for them. Is this fair - of course not. Why are these veterans being treated differently? Is it because they make a few dollars more than $24,000 a year? What is the "concern" that we can't do what is right for all veterans who have earned it? Under Title 38, USC, the term "veteran" means a person who served on active duty and who was discharged from service under conditions other than dishonorable. All veterans should be treated fairly.

We must be willing to provide full funding for all veterans. To address the mismatch between funding for the VA and the demand for services, the Interim Report released to the President on July 31, 2002 said: "The PTF believes the Federal Government should provide sufficient funding to allow timely access to VA health care for all enrolled veterans." Current service members, veterans, retirees, and family members of active or retired service members – should have full and timely access to the health care services that Congress has authorized for them.

I am concerned that we appear to be moving toward the creation of two classes of veterans – those who retire from the military and the "citizen soldier" who make up most of the military services during wartime. Why do I say this? We are saying the Priority 8 veteran cannot receive his or her health care for these reasons. First, the budget submitted by the Office of Management and Budget and passed by Congress is inadequate. And most of the time the Appropriations Committee will not add much to what the President requests. In addition, some will say those "citizen soldiers" making a few dollars more than $24,000 a year is a "higher income" veteran.

Now let's compare that with the retired generals, colonels and other top officers and non-commissioned officers. Under Tri-Care for life, at age 65 those retirees will be

entitled to free health care, even though some have incomes of $100,000 per year or more. In addition his widow will also be entitled to free health care. Is this also a "higher income" veteran? Some will say it is a retirement benefit. If so, why did it not come about until two or three years ago?

So to me discretionary funding is not going to solve current budgetary problems. Current problems will only be solved when the Congress decides to provide veterans' health care through mandatory funding. As to Priority 8 veterans, our Report states: "The present uncertain access status and funding of Priority Group 8 veterans is unacceptable. Individual veterans have not known from year to year if they will be granted access to VA care. The President and Congress should work together to solve this problem." I can tell you that no satisfactory answer was provided as to why they should be treated differently from others. For those who "think it may be too expensive", I would suggest we look at the total cost of a war. Aren't veterans benefits and services a cost of war? What will be the final cost of the war in Iraq? It will be far more than the costs of sustaining the active duty force.

One of the drafts of our Final Report expresses the strong feelings of our citizens for those who have defended our country – all of them. It said:

"VA's mission is to deliver the finest health care to those who served in the Nation's Armed Forces. Many of today's service members are now in harm's way in defense of our country. This country should honor their courage and sacrifice when they need access to high-quality health care, both while in military service and as veterans. However, the combination of the evolving nature of the VA mission, changing veteran enrollment patterns, and an increasingly complex national health care landscape has produced an untenable situation. Today, the fact that enrolled veterans face long waiting times for appointments in unacceptable because of its implication for veterans' health care and its derogation of our national obligation to those who serve."

I urge the Committee to move legislation without delay to implement mandatory funding for all veterans. One thing is certain. If Priority 8 veterans are not included, veterans throughout the country will raise serious questions as to why veterans are not treated equally.

Again I thank the Committee for allowing me to present my views on the recommendations of the Final Report.

Statement of

Sue Schwartz, DBA, RN

Commissioner, President's Task Force

to

Improve Health Care Delivery For Our Nation's Veterans

Before the

Committee on Veterans' Affairs

U.S. House of Representatives

June 17, 2003

Mr. Chairman and distinguished members of the subcommittee, thank you for this opportunity to share my views as a commissioner on the final report of the President's Task Force (PTF) to Improve Health Care Delivery for Our Nation's Veterans. It has been a privilege to serve as a commissioner and have the opportunity to assist in honoring our nation's obligation to those who currently serve and those who have served our nation in uniform.

Since the work of the commission has ended, I am here today to ask the Subcommittee's support to enable implementation of our recommendations. As the Subcommittee is well aware, other commissions have worked to the same effort in the past, only to have their recommendations sit on the shelf. Successful implementation will require congressional authority and additional funding.

I would like to highlight some of our recommendations with the hope that Congress, the Administration and both the VA and DoD will continue to move forward with greater collaborative effort to enhance the delivery of quality health care to beneficiaries who have earned these benefits through service to their country in uniform.

What distinguishes this report from others is it focuses on the importance of senior leadership's commitment as the key to sustaining collaboration. Over the past two years, there has been a flurry of interest in collaboration activities between the two agencies based in part on the attention focused on the issue by the President and the creation of the PTF. In addition, recent Congressional interest such as the FY 2003 National Defense Authorization Act (NDAA) (P.L. 107-314) was also important, as it codified the Joint Executive Counsel (JEC) and provided an additional framework for collaboration activities.

Recently the JEC has made strides forward, laying the groundwork to institutionalize additional collaborative, and joint venture efforts. The infrastructure is now in place to further these efforts, and steps are being taken to "institutionalize" collaborative activities. As the PTF report says, "What is needed is the will to change." Continual Congressional oversight will keep both agencies focused on this goal, making sure that "the will" does not wane.

Leadership at the top and empowerment at the local level are critical in order for collaboration efforts to succeed. In visits to several joint ventures, I was impressed with the ability of the staff to overcome numerous obstacles at the local level and their commitment to make these ventures succeed. Unfortunately, this resulted in an over-reliance on personal commitment rather than leadership guidance or the provision of recognition and reward. Without support from the top and empowerment at the grassroots, the recommendations of this commission are unlikely to come to fruition.

The goal of providing a seamless transition to veteran status for retirees or for those separating from military service is significant for many reasons and will rely on collaboration for success. As soon as an individual enters the armed services, both agencies have a stake in his or her health status. Therefore, in order to provide quality health care, that information must be shared between the VA and DoD.

We have learned from the 1st Gulf War that a better job must be done to collect, track and analyze occupational exposure data. Without this information, benefits determinations cannot be adjudicated fairly, nor can the causes of service related disorders be understood. This April, DoD initiated an enhanced post-deployment health assessment process for active duty and reserve service members deployed in support of Operation Iraqi Freedom. The outcome of this project will be a marker to determine if this PTF recommendation is being heeded.

In order for this assessment program to be effective in the long run, this information and any other health status data must be shared electronically between both agencies. VA and DoD will have to finally take steps to develop an interoperable bi-directional electronic medical record (EMR). Just as leadership is the key to the success of overall collaboration activities, the EMR is the lynchpin to a seamless transition. The technology exists, but again, "the will" must be there to move forward.

Another recommendation that is significant is "the one-stop shopping" process to facilitate separation or retirement. Offering one discharge physical, providing outreach and referrals for a VA Compensation and Pension examination, as well as following up on claims adjudication and rating is not only more cost effective in terms of capital and human resources. It is the right thing to do -- to ensure that servicemembers receive the benefits they have earned and deserve.

The government has been talking about development of an electronic DD 214 for many years. It is 2003, when will the DD 214 be in an electronic format? Whatever start-up costs this would incur would be paid back many times over in efficiencies gained. Again, this is not just a matter of conserving resources. It is the right thing to do -- to remove barriers that hamper a veteran's ability to complete the benefits determination process.

I am pleased that the PTF supported greater collaboration and sharing, not the integration of two systems with unique missions and varied populations. Efforts must be increased to improve DoD/VA coordination. However, these activities must enhance and maintain access to quality health care earned by each category of beneficiary. At a minimum, these activities must preserve or enhance benefits for all stakeholders. Collaboration activities should not be undertaken based solely on gaining government efficiencies that, if implemented, would come at the expense of beneficiaries.

Collaboration activities must remain beneficiary-focused and driven by a shared vision in both Departments of improving health care delivery for all stakeholders. This will not be without its challenges, as the vision must accommodate critical differences in cultures, missions, beneficiary populations, and benefit structures. As the JEC moves forward, development of beneficiary-focused collaboration that results in better management practices, resource use, accountability, and budget savings will continue to pose challenges.

The report highlights organizational barriers that hinder collaboration between these two behemoth organizations. One of the problems is that management structures and geographic responsibilities make it problematic at the local level for the two agencies to work together. The VA has 21 Veterans Integrated Service Networks (VISNs) who have a great deal of autonomy in setting policy, whereas DoD is decreasing the number of its regions from 12 to 3. Therefore, the DoD Lead Agents of the 3 TRICARE regions will have to work with multiple VISNs who each have their own way of doing business. It becomes even more difficult as Lead Agents lack autonomy over local military hospitals, which belong to the three individual military branches, and DoD's private care network is provided through Managed Care Support Contractors.

Given these challenges, the recommendations to develop "structural congruence" and joint budgeting are higher order objectives that have yet to be reached within the three military branches (there are myriad accounting systems within DoD). Making that happen will take years of leadership commitment and may require further legislative action.

In our deliberations on collaboration, we often asked, " Is the juice worth the squeeze"? In other words, collaboration is certainly a worthy goal, and would make those with green eyeshades happy, but is it a worthy enough goal to invest the time and energy it will take to change the management structures of these two agencies? Some in DoD would argue that the military system's readiness mission relies upon the autonomy of each service to exert command and control of its resources and its personnel system needs to remain intact. Others might ask whether collaboration is a worthy goal if it conflicts with DoD' current health care management and readiness model.

What will be needed is institutionalization of a framework to provide clear guidance and a blueprint for success, providing rewards and seed money. I would also suggest that each agency has its own work to do first. There are no short-term fixes to collaboration. The Capital Asset Realignment for Enhanced Services (CARES) and the Base Realignment and Closure (BRAC) process will afford an opportunity for the agencies to work together to identify underutilized facilities to match demand with infrastructure.

One of the goals of my organization, MOAA, is that TRICARE services be provided in BRAC areas. Permitting DoD beneficiaries to utilize VHA facilities, as TRICARE providers in BRAC areas would help accomplish that goal. The House version of this year's NDAA, H.R. 1588 SEC. 705, contains language that establishes a working group to assist the 2005 Defense BRAC Commission evaluate accessibility to health care in BRAC areas, develop selection criteria/ recommendations and to provide a plan for the provision of services to beneficiaries impacted by closures. Should this provision be enacted, I would hope that the working group would take into consideration collaboration with the VA's CARES program. This would provide an opportunity for cooperation between the two agencies that should not be missed.

One caution in this area is the growing gap between demand and capacity in VA health care that made the "core funding" issue a significant challenge for the PTF. It became apparent that collaboration between the two agencies is severely hampered because of the VA's shortfalls in funding. VA's continuing "open enrollment" policy, increased costs for health care in the private sector; and a lack of a Medicare prescription drug benefit have driven increased enrollment. However, annual appropriations have not kept up with demand, and 250,000 veterans are on waiting lists of six months or more for appointments. As long as disable and indigent veterans are still waiting lengthy periods for care in VA facilities, meaningful collaboration will remain a challenge.

Much has been made about the fact that the PTF did not come up with a firm recommendation for care for the category 8s. As this was a consensus driven report, the commissioners could not all agree on the level of service guaranteed to be provided to those without service-connected disabilities whose incomes were above the means test. I hope this controversy does not overshadow our unanimous decision that those enrolled in categories 1-7 should be fully funded. Funding should be through either mandatory spending or some other modification to the current process.

The consensus of the commissioners is that first priority must be given to making things right for the veterans for whom the VA has traditionally provided care, those with service-connected disabilities, and the indigent.

To the extent that facilities are unable to meet VA's modest access standards, there is a need to be able to refer veteran beneficiaries to a non-VA provider, unless the veteran prefers to wait for a VA appointment. This recommendation would put veteran beneficiaries on the same footing as TRICARE beneficiaries. Under the DoD system, if a patient cannot be seen in the direct care system, an appointment with a civilian provider must be made in line with DoD's more stringent access standards. If the VA enrolls beneficiaries when they lack the capacity to care for them, they will be obligated to buy the care in the private sector. This recommendation will require a significant amount of additional funds and most likely would require legislative authority. But it offers one solution to cutting down the many months that our veterans endure as they wait for primary and specialty care.

Again, thank you for the opportunity to share these thoughts with you. We will look to the Subcommittee for your leadership to help in the implementation of these recommendations. I look forward to answering your questions.

STATEMENT OF
ROBERT W. SPANOGLE, NATIONAL ADJUTANT
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
REPORT OF THE PRESIDENT'S TASK FORCE TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATION'S VETERANS

JUNE 17, 2003

Chairman Smith and the Members of the Committee, I appreciate the opportunity to appear today to offer this Commissioner's views on the Final Report of the President's Task Force (PTF) to Improve Health Care Delivery For Our Nation's Veterans.

I was honored to be asked by the President to serve as a Commissioner on the Task Force. I am equally honored to appear before this bi-partisan Committee of veterans' advocates. I say bi-partisan because taking care of America's veterans is a national mandate. About the only question not asked of an enlistee is what is your political affiliation, because it really doesn't matter. Once you raise your hand and take the oath of enlistment, everything that ***really*** matters will be taught to you by your drill sergeant and your fellow service members.

I have never met a veteran that said, "The military didn't change me as a person." Some of the changes were more dramatic than others. Some of the changes left scars, both physical and mental. But I can honestly say that every veteran contributed to the price of freedom. Granted, some contributions were minimal, while others paid the ultimate sacrifice. Freedom was obtained, is sustained, and will continue to be secured by military veterans.

I understood the mission of this Task Force was to help this Nation meet its obligation to the men and women of the armed forces – past, present, and future.

As a veterans' advocate, I would commend to you and your colleagues a book entitled **The Wages of War – When America's Soldiers Came Home – From Valley Forge to Vietnam**. The authors present a vivid account of the treatment of American veterans throughout history. Tragically, it is not a very proud record. Well-documented words of praise used all too often in this city: like "to care for him who shall have borne the battle" and the "thanks of a grateful nation," are lacking in actions and filled with broken promises. The one point that is clearly obvious, is that not all veterans – past, present, or future -- are treated equally. Nothing supports that statement more than does Recommendation 5.3 in this newest report.

Contrary to comments made during Commission meetings, there are no "core veterans" – a veteran is a veteran. The "traditional" veterans treated in VA medical facilities are any veteran needing medical care. In the 1980s, "budgetary constraints" created distinctions through means-testing; before then any veteran was welcomed in a VA medical facility.

Just like the other barriers for collaboration identified in this final report, removal will require a degree of leadership and personal commitment by you and your colleagues. Nearly every barrier identified by this Task Force was identified by previous commissions in 1991 and 1998 and some of the recommendations are similar. However, the very best recommendations are meaningless without the necessary actions to bring about change.

On June 3, Dr. Wilensky testified as the Task Force's Co-Chair. I welcome the opportunity today to specifically discuss the only portion of the PTF report that failed to muster consensus by all Commissioners – Recommendation 5.3 addressing Priority Group 8 veterans. Personally, I believe this is the most critical issue in the entire report because it deals with the greatest portion of the veterans' population – the average G.I. Joe and Jane. Needless to say, I am less than pleased with this final recommendation.

This Task Force was asked to offer recommendations, not to draft legislation. Every other recommendation in this report will require a paradigm shift either administratively or legislatively. Recommendation 5.3 provides little guidance other than "good luck." However, the dissenting recommendation provided as a "footnote" in the full report on page 80 offered tangible, achievable actions.

The title of the Task Force includes the phrase to "Improve Health Care Delivery for Our Nation's Veterans" -- not just "core veterans" or "traditional veterans," but rather all American veterans. The leadership of the PTF, in my opinion, did not make the funding issue the primary concern of the Commission.

Some Commissioners came to the PTF with experience and knowledge of the VA health care delivery system. They had an understanding of VA health care funding. They were consistent in asking that health care funding be the primary goal on the PTF agenda.

That, however, did not happen. The issue of funding was relegated to the fourth or fifth item on the agenda. The Commission was still trying to reach consensus on a funding recommendation at its meetings of March and April 2003. Funding was still being discussed during the final Commission meeting April 25, 2003.

Though funding the veterans health care system was discussed throughout the life of the Commission, it was never the first topic discussed. On more than one occasion, when Commissioners asked about funding, they were reminded that in the opinion of the Chair the primary PTF mission was, first and foremost, to make recommendations on VA and DOD collaboration.

In PTF's early meetings, stakeholder panels of veterans' service organizations and military associations were invited to offer their views. Their views were consistent. Funding the VA health care system was their first priority. They encouraged the Commission to make funding its first priority. I also must note that none of the testimony received from the veterans' community was listed in the bibliography.

There are some organizations that would say that the PTF majority recommendation on full funding Priority 1-7 veterans was a landmark recommendation. I do not share that opinion. For the record, the recommendation is as follows:

"The Federal Government should provide full funding to ensure that enrolled veterans in Priority Groups 1 through 7 (new) are provided the current comprehensive benefit in accordance with VA's established access standards. Full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism, or by some other changes in the process that achieve the final goal." (PTF - Recommendation 5.1).

I do not believe it is a landmark recommendation because it fails to address the funding needs of an entire class of eligible veterans -- Priority Group 8 veterans.

The majority will tell you otherwise. However, in examining their recommendation on Priority Group 8 veterans, I think you will find it does not rise to the level of a recommendation, but is merely a statement, as follows:

"The present uncertain access status and funding of Priority Group 8 veterans is unacceptable. Individual veterans have not known from year to year if they will be granted access to VA care. The President and Congress should work together to solve the problem." (PTF - Recommendation 5.3)

Yes, the present status is unacceptable. The statement is a discovery of the obvious.

Is the PTF majority saying, "Priority Group 8 veterans, you're really not enough of a concern for us to make a concrete recommendation concerning your health care?" Is this the subliminal message they are sending to the President, Congress and to the veterans of this Nation?

Are they suggesting the repeal of Title 1 of the Veterans' Health Care Eligibility Reform Act of 1996 as it amended section 1710 of Title 38, United States Code, establishing the eligibility of Priority Group 8 veterans for health care?

Certainly, the PTF majority making this recommendation were familiar with the Veterans Health Care Eligibility Reform Act of 1996.

They were certainly aware of Title 38, USC, which, by the adoption of the Health Care Act, established the eligibility of Priority Group 8 veterans for VA health care.

The PTF majority was further aware that there are Priority Group 8 veterans who served two combat tours in Vietnam or may have flown thirty combat missions in World War II, but by the grace of God, do not qualify as Priority Group 1-7 veterans.

The PTF majority was certainly aware that the Priority Group 8 veterans currently enrolled in the VA make payments for their health care under third party reimbursement authority, when treated at VA medical facilities. They were certainly aware that these veterans pay the required co-payments and their insurance is billed.

And they were aware that the cost of VA medical care for Priority Group 8 veterans is not borne entirely by the Federal government.

However, the PTF majority continued to cite the so-called "core mission" of the VA, when discussing the issue of funding Priority Group 8 veterans.

There are PTF commissioners who are on record as defining these so called "core mission" veterans as only those who are service connected or have incomes below the established thresholds. On more than one occasion, they referenced this myth as the "historical mission" of the VA.

Even when confronted with the indisputable fact that no such "core mission" exists in Title 38, USC now, or before 1996, they remained steadfast in their view and remained unpersuaded.

Three PTF Commissioners -- Harry Walters, former Administrator, Veterans Administration; Mack Fleming, former staff director and general counsel to this committee, and I -- filed and circulated a dissent that offered an alternative to the PTF majority opinion on the funding for Priority Group 8 veterans. This recommendation would expand and strengthen third party reimbursement authority.

The alternative to the majority opinion on funding Priority Group 8 veterans submitted is:

"Title 38, USC, defines a veteran as 'a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.'"

Eligibility for veterans' health care is defined in the Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104-262). Veterans eligible and enrolled are currently placed in one of 8 categories although only seven existed at the time of the passage of PL 104-262.

The PTF reached consensus on a strong recommendation for Priority 1-7 (new), but failed to do so for Priority Group 8 veterans.

The VA enrolled Priority Group 8 veterans until January 17, 2003, when the Secretary of VA suspended new enrollments based on an insufficient budget.

Therefore, those of us who dissented with the majority recommended that the following funding mechanism be enacted:

- All enrolled Priority Group 8 veterans would be required to identify their public/private insurance.
- VA would be authorized as a Medicare provider for Priority Group 8 veterans and be permitted to bill, collect and retain all or some defined portion of third party reimbursements from CMS for the treatment of non-service connected medical conditions.

- VA should be authorized to offer a premium-based health insurance policy to any enrolled Priority Group 8 veteran with no public/private health insurance.
- All enrolled Priority Group 8 veterans would be required to make co-payments for treatment of non-service connected medical conditions and prescriptions.
- All enrolled Priority Group 8 veterans with no public/private health insurance would agree to make co-payments and pay reasonable charges for treatment of non-service connected medical conditions.

Why not a "pay as you go system" for Priority Group 8 veterans? Medicare subvention is under active consideration by the VA and HHS. VA is seeking the authority to require "proof of insurance." VA, like other federal agencies, could offer a health insurance plan. VA has had collection authority since 1986.

If the dissent seems brief, it is. Dissents were limited to no more than 300 words by a ruling of the PTF co-chairs.

Our dissent (alternative) appears only in the PTF final report. It does not appear in "A Brief Guide to the Final Report."

I have written the co-chairs concerning this omission, since I believe the "Brief Guide," which represents only the majority PTF opinion on Priority Group 8 veteran funding, is an unfair representation of the fact that this was not a consensus recommendation.

Our dissent simply expands third party collection authority for Priority Group 8 veterans by opening new and existing revenue streams.

We believe that this funding mechanism is essential not only to the survival of the VA Health Care System, but also should be enacted out of fairness to the vast majority of veterans who are currently locked out of the VA system. To reiterate, its provisions would include:

- Priority Group 8 veterans who are Medicare eligible be allowed to use their Medicare for medical treatment at the VA, if they chose VA, just as they would at their local hospital or doctor's office.

- Medicare fee for service. Allow VA by law to become a Medicare provider, the same as the Indian Health Service, another federal health service provider.

- Priority Group 8 veterans who have public/private health insurance must show "proof of insurance," so VA can bill for treatment of non-service connected medical conditions.

- Allow VA to offer Priority Group 8 veterans who are not Medicare eligible and have no public/private health insurance a premium-based health insurance policy, similar to Tri-Care.

- Finally to those Priority Group 8 veterans' who are not Medicare eligible, do not have public/private insurance, and do not purchase the VA premium-based health insurance

policy, would pay the reasonable and customary charges as they would at any other health care provider.

I wish to thank you, Mr. Chairman, and the Committee for allowing me the privilege of appearing before you today. In one of the final Commission meetings, Harry, Mack, and I were warned by a colleague not to wear veterans' advocacy on our sleeves. Mr. Chairman, I will readily admit to this committee that I am proud to be a veterans' advocate and I consider fighting for the rights of every American veteran, a badge of honor.

That concludes my testimony and I would welcome your questions.

STATEMENT OF
HARRY N. WALTERS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRSENTATIVES
ON
REPORT OF THE PRESIDENTS'S TASK FORCE TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATIONS'S VETERANS

JUNE 17, 2003

Chairman Smith and Members of the Committee,

I welcome the opportunity to appear today to offer my own views on the Final Report of the President's Task Force To Improve Health Care for our Nation's Veterans.

I was honored to have been asked by the President to serve as a Commissioner and I am indeed honored to be here this morning in front of this prestigious Committee of the Congress of the United States.

When I last appeared before this Committee in 1985, the veteran community could not begin to discuss some of the issues we are discussing today. Since 1985, VA has developed a contemporary medical care system second to none in our country and the Veteran Service Organizations are more open to discuss methods in which to expand quality health care to more veterans. In that spirit, Congress passed legislation in 1996 allowing Category 7 veterans access to the VA medical system. By utilizing third party reimbursement to pay for their care, the Congress was requiring the VA to act like a private sector hospital in that regard. While the VA medical centers have had some difficulty in developing private sector billing and coding expertise, I was pleased to see that over the last year there has been significant improvement in collections. I am confident that improvement will continue. It is not easy to implement private sector procedures in a public environment but it is accomplishable. I have been and will be a proponent of policy changes that require the VA to compete for additional patients. Eighteen years ago, I would not have dared to utter these words. We have come a long way.

My opening statements, Mr. Chairman, are given so that you and the Committee may better understand my views on the Task Force Final Report.

I believe that the Task Force has put forth some good ideas in defining ways and methods for which the DOD and DVA may collaborate and share resources.

The recommendations in Chapter 3 dealing with Providing a Seamless Transition to Veteran Status are especially pivotal in setting the ground work for better cooperation in the future. Without a good start in this area, the prospects for future sharing are diluted. In the course of all of our discussions about sharing, this issue had the strongest consensus among the Commissioners.

We also addressed the need for leadership and elimination of barriers to collaboration. My experience in attempting to start an informal partnership with DOD in 1983 was brief and non productive. Strong leadership from DOD and VA will be necessary to implement our recommendations. These discussions on barriers and leadership soon revealed the most obvious barrier to sharing and collaboration, the VA's inability to meet the requirements for their own veteran patient load and the growing mismatch between funding and demand in the DVA medical system. This issue led the Task Force to devote an entire chapter, Chapter 5, to this matter.

The Commissioners all agreed with recommendation 5.1 dealing with Category 1 through 7 veterans. "The Federal Government should provide full funding to ensure that enrolled veterans in Priority groups 1 through 7 are provided the current comprehensive benefit in accordance with VA's established access standards. Full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism or other changes in the process to achieve the desired goal."

It should be noted, however, that the Task Force did not come to closure on the funding mechanisms. Two alternative approaches were discussed but the Commissioners did not recommend either of them. We simply did not discuss them in enough detail to provide a recommendation. In my view, the alternative that suggests an outside board of experts has not been properly vetted with the veteran community. They have a stake in the VA and their views, to my knowledge, have not yet been heard.

Recommendation 5.2 also had strong consensus among the Commissioners. Twenty years ago the out sourcing of VA health care would have been contentious. Now it seems that the veteran community favors it. What a difference 20 years can make.

Category 8 veterans were the last issue on the table for discussion. Perhaps, it should have been the first issue on the table. An issue of this magnitude certainly deserved more time. Recommendation 5.3 is not really a recommended solution for category 8 veterans. It only calls for the Congress and the President to solve the problem while stating that the present situation is not acceptable.

The footnote or dissent to recommendation 5.3 outlines five specific recommendations for solving the problem for Category 8 veterans. I hope that the committee will take these recommendations under serious consideration. The opportunity to create new revenue streams for the VA is discussed in this dissent. It features a "pay as you go" methodology and for older veterans the use of their Medicare benefit in VA hospitals. The Medicare reimbursement issue was supported by all of the Veteran Service Organizations that testified in our Public Hearings.

I think that PFC Jessica Lynch will be a Category 3 veteran following her discharge from the active force. She deserves that priority and the country is proud of her service. The 100 or so members of our armed forces who risked their lives to bring her to safety will most likely be category 8 veterans. While most category 8 veterans will not seek care in VA hospitals, those who choose to come to the VA presently do not have the choice.

In closing my remarks, I am reminded how important the VA is to our country. While we have a large contingent of our armed forces in harms way, we should be especially diligent in ensuring the continued success of the VA.

Thank you for the invitation to present my views to you and the Committee.

Respectfully,

Harry N. Walters
Former Administrator of Veterans Affairs

STATEMENT OF

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

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

PRESIDENT'S TASK FORCE TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATION'S VETERANS

WASHINGTON, D.C. JUNE 17, 2003

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the 2.6 million men and women of the Veterans of Foreign Wars of the United States and our Ladies Auxiliary, I wish to thank you for including us in today's most important hearing. Under discussion today is the recently released report of the *President's Task Force to Improve Health Care Delivery for our Nation's Veterans* (PTF).

The VFW views this report as being a major milestone with respect to devising the means to improve access, enhance services and generally enhance the quality and timeliness of the health care provided by the Departments of Defense and Veterans Affairs to their respective beneficiaries.

The PTF has devoted more than two years of research, study, and analysis in producing what we view to be an authoritative guide toward addressing the manifest challenges inherent in fully meeting this nation's obligation to her defenders and her veterans with respect to medical care and benefits. The Task Force places special emphasis on the need for senior and sustained leadership on the parts of DOD and VA with respect to enhanced collaboration as well as the general provision of health care. In keeping with PTF findings, it is the VFW's position that a veritable sea change is in order with respect to establishing and institutionalizing ***ongoing*** goals and accountability by the Departments.

As noted in the PTF report, economic, budgetary, and structural changes and exigencies over the past ten years have greatly increased the demands placed on the VA and DOD health care. At the same time funding, particularly with respect to VA, has declined dramatically. Per-patient expenditures for VA have declined from almost $10,000 to slightly more than $4,000 since 1992.

The VFW places special emphasis on the PTF finding that even if VA were operating at "maximum efficiency," it would be unable to properly meet its obligations to enrolled veterans at the current funding level. This situation is intolerable and is only certain to worsen absent strong and effective action in addressing the very real mismatch between funding and demand. It is also shown that even with ideal collaboration between DOD and VA, while decidedly enhancing services and providing resource efficiencies, this would not in itself make up for inadequate health care dollars. The only true answer is the full, consistent, and predictable funding of veterans' medical care.

For the sake of timeliness, the VFW will not now provide its views on all of the PTF's findings and recommendations. We will, however, focus on several of the key points—the first among equals, as it were—to better play a role in this process.

To begin, the growing mismatch between funding and demand must be addressed. The VFW has historically and continues to support providing all veterans seeking such timely access

to VA health care. We do, however, acknowledge and applaud the PTF recommendation that the Federal Government provides full funding to ensure that enrolled veterans in Priority Groups 1 through 7 are provided the current comprehensive benefit in accordance with VA's established access standards. We concur that ***full*** funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism, or by some other changes in the process that achieve the desired goal.

It is an outrage that there are veterans who must wait six months or longer for a primary care or specialized care appointment. The VFW has long insisted that VA facilities be held accountable in meeting the Department's own access standards for enrolled veterans. In this, we support the PTF recommendation that this standard apply for Priority Groups 1 through 7. In instances where an appointment cannot be offered within the access standard, VA should be required to arrange for care with a non-VA provider, unless the veteran elects to wait for an available appointment within VA.

The VFW also strongly agrees that the present uncertain access status and funding of Priority Group 8 veterans is unacceptable. Individual veterans have not known from year to year if they will be granted access to VA care. This situation is grossly unfair, amounting to the outright denial of care to countless veterans in need, and we insist that it be rectified.

There are two approaches of merit cited by the PTF: First, form an impartial board of experts, actuaries, and others from outside VA to identify the funding required for veterans' health care that must be included in the discretionary budget request. This part of the budget submission would be ***protected*** from the customary budget guidance provided by the Office of Management and Budget.

Secondly, require mandatory funding for VA health care. This approach would require that VA be funded in a given year based on a capitated formula established in authorizing language. Funds would continue to be allocated as part of the Department's annual funding process; however, the funding requirement would not be subject to the agency budget development process.

The VFW is also very encouraged by the recommendation of the Task Force to continue discussions to clarify Medicare reimbursement for eligible veterans. It makes no sense that a veteran who has paid into Medicare cannot use his or her Medicare benefit in a VA Medical Center for their non-service connected health care. It is the VFW's contention that the veteran, VA and the Medicare Trust Fund, due to lower VA medical costs, would all benefit under such an arrangement.

While the precise funding methodology remains to be devised and implemented, there may be no doubt that a budgetary solution must be quickly forthcoming or countless deserving veterans in need will suffer as a consequence. We as a nation must not allow this to happen.

Another area addressed by the PTF that the VFW views as being of critical importance is providing for a " 'seamless transition' from military service to veteran status." The VFW strongly supports the Task Force's assertion that an institutional environment should be created in which information flows easily across all components of care, across geographic sites, and across discrete patient-care incidents while protecting privacy and confidentiality: "the lines limiting organizational jurisdiction and authority should be invisible to the service member or veteran crossing them."

One key element in this regard is the PTF recommendation that VA and DOD should develop and deploy by fiscal year 2005 Electronic Medical Records (EMRs) that are interoperable, bi-directional, and standards-based. While VA and DOD's respective accomplishment in the area of Electronic Medical Record keeping have been acknowledged by the PTF and others, the fact that they cannot "communicate" system to system presents, in our view, an absolute barrier to seamless transitioning that must be remedied. The establishment and utilization of fully compatible EMRs is critical in this regard.

Another problem facing our men and women in uniform at this time is that there is no clear or consistent record of their heath status as they leave military life. The VFW, therefore, supports the PTF recommendation that the Departments should implement by fiscal year 2005 a

mandatory single separation physical as a prerequisite of promptly completing the military separation process. Upon separation, DOD should transmit an electronic DD214 to VA.

Further, we agree that VA and DOD should expand their collaboration in order to identify, collect, and maintain the specific data needed by both Departments to recognize, treat, and prevent illness and injury resulting from occupational exposures and hazards experienced while serving in the Armed Forces; and to conduct epidemiological studies to understand the consequences of such events.

Along with particular occupational exposures, as this nation turns to fight the global terrorist threat, there will be an increasing number of small, discrete military actions, each with their own attendant illnesses and disabilities. Maintaining accurate and inclusive medical data on these actions is absolutely essential toward maintaining the health and well-being of those who serve this nation in uniform.

The final area undertaken in the PTF report that the VFW will address today is the critical need to remove all barriers to collaboration between VA and DOD. As vital as this action is, with respect to properly providing for the health care needs of our active duty military and veterans, past results have been spotty at best.

As stated by the PTF: "Prior Secretaries of Veterans Affairs and Defense have not been successful in establishing and institutionalizing common purposes and goals, creating measurements with common indices to monitor progress, demanding accountability, and promoting effective collaboration through incentives and other mechanisms." The VFW places special emphasis here on the necessity of bringing about a "culture" change within the Departments to assure positive processes and outcomes.

Again, the PTF clearly illustrates that a primary reason for [the past] lack of follow-through is the absence of a defined, consistent leadership structure at the national, regional, and local levels of either VA or DOD with clearly defined roles and responsibilities for implementing and institutionalizing recommended actions. Simply said, past leadership failed to bring about the requisite change in "institutional culture" to even give enhanced collaboration a fighting chance.

Toward this end the VFW strongly supports the PTF recommendation that the Secretaries of Veterans Affairs and Defense revise their health care organizational structures in order to provide more effective and coordinated management of their individual health care systems, enhance overall health care outcomes, and improve the structural congruence between the two Departments.

Mr. Chairman and members of this Committee, I again thank you for including the Veterans of Foreign Wars in today's most important forum. I can assure you that we are committed to working together with you toward realizing implementation of the Task Force's recommendations. I will be happy to respond to any questions you may have.

STATEMENT OF

RICHARD B. FULLER

NATIONAL LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

REGARDING

THE REPORT OF

THE PRESIDENT'S TASK FORCE TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATION'S VETERANS

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

JUNE 17, 2003

Chairman Smith, Ranking Member Evans, Members of the Committee, thank you for affording me the opportunity to present the views of the Paralyzed Veterans of America (PVA) on the final report of the President's Task Force to Improve Health Care Delivery for our Nation's Veterans (PTF).

PVA has closely monitored the PTF's progress. We have attended meetings and testified last year. Likewise, we testified before two House subcommittees last year regarding sharing between the Departments of Defense (DOD) and Veterans Affairs (VA). We have consistently advocated for sharing between the two health care systems when feasible and in the best interests of the patients who look to these diverse systems for health care. But we have also stated clearly and unequivocally that these systems must maintain their separate and unique identities. As we stated in our testimony before the PTF on January 15, 2002:

> VA typically treats a population of older Americans, chronically ill and disabled veterans. As the Nation's leader in such specialized services as blind rehabilitation, spinal cord injury, and mental health, the VA provides the full continuum of health care to veterans, from nursing homes and assisted living in long-term care facilities, to adult daycare and geriatric services. VA prosthetics and research provide services and innovations unmatched in other health care environments. These missions too, are unique to U.S. medicine and could be threatened if some form of merger were to take place between VA and DOD.
>
> Typically, DOD medical facilities treat younger and much healthier patients. DOD facilities have expertise in prenatal, obstetrics, and pediatrics for family members and our active duty military. When DOD beneficiaries acquire conditions typically treated by VA, they are discharged and therefore become eligible for enrollment as VA beneficiaries. This is another example of how the two Departments do work together, but also why, in fact, they are unique entities.

We were pleased to see that the PTF has not recommended a merging of the two health care systems, but we do note that these systems, for all intents and purposes, will be merged if veterans and DOD beneficiaries have their choices limited, and their health care options diminished. We note that the PTF stated that:

> Without question, the two Departments have separate functions driven by their core missions that should remain distinct and freestanding. However, other functions are prime candidates for the development of common standards, creation of interoperable and interchangeable program elements, and joint development and operation of functional elements in the name of increased efficiency, cost avoidance, and improved access for beneficiaries.

Also in our testimony from last year, we stated that:

> PVA recognizes there are many areas of VHA/DOD sharing that could provide significant advantages, such as joint purchasing of pharmaceuticals, supplies and equipment. Additionally, there is a need for improved information exchange between the two systems. We do not, however, believe that there are any savings to be gained by forcing patients of one system to use the facilities of the other. While many local arrangements work to improve access and convenience of veterans and DOD beneficiaries, we do not see any need for a national initiative to force increased cross-system patient care. Beneficiaries of both systems must maintain the full range of health care choices.

We notice that many of the recommendations contained in the PTF report in chapter 4 contain explicit recommendations regarding how the two systems can save taxpayer dollars by joint purchasing arrangements. We were also heartened to see attention paid to facility upkeep and planning, issues similar to what PVA has recently testified to concerning VA construction. Indeed, there are many recommendations in this report that make sense.

PVA believes that the bottom line in any VA/DOD sharing effort is that the health care accorded to veterans and DOD beneficiaries is improved, not solely just because there is efficiency here, or a cost-savings there. These are important, but they are only a step toward the larger goal of improving patient care and options. It is in this light that we judge any recommendation put forward as to the efficacy, and desirability, of VA/DOD sharing.

PVA views Chapter Five of the final report, "Timely Access to Health Services and the Mismatch between Demand and Funding," as the crux of the PTF's recommendations. We were pleased to see the PTF attempt to tackle these vital issues, but we think that they did not go far enough.

Recommendation 5.2 reads that "VA facilities should be held accountable to meet the VA's access standards for enrolled Priority Groups 1 through 7 (new). In instances where an appointment cannot be offered within the access standard, VA should be required to arrange for care with a non-VA provider, unless the veteran elects to wait for an available appointment within VA."

Access is indeed a critical concern of PVA. As *The Independent Budget for Fiscal Year 2004* states:

> 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 a projected 4.5 million in 2002. An additional 600,000 veterans are projected to enroll in VA health care in 2003. Unfortunately, VA health-care resources do not meet the increased demand for services and the system is unable to absorb this significant increase. With more than 235,000 veterans 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.
>
> Though caring for veterans with service-connected disabilities is a core commitment for VA, this does not provide timely access to quality health care for all eligible veterans who were authorized access to VA health care under the provisions of the Health Care Eligibility Reform Act of 1996. To ensure that all service-connected disabled veterans, and all other enrolled veterans, are able to access the system in a timely manner, it is imperative that our government provide an adequate health-care budget to enable VA to serve the needs of veterans nationwide.

Access standards without sufficient funding are standards in name only. In addition, although we applaud the PTF for bringing up the importance of access standards, we have concerns over the recommended enforcement method – arranging for care to be provided at non-VA providers when these standards are not met. The VA is a national asset, and steps taken to shift patients to non-VA providers can set a dangerous precedent, encouraging those who would like to see the VA privatized and the federal government turning its back on its promises to the men and women who have served. We do think that access standards are important, but we believe that the answer is in providing sufficient funding in the first place in order to negate the impetus driving health care rationing.

Indeed, as the PTF recognized, providing adequate health care funding is the key to shoring up and improving VA health care. Many of the recommendations in the report will ultimately have very little effect if the VA funding structure is not reformed. Although the PTF must be commended for attempting to grapple with this issue, we are disappointed with the extent, and the scope, of their Recommendation 5.1.

This Recommendation states that the "Federal Government should provide full funding to ensure that enrolled veterans in Priority Groups 1 through 7 (new) are provided the current comprehensive benefit in accordance with VA's established access standards. Full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism, or by some other changes in the process that achieve the desired goal."

PVA strongly agrees with the position advocated by task force members Alvarez and Wallace, which called for "guarantee[d] access and funding for Priority 8 veterans." The PTF, in their recommendation 5.3 merely called the uncertainty facing Priority Group 8 veterans "unacceptable" and urged the President and Congress to "work together to solve this problem," while excluding this from Recommendation 5.1. We also note that task force members Spanogle, Walters and Fleming also urged continued access and health care for Priority Group 8 veterans. PVA believes the Priority 8 veterans must be included in any guaranteed funding mechanism developed for Priority 1 through 7 veterans.

As stated before, the PTF called for full funding, "by using a mandatory funding mechanism, or by some other changes in the process that achieve the desired goal." One of two alternative mechanisms suggested by the PTF in regards to Recommendation 5.1 calls for the creation of an "impartial board of experts, actuaries, and others from outside VA to identify the funding required for veterans' health care that must be included in the discretionary budget request." This approach, while different from the mandatory funding mechanism we have become familiar with, is well worth investigation and full consideration. The panel of actuaries approach may be a valid solution to this long-standing funding problem. No well-intended concept should be disqualified out-of-hand if it is designed to produce the end result – the dollars needed to maintain the quality and quantity of veterans' health care. We congratulate Chairman Smith for his advocacy and leadership on this issue in introducing legislation bringing this new funding concept to the table.

There really is no mystery concerning the amount of funding needed by the VA health care system. PVA has, along with AMVETS, Disabled American Veterans, and the Veterans of Foreign Wars, published *The Independent Budget*, now in its 17th year, which provides an independent assessment of the VA's true resource requirements. Indeed, even the VA comes somewhat close at times, if you strip away OMB's artificial budget caps, all the far-fetched policy initiatives, wildly overstated numbers regarding third-party collections and such things as the perennially popular "management efficiencies."

For this reason, PVA must again restate our support for guaranteed mandatory funding of VA health care. This was the second of the two alternative approaches identified by the PTF:

> In recent years, legislation has been introduced to require mandatory funding for VA health care as a possible solution. This approach would require that VA be funded in a given year based on a capitated formula established in authorizing language. Funds would continue to be allocated as part of the Department's annual funding process; however, the funding requirement would not be subject to the agency budget development process, but based on the number of veterans enrolled as of a given date. While this or a similar methodology would not guarantee access, it would likely eliminate one of the major impediments to providing access: unpredictable or subjectively developed budget requests.

PVA strongly believes that some form of mandatory funding system is the only realistic solution to the VA's budget woes. We would also commend Ranking Democratic Member Lane Evans (R-IL) for introducing legislation, H.R. 2318, calling for mandatory funding for health care for all currently eligible veterans. Guaranteed, mandatory funding is an approach recommended by veterans' groups, and supported by many of you on this Committee. We urge this Committee and this Congress to quickly adopt a guaranteed funding approach for VA health care.

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

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

Fiscal Year 2003

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $220,000 (estimated).

Fiscal Year 2002

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $179,000.

Fiscal Year 2001

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $242,000.

SERVING
WITH
PRIDE

TESTIMONY

of

Richard Jones
AMVETS National Legislative Director

before the

Committee on Veterans' Affairs
U.S. House of Representatives

on

The President's Task Force to Improve Health Care Delivery for our Nation's Veterans

Tuesday June 17, 2003
10:00 A.M.
Room 334
Cannon House Office Building

A M V E T S

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Mr. Chairman, Ranking Member Evans, and Members of the Committee:

On behalf of W.G. "Bill" Kilgore and the nationwide membership of AMVETS, it is an honor to appear before you and the distinguished members of the Committee on Veterans' Affairs to discuss the report of the President's Task Force to Improve Health Care Delivery for our Nation's Veterans.

Mr. Chairman, AMVETS has been a leader since 1944 in helping to preserve the freedoms secured by America's Armed Forces. Today, our organization, composed of a large number of Vietnam veterans, continues its proud tradition, providing, not only support for veterans and the active military in procuring their earned entitlements, but also an array of community services that enhance the quality of life for this nation's citizens.

AMVETS deeply appreciates the President's decision to establish this task force to improve healthcare delivery to veterans and active duty military. If for no other reason, the President's directive has brought into focus the fact of an enormous, continuing gap between resources and capacity of the system to deliver timely, quality care to our nation's veterans.

As directed under Executive Order 13214, the task force was created to recommend specific reforms to better coordinate the activities, benefits and services for VA and DoD. Though the observations in this report are nothing new to members of this committee, nor to ourselves, the recommendations heighten the possibility of improved opportunities for resource sharing, more coordinated information technology, and perhaps advances in a seamless transition of medical records from military service to veterans status.

In review of the report and its 23 numbered recommendations, AMVETS finds the task force recommendations fine as far as they go, but frankly they do not go

far enough. In specific, the report offers a strong funding recommendation for enrolled veterans in Priority Groups 1 through 7. However it declined to establish a specific recommendation on healthcare access for between 1.8 and 2 million so-called high-income veterans with nonservice-connected disabilities who fall into a Priority 8 category.

According to the study, veterans in this category "do not know from year to year whether they will have access to VA care" and that "this uncertainty should be resolved." Rather than a specific recommendation, the task force kicks-the-can without laying out a plan of action to correct what it terms an "unacceptable" situation.

While the task force call for full funding of the seven groups is certainly commendable, AMVETS is extremely disappointed that a majority of the panel members would present a document that excludes a broad category of veterans from access to health care.

In looking at Title 38, United States Code, the definition of the word veteran is "a person who served in the active military, naval or air service and who was discharged or released therefrom under conditions other than dishonorable." Moreover Chapter 17 clearly indicates that all veterans are eligible for VA health care, including Priority 1 through 8.

Under the directive given the task force, namely to improve healthcare delivery for our nation's veterans, failure to address this glaring omission is a disservice to the brave men and women who served honorably in the military uniform and who are currently eligible for care under the Reform Act of 1996 which opened access to VA care to all veterans.

Mr. Chairman, there's not one member of AMVETS who would refuse to give up their position in VA's waiting line to allow a service connected veteran medical

services for a service-connected condition. In fact, many of our members, service connected and nonservice connected, are grateful for the task force highlighting the obvious finding that there exists a "mismatch between demand for access and available funding." This is something AMVETS and many others interested in quality health care for veterans have testified to for many years.

Yes, there is a mismatch in demand for services and resources necessary to provide health care. Over the years, vital VA healthcare programs keyed to assisting veterans have, in the main, seen chronic under funding. These trends deeply trouble AMVETS because we believe, like you, that a sacred commitment to those—current, past and present—who wear this nation's military uniform falls short of the honor our forebears intended.

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.

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.

In reviewing task force documents AMVETS would like to point out an observation made by panel member and former VA Administrator Harry Walters during task force debate when he commented about the task force and its members misdirected concerns with the economics of health care rather than with delivery of health care to veterans. He told about the then recent repatriation of PFC Jessica Lynch saying, "Broken legs and all, she's home, and

she will be a Category 3 veteran...she will have access to the VA medical care system."

However, "The 100 or so brave people that rescued her and dug up the six bodies of her comrades with their own bare hands will also come home, and a good deal of those veterans will be Category 8 veterans, some of whom may not have insurance when they return and may elect not to have insurance because it's too costly for them, and they have families, and the VA will not be there for them – will not be there for them."

Again, AMVETS supports a policy aimed to ensure that severely disabled veterans receive prompt care. With nearly 165,000 veterans waiting for an appointment, granting priority in scheduling healthcare appointments for severely disabled veterans is the right thing to do. But we are deeply troubled by the task force failure to make a specific recommendation on veterans already eligible for care.

In reading task force transcripts, it seemed that some members of the panel wanted to disregard the enactment of the Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104-262). They spoke of "traditional" and "historical" users of VA. Then aimed to blame a category of eligible, legitimate users of VA saying, "But what has happened has been the worst of all worlds: the traditional users are getting the short end of the stick."

The task force highlighted the Reform Act of 1996 as a major contributing factor to the current "mismatch between demand and resource." But they failed to recognize the reality of the statute, which provides all enrolled veterans access to the same level of health care. Instead of looking to improve healthcare delivery for the nation's veterans, they looked with green-eye shades to change eligibility for enrollment. And they carried that failure over to their final report. (page 70)

One of the results of this failure is found perhaps in the task force determination that, despite unceasing under funding of VA medical care, the administration's current budget recommendation magically closes the gap for next fiscal year. AMVETS knows this panel does not agree with that assessment, and we appreciate your support for full funding in the recently approved budget resolution.

Today, as we discuss the task force report, the condition of the VA healthcare system remains troubled. We fully agree that demand for care is exceeding resources. We fully agree that management efficiencies will not bring the two in line. Unlike the task force, however, the members of AMVETS see inadequate funding as the reason for the erosion of timely care, not Priority 8 veterans.

Each year, the accumulated shortfall is built into the budget process. In past years, VA has responded by delaying equipment replacement, postponing maintenance, cutting information resources and other related activities. More recently, VA has been forced to ration veterans care – first by delaying elective procedures and medical appointments and, more recently, by barring access to the system.

AMVETS among others 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. Since a large majority of those seeking treatment for nonservice-connected disabilities are Medicare eligible and VA can provide those services at less cost than private sector providers, allowing veterans to use their Medicare eligibility within the VA system is a good idea.

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 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.

The members of AMVETS believe mandatory funding of VA health care would provide 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 the war on terrorism continues, we are reminded daily of the sacrifice and invaluable service given by those who wear the military uniform. For the benefit of our soldiers, sailors, airmen and marines – past, present and future – AMVETS stands ready to work with you to express our gratitude and our obligation to them as a nation.

AMVETS believes that adequate funding is essential to VA's ability to deliver quality health care to the men and women who have sacrificed and served in the military. We call on the administration and Congress to provide the resources needed to care for America's veterans.

This concludes my testimony. Again, thank you for 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 the

MILITARY OFFICERS ASSOCIATION OF AMERICA

on
the Final Report of
The President's Task Force to Improve Health Care Delivery for
Our Nation's Veterans

before the

House Committee on Veterans' Affairs

June 17, 2003

Presented by
Colonel Robert F. Norton, USA (Ret.)
Deputy Director, Government Relations
Military Officers Association of America

Chairman and Distinguished Members of the Committee, I am pleased to present the views of the Military Officers Association of America (MOAA) on the Final Report of the President's Task Force (PTF) to Improve Health Care Delivery for Our Nation's Veterans. MOAA does not receive any grants or contracts from the federal government.

Introduction

MOAA is very pleased to see that a number of our recommendations for improving collaboration between the VA and DoD health care systems have been incorporated into the Final Report. MOAA testified before the PTF on 15 January 2002, early in its deliberations, and we contributed to the statement presented by The Military Coalition on 7 March 2002 before a joint hearing of the Military Personnel Subcommittee of the House Armed Services Committee and the Subcommittee on Health of the House Veterans Committee. MOAA also was a signatory of a letter from The Military Coalition to the PTF Co-Chairs on 20 September 2002 outlining key issues that we collectively recommended for inclusion in the final report.

From the outset, we have emphasized that the work of the PTF ultimately would be judged by stakeholders on the principle of preserving or improving access to quality health care for all beneficiary groups. To its credit, the PTF did not take up an administration budget proposal that would have singled out dually eligible military retired veterans to relinquish earned health care benefits available from either the DoD or VA systems.

Task Force Recommendations

Provide Clearer Leadership

Collaboration between the Department of Defense and the Department of Veterans Affairs begins with leader commitment and strategic planning. The administration's commitment to this enterprise has instilled a new sense of purpose between DoD and VA senior leaders. Congress recognized the importance of leader engagement by establishing the Joint Executive Council. Now, legislation recently passed by the House would advance PTF Recommendation 2.1 by creating a broader charter for the interagency leadership committee beyond health care. MOAA endorses this recommendation.

MOAA supports PTF Recommendation 1.1 that the Secretaries of Defense and Veterans Affairs report annually to Congress on their joint plans and programs for collaborative activities. We believe the departments should issue from time-to-time a "national strategy for DoD – VA collaboration." MOAA also recommends that the Armed Services and Veterans Affairs Committees hold periodic joint hearings on the progress of the departments in strategic cooperation. These interactions should be informed by a vision that focuses on the needs of servicemembers from the first day they enter military service and throughout their lives as the primary reason for DoD – VA collaborative activities.

Create a Seamless Transition from Military to Veteran Status

MOAA applauds Task Force Commissioners and staff for the strong recommendations in the Final Report on seamless transition. Despite tremendous strides in management efficiency and service delivery, the VA is still not able to provide timely delivery of benefits for our nation's veterans. Late last year, approximately 463,000 claims including 97,000 on appeal were backlogged in the VA system. The problem has its roots in absent or incomplete medical records, the lack of a common separation physical, non-existent documentation on occupational exposures, and an inability of DoD and VA to seamlessly share medical data.

MOAA strongly recommends that Congress incorporate PTF Report recommendations in Chapter Three on seamless transition into public law and authorize the necessary funding to implement the recommendations as soon as possible. We believe that implementation of these recommendations can have a sustained, positive impact on the lives of millions of veterans and enable more efficient and effective use of government resources.

Remove Barriers to Collaboration

MOAA appreciates Report Recommendation 4.4, which would permit prescriptions written by either the VA or DoD to be filled for dually eligible military retired veterans by the other Department's pharmacies.

The PTF Report recommends a strategic approach to medical facilities planning between DoD and the VA and we support this approach. (Recommendations 4.7 and 4.8)

We have some reservations about Report Recommendation 4.3 that proposes the creation of a national (DoD – VA) core formulary. The VA conducts pharmacy operations within its direct care (or, closed) system, whereas the DoD TRICARE pharmacy benefit is delivered through direct (military treatment facilities) care, retail (purchased care) and mail order. As the Report notes, DoD and the VA can realize increased efficiencies and savings through joint purchasing from the federal schedule. It also notes that a joint national formulary "could reduce the number of therapeutic alternatives within a drug class. . ." and reduce adverse events as beneficiaries move between facilities and Departments. It is our view that reducing therapeutic alternatives would lead to lower quality care for all beneficiary groups; and, the interaction of eligible patients with either system is best served by upgrading the information management capabilities of the two Departments as indicated in Recommendation 4.6 of the Report. Therefore, MOAA questions whether a national core formulary would maintain or enhance the quality of care and increase savings.

Address the Mismatch Between VA Demand and Resources

Dr. Gail Wilensky, PTF Co-Chair, emphasized in her testimony before the Committee on 3 June 2003 that improved coordination between VA and DOD could not be fully realized until the gap between demand for care and resources is resolved. We agree.

On March 20, before a joint hearing of the House and Senate Veterans Affairs Committees, MOAA testified that "demand for VA health care continues to exceed the VA's capacity to provide timely, quality services to enrolled veterans. Under the VA's open enrollment program (which was suspended in January this year) 6.5 million veterans were enrolled in VA care (as of September 2002) and nearly five million veterans sought care in the system last year."

The MOAA statement continues: "Last summer [2002], 315,000 veterans were on unacceptably long waiting lists ranging from six-months to one-year for initial or specialty appointments. That number has dropped to about 200,000 veterans on these waiting lists, a considerable improvement. But this issue is not about making the numbers look good. It's about real people, our nation's veterans, who are in many parts of the country still forced to wait long periods for their health care appointments. The demand – resources gap is having an adverse impact on veterans' health because many simply can't get care when they need it. MOAA believes that the VA should be fully funded to meet its own access standards. That means that a veteran should be able to obtain routine care within 30 days. Once the VA has agreed to accept a veteran for care there is an absolute obligation of the government to provide high quality care in a timely manner."

The means to achieve full funding in accordance with VA access standards was a matter of intense discussion and debate in the PTF and among external stakeholders. MOAA believes that the PTF's concept (p. 77) of forming an impartial board of outside experts to identify the funding required to meet the full funding objective is sound and should be adopted.

MOAA supports mandatory funding or modification of the current system to fully fund the care of core mission veterans, those in Priority Groups 1-7. (Recommendation 5.1) More importantly, we urge the Committee and Congress to make an absolute commitment to ensure full funding as soon as possible. Pending the outcome of debate on this issue, MOAA recommends Congress approve a supplemental appropriation to ensure full funding of PG 1-7 veterans for FY 2004.

The Report (pg. 70) points out the current demand-resources mismatch is a product of unrestrained demand from open enrollment and a policy that "omits explicit funding for Priority Groups 7 and 8, in part because VA anticipated that first-and third-party collections would cover a significant part of the cost of care provided to these veterans." But revenues for these groups cover only about 24% of the cost according to the PTF. In building annual budget requests, the projected revenues from third-party collections are incorporated into the budget and that amount is offset, thereby nullifying any net gain from collections. In other words, the VA does not consider lowest priority enrollees for budget purposes until they actually are seen in a VA facility; and, then, when they are counted, the cost of their care is understated by subtracting third party medical insurance collections.

MOAA strongly recommends that if Congress elects to continue the current annual appropriations process, it should require the administration to submit a true estimate of the cost to fully fund the care of core mission veterans in accordance with VA access standards.

Should the Committee and Congress endorse mandatory funding, the panel of outside experts should be used to develop a costing model that will cover future projected costs. The enabling legislation should include authority for a medical board of actuaries to recommend adjustments to the capitation formula to assure it keeps pace with the actual cost of full funding over time. As Chairman Smith suggested at the 3 June hearing, mandatory funding might fall short of the full funding mark if a flawed capitation model were used to calculate the needed resources.

Veterans currently enrolled in the new PG-8 category are grandfathered in the system and the cost of their care should be included in mandatory funding or modification of the existing appropriations process.

The PG-8 category was created just a few short months ago in response to overwhelming demand on the system. In our view, The PTF was not established to parse specific "rules of engagement" on enrollment, but to take the longer view on DoD – VA health care collaboration. We do agree that the situation presented by the uncertain status and funding of PG-8s is unacceptable and we support Recommendation 5.3 that the administration and Congress must resolve this problem.

MOAA was disappointed that the PTF Report did not address the use of Medicare funds in VA facilities for the care of Medicare-eligible veterans with no service connection. We believe that a properly structured Medicare Subvention program would benefit PG 7 and 8 enrollees, the VA health care system and, the government -- potentially, a "win-win-win" situation.

Veterans who have paid into Medicare throughout their working lives should have the option of choosing to receive their Medicare benefits in VA facilities. VA research has shown that the government often pays twice for similar diagnostic tests and procedures performed in Medicare-sponsored facilities and repeated in VA facilities. The theory behind Medicare subvention is that the government could potentially reduce costs if the VA can demonstrate greater efficiency than Medicare providers. The VA plans to implement a Medicare + Choice Plan for PG-8 veterans later this year. Such a program may help relieve funding and access challenges for this cohort.

Conclusion

The Military Officers Association of America appreciates the hard work of the Presidential Task Force to Improve Health Care Delivery for Our Nation's Veterans. The continued support of the Veterans Affairs Committee in partnership with the Armed Services Committee will be pivotal to realizing the far-reaching recommendations in the PTF Report. Thank you for the opportunity to submit testimony on behalf of the members of MOAA.

STATEMENT OF
STEVE ROBERTSON, DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
REPORT OF THE PRESIDENT'S TASK FORCE TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATION'S VETERANS

JUNE 17, 2003

Mr. Chairman and Members of the Committee, The American Legion would like to take this opportunity to publicly thank the Commission Members of the President's Task Force (PTF) for their time, energy, effort, and cooperation throughout this process. I would also be remiss if I failed to applaud the PTF's professional staff for an exceptional performance. From the very first day, the professional staff established an unprecedented working relationship with the entire veterans' community. Although not recognized in the Report's bibliography, attached to this testimony are samples of the material provided to the PTF's professional staff by The American Legion. All material was readily accepted, but closely scrutinized by Commission Members. This included information gathered during a visit with the Indian Health Services in Albuquerque, NM to learn more about their successful billing and collection practices of third-party insurers, to include Medicare and Medicaid. Although Members of the PTF made two separate trips to Albuquerque to visit the New Mexico VA Health Care System and 377th Air Force Medical Group, Kirtland AFB, New Mexico, they never visited the Indian Health Services located just blocks away.

The American Legion continues to work closely with the Department of Veterans Affairs (VA), the Department of Defense (DOD), and Congress towards a mutual goal – meeting the needs of America's veterans and their families. Although this is a shared objective, each seems to have its own "road map" for achieving that vision. Frequently, compromise is reached and life is made just a little better for veterans and their families, but unfortunately there is still rough terrain to traverse to improve health care delivery for the Nation's veterans.

Executive Order 13214's mandates were clear:

- *Identify ways to improve benefits and services for the Department of Veterans Affairs beneficiaries and Department of Defense military retirees who are also eligible for benefits from the Department of Veterans Affairs through better coordination of the activities of the two Departments;*
- *Review barriers and challenges that impede Department of Veterans Affairs and Department of Defense coordination, including budgetary processes, timely billing, cost accounting, information technology, and reimbursement. Identify opportunities to improve such business practices to ensure high-quality and cost-effective health care; and*
- *Identify opportunities for improved resource utilization through partnership between the Department of Veterans Affairs and the Department of Defense to maximize the use of*

resources and infrastructure, including buildings, information technology and data sharing systems, procurement of supplies, equipment and services, and delivery of care.

Clearly, The American Legion embraces these mandates. Long before President Bush created this bold initiative, The American Legion developed an internal task force with a simple mandate – design an integrated health care delivery system to meet the needs of all veterans and their families.

G.I. Bill of Health

Over a decade ago, The American Legion offered its blueprint for VA in the 21st Century called the G.I. Bill of Health. The vision was to create a national integrated veterans' health care network accessible by all veterans and their dependents, including military retirees and their eligible family members. This bold plan called for Congress, beneficiaries, and third-party insurance providers to meet their respective fiscal obligations.

Federal Government Pays Only One Veterans' Health Care Delivery System

The first step called for enrollment of all beneficiaries seeking enrollment in the Veterans Health Administration (VHA). Enrollment would provide the VA Secretary with a quantified and defined patient population. Once enrolled, each beneficiary would identify how his or her health care coverage would be paid. If a beneficiary was eligible for full health care coverage paid for by just the Federal government (Medicare-eligible, 100 percent service-connected disabled veteran or military retiree), Congress would appropriate funds to cover that cost. However, if the beneficiary was eligible for full health care coverage paid by several Federal agencies (a Medicare-eligible, 100 percent service-connected disabled veteran, and a military retiree), Congress would make only one payment; however, the beneficiary would seek health care only within VHA unless referred to the private sector for care. Medicare-eligible veterans choosing this option would be authorized to seek health care only from within VHA medical facilities (Medicare+Choice model).

Third-Party Reimbursements Contribute to the Costs

Those beneficiaries choosing to enroll, with private or public health benefit coverage, would identify their third-party insurance provider and would agree to meet all co-payments and deductibles described by their policy. Should the third-party insurer refuse to make reimbursements to VA for the treatment of nonservice-connected medical conditions, the beneficiary would be denied enrollment.

Uninsured Beneficiaries have Affordable Options

For those beneficiaries choosing to enroll with no health benefit coverage, VA would be authorized to offer affordable health benefit packages to meet their individual health care needs. The Secretary would establish the premiums for each health benefit package and could waiver premiums on a case-by-case basis.

For those beneficiaries identified in title 38, United States Code (USC), for the VA Secretary to provide care, Congress would appropriate funds to cover the cost of the required health benefit coverage necessary, based on their individual health care needs. For those beneficiaries identified by the DOD Secretary to receive care, Congress would appropriate funds to cover the cost of the required health benefit coverage necessary, based on their individual health care needs. For those Medicare-eligible beneficiaries, Congress would appropriate funds to cover the cost of the required health benefit coverage necessary, based on their individual health care needs. All other beneficiaries would be responsible for meeting their health care needs through co-payments, deductibles, premiums, or third-party reimbursements from public or private insurance providers. All revenue streams (Federal appropriations, co-payments, deductibles, premiums, and third-party reimbursements) would go to a Veterans Health Trust Fund, similar to the Social Security and Medicare Trust Funds.

TRICARE

At the time as The American Legion was developing its G.I. Bill of Health, DOD's military health care system was experiencing tremendous problems in meeting its commitment to its beneficiaries, especially its large military retirement community. The cost of providing health care to all of its beneficiaries grew tremendously which forced many of its patients to "game" the system in order to receive timely access to health care.

Shared Cost of Health Care

DOD's solution was the creation of TRICARE – a unique quasi-governmental health care network consisting of the military health care system and private contractors. Under TRICARE, active-duty service members and their eligible beneficiaries receive health care coverage paid for by DOD; however, all other beneficiaries have four health care options to choose from that also require out-of-pocket costs:

- TRICARE Standard (fee-for-service – co-payments and deductibles)
- TRICARE Extra (preferred provider organization – co-payments and deductibles)
- TRICARE Prime (health maintenance organization – enrollment fee and co-payments)
- TRICARE for Life (Medicare+Choice option – must have Part B coverage and stay within the system)

President's Task Force To Improve Health Care Delivery For Our Nation's Veterans

The PTF's challenge was clear from the very beginning. Although VA and DOD are committed to the timely delivery of quality health care, each health care network is truly distinctive in its leadership structure, operational mandates, information technologies, procurement systems, and are equally committed to meeting their unique missions. Nearly all of the witnesses testifying before the PTF from the veterans' community shared the same key message point – maintain each health care delivery system as an independent entity – don't try to consolidate into one Federal health care delivery network. All Commission Members unanimously agreed to the following recommendations, with the exception of **Recommendation 5.3**.

Introduction and Background

Recommendation 1.1: *The interagency leadership committee should, on an annual basis, report to the Secretaries on the status of implementing its collaboration and sharing initiatives and the recommendations in this Final Report, together with any other matters that the committee deems appropriate. Within 60 days after receipt, the Secretaries shall transmit the report, together with any related comments, to the President.*

The American Legion sees merit to this recommendation. Suggested collaboration and sharing initiatives should be formally recognized and monitored for desired results. However, those recommendations not accomplished should also be recognized and monitored to determine the obstacles prohibiting collaboration and sharing initiatives.

The Need for Leadership, Collaboration, and Oversight

Recommendation 2.1: *Congress should amend the fiscal year 2003 National Defense Authorization Act to create a broader charter beyond health care for the interagency leadership committee. Additionally, consideration should be given to using civilian experts as consultants to the committee to bring in new perspectives regarding collaboration and sharing.*

The American Legion strongly agrees with the first part of this recommendation calling for a broader charter. This Committee and the Committee on Armed Services should provide timely oversight to monitor the focused commitment and leadership to achieve effective collaboration and sharing. The American Legion noted greater collaboration and sharing at the joint operations hosted by VA rather than DOD. With current discussion of another round of base closings, there well may be opportunities for collaboration and sharing initiatives, especially if DOD decides to close yet more Military Treatment Facilities (MTFs).

The American Legion **disagrees** with the second part of this recommendation to hire civilian experts as consultants to the committee. Both agencies employ resourceful, professional health care administrators. Given encouragement and motivation by the senior leadership to unleash their creative juices, these current employees will produce positive results.

Recommendation 2.2: *The Departments should consistently utilize a joint strategic planning and budgeting process for collaboration and sharing to institutionalize the development of joint objectives, strategies, and best practices, also with accountability for outcome.*

The American Legion agrees with this recommendation. By placing this requirement in performance standards for each Department's strategic planners and budgeters, this would also demonstrate the commitment of senior leadership. More importantly, successful collaboration and sharing initiatives should be rewarded both publicly and professionally.

Recommendation 2.3: *The Departments should jointly develop metrics (with indicated accountability) that measure health care outcomes related to access, quality, and cost as well as progress toward objectives for collaboration, sharing and desired outcomes. In the annual report recommended in Recommendation 1.1, the interagency leadership committee should include these results and discuss the coming year's goals.*

The American Legion strongly supports this "scorecard" management style. Accountability is key to the successful measure of desired outcomes. Again, senior leadership's focus on collaboration and sharing initiatives will generate attention at every level.

Providing a Seamless Transition to Veteran Status

Recommendation 3.1: *VA and DOD should develop and deploy by fiscal year 2005 electronic medical records that are interoperable, bi-directional, and standards-based.*

The American Legion fully supports this recommendation and recognizes the importance of electronic medical records, especially for veterans with service-connected disabled medical conditions. The electronic medical records should also be accessible for those in the Reserve components. A service member going from active-duty to the National Guard or Reserves should not close one set of medical records and open another set with no connectivity until collected and consolidated by VA.

Having access to a patient's entire medical record is extremely important and helpful to health care professions, especially in large integrated health care systems like VA and DOD. In today's military, a veteran may have several forms of medical records. It is not uncommon for a service member to become a military dependent upon discharge from active duty; however, seldom will the active-duty military medical record be consolidated with the military dependent's medical record, because a military family member is filed under the active-duty service members social security number. This situation is further aggravated if the military family member enlists into the National Guard or Reserves, the military dependent's medical record and prior service medical records are not consolidated with the Reserve component's medical records. Electronic medical records should make consolidation easier.

When a veteran enrolls in VA for health care or files a disability claim, consolidating a veteran's total military medical record is extremely important. The faster this consolidation occurs, the faster quality health care can be provided or a disability claim can be adjudicated.

Recommendation 3.2: *The Administration should direct HHS to declare the two Departments to be a single health care system for purposes of implementing HIPAA regulations.*

The American Legion supports this recommendation.

Recommendation 3.3: *The Departments should implement by fiscal year 2005 a mandatory single separation physical as a prerequisite of promptly completing the military separation process. Upon separation, DOD should transmit an electronic DD214 to VA.*

The American Legion supports a mandatory single separation physical and the transfer of an electronic DD Form 214 to VA. The mandatory single separation physical established an important health care baseline. This is extremely important, especially when dealing with medical conditions that may manifest over a period of time.

The DD Form 214 is the "passkey" to every VA benefit because it establishes eligibility of veteran's status. Providing VA with an electronic version of the DD Form 214 will help ease the transition.

Recommendation 3.4: *VA and DOD should expand the one-stop shopping process to facilitate a more effective seamless transition to veteran status. This process would provide, at a minimum: 1) a standard discharge examination suitable to document conditions that might indicate a compensable condition; 2) full outreach; 3) claimant counseling; and 4) when appropriate, referral for a Compensation and Pension examination and follow-up claims adjudication and rating.*

Clearly, The American Legion and other veterans' and military service organizations can play an important role in this effort. The American Legion and other veterans' service organizations have well-trained service officers around the country to assist veterans, free of charge, in filing disability claims with VA and other claims assistance.

Recommendation 3.5: *VA and DOD should expand their collaboration in order to identify, collect, and maintain the specific data needed by both Departments to recognize, treat, and prevent illness and injury resulting from occupational exposures and hazards experienced while serving in the Armed Forces; and to conduct epidemiological studies to understand the consequences of such events*

The American Legion supports this recommendation. Over the years, The American Legion has lobbied Congress, VA, and DOD on such exposure issues as Agent Orange, radiation, and Gulf War Illness. Each and every time, DOD's and VA's medical record-keeping shortfalls hampered timely access to quality health care and just compensation of service-connected medical disabilities.

Recommendation 3.6: *By fiscal year 2004, VA and DOD should initiate a process for routine sharing of each service member's assignment history, location, occupational exposure, and injuries information.*

The American Legion supports this recommendation and believes this is not a technological, but rather a philosophical barrier. There appears to be a reluctance by DOD to fully cooperate with VA in providing much of this information, because of its sensitivity. The American Legion believes declassified information could be developed to meet this recommendation without compromising classified information. Exact locations can be vague, but the fact a veteran was within an area exposed to high levels of radiation or contamination. This information would provide valuable information to a claims adjudicator without revealing the veteran's exact physical location, mission, or other classified data. With senior leadership's focus and support, this recommendation is achievable.

Recommendation 3.7: *The Departments should: 1) add an ex officio member from VA to the Armed Forces Epidemiological Board and to the DOD Safety and Occupational Health Committee; 2) implement continuous health surveillance and research programs to identify the long-term health consequences of military service in high-risk occupations, settings, or events;*

and 3) jointly issue an annual report on Force Health Protection, and make it available to the public.

The American Legion supports this recommendation.

Removing Barriers to Collaboration

Recommendation 4.1: *The Secretaries of Veterans Affairs and Defense should revise their health care organization structures in order to provide more effective and coordinated management of their individual health care systems, enhance overall health care outcomes, and improve the structural congruence between the two Departments.*

The American Legion agrees with this recommendation. Currently, VA has 21 Veterans Integrated Service Networks (VISNs), while TRICARE consists of three regions. The American Legion suggests VA reevaluate its current decentralized organizational structure and consider reducing the number of VISNs.

In addition, VA should also reevaluate the current Veterans Equitable Resource Allocation (VERA) formula for the distributions of annual appropriations. One area of great concern is the failure to account for all enrolled veterans rather than excluding Priority Groups 7 and 8, even if they are noncompensable, service-connected disabled veterans. If they are enrolled, then they are patients and should be treated as such in the consideration of fiscal distributions.

Another area of concern is ending VERA at the VISN level rather than the facility level. The distribution of resources is formula based to the VERA director – from that point on, it is purely subjective. The American Legion believes that the factors used in determining the VERA allocation to the VISN should also apply to the further distribution to the local medical facility.

Finally, all third-party reimbursements should be retained by the medical facility providing the service, not redistributed to other medical facilities within or outside the VISN.

Recommendation 4.2: *The Secretaries of Veterans Affairs and Defense, based on the recommendations of the interagency leadership committee, should provide significantly enhanced authority, accountability, and incentives to health care managers at the local and regional levels in order to enhance standardized and collaborative activities that improve health care delivery and control costs.*

The American Legion supports this recommendation.

Recommendation 4.3: *VA and DOD should integrate clinical pharmacy initiatives through the coordinated development of: 1) a national joint core formulary; and 2) a single, common clinical data screening tool by fiscal year 2005 that ensures reliable, electronic access to complete pharmaceutical profiles for VA/DOD dual users across both systems.*

The American Legion supports this recommendation and strongly encourages collaboration and sharing initiatives with all 7 VA Consolidated Mail Outpatient Pharmacies (CMOP) sites. In

fact, The American Legion advocates increasing the number of CMOP sites across the Nation should increased demands exceed the current ability to deliver prescriptions in a timely manner.

Recommendation 4.4: *VA and DOD should collaborate on policy and program changes, through local sharing arrangements, which would permit prescriptions written by either VA or MTF providers to be filled for dual users by the other Department's pharmacies.*

The American Legion supports this recommendation and would consider expanding this authority to any Federal health care provider, including Indian Health Services.

Recommendation 4.5: *VA and DOD should work with industry to establish a uniform methodology for medical supplies and equipment identification and standardization and to facilitate additional joint contracting initiatives. VA and DOD should identify opportunities for joint acquisitions in all areas of products and services.*

The American Legion supports this recommendation.

Recommendation 4.6: *The interagency leadership committee should identify those functional areas where the Departments have similar information requirements so that they can work together to reengineer business processes and information technology in order to enhance interoperability and efficiency.*

The American Legion fully advocates this recommendation.

Recommendation 4.7: *VA and DOD should implement facility lifecycles management practices on an enterprise-wide basis. This should be accomplished by aligning business rules, eliminating statutory barriers, and adopting best practices.*

The American Legion supports this recommendation.

Recommendation 4.8: *VA and DOD should declare that joint ventures are integral to the standard operations of both Departments. Through the interagency leadership committee, the Departments should articulate policy requiring that: 1) all major initiatives of each Department be designed and tested for effectiveness and suitability in joint venture sites; 2) lessons learned from successful joint ventures be shared with other joint venture sites and also throughout the health care delivery systems of the two Departments; and 3) all proposed VA and DOD facility construction within a geographic area be evaluated as a potential joint venture.*

The American Legion fully supports this recommendation, especially with renewed talks regarding another round of base closures. Before any future MTF is selected for closure, join venture operations should be explored.

With increased dependence on Reserve components, VA and DOD should evaluate possible collaboration and sharing initiatives for meeting the health care needs of National Guard and Reserve personnel. Serious consideration should also be given to the establishment of more Reserve component billets for health care professionals.

Recommendation 4.9: *VA and DOD should work together to identify and address staffing shortfalls, develop consistent clinical scopes of practices for non-physician providers, and ensure that their provider credentialing systems interface with each other.*

The American Legion supports this recommendation with special emphasis being placed on recruiting, educating, credentialing and hiring recently separated active-duty service members, especially those with service-connected medical disabilities. Both agencies should also consider recruiting, educating, credentialing and hiring members of the National Guard and Reserve. Veterans make great employees because they are certifiably drug-free, possess a good work ethic, understand teamwork, are trainable to standards, and understand the military life style.

Another window-of-opportunity is the recruitment of health care specialists, faced with extremely high malpractice insurance premium, to join VA and DOD professional staff. Many highly qualified health care specialist, especially neurosurgeons, ob-gyns, emergency physicians, orthopedic surgeons, and general surgeons. For an example, the average annual cost of medical-liability premium for a neurosurgeon is approximately $71,200, but in Chicago, it is $283,000 and in Philadelphia, it is $267,000. This represents a 35.6 percent increase from 2001 to 2002.

According to the American Medical Association, seven hospital obstetrics units have closed and six medical centers no longer perform mammographies, just in Florida. In Pennsylvania, over 900 doctors have either closed practices, limited their services, or left the state since 2001. In Nevada, more than 30 ob-gyns have closed their practices. In Tacoma, Washington, have of the ob-gyns won't deliver babies. This medical-malpractice crisis in 18 states (NY, CT, NJ, PA, WV, OH, KY, NC, GA, FL, IL, MO, AR, MS, TX, NV, OR, and WA) offers a unique opportunity for recruit by both VA and DOD for specialists.

Timely Access to Health Services and the Mismatch Between Demand and Funding

The American Legion believes this is the most salient and challenging issue addressed by the PTF. Clearly, The American Legion strongly believes timely access to quality health care is a moral, ethical, and legal obligation of any health care delivery system. Preventive medicine has demonstrated its life-saving benefits, not to mention the economical impact as well.

For years, The American Legion watched the national rationing of VA health care through a complex and complicated maze of rules, regulations, and policies governing who would receive health care in what setting under which conditions. The American Legion advocated a dramatic shift from a hospital-based to a managed-care health care system. Finally, Congress stopped the madness with enactment of the Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104-262). The vision called for opening enrollment in VHA to any eligible veteran seeking access to quality health care, within existing appropriations. The idea was to receive co-payments and third-party reimbursements for the treatment of nonservice-connected medical conditions to help supplement VA's discretionary appropriations. Unfortunately, the largest single identified health insurance program (Medicare) is exempt from reimbursing VA for the treatment of Medicare-eligible veterans' nonservice-connected medical conditions.

Secondly, many private health insurance providers failed to recognize VA as a medical care provider and refused to reimburse VA for treating their policyholders. Others effectively

challenged VA's billing and collection practices, then denied payments. VA's Medical Care Collection Fund (MCCF) had far more excuses than solutions to their billing and collection process. In fact, their collection rate was well below acceptable industry standards. A major contributing factor was VA's inability to collect from Medicare. In order to collect from Medicare supplemental insurance providers, VA had to bill Medicare, as though VA could collect, to reflect the amount due from the supplemental insurers.

Although VA medical care receives discretionary appropriations, those appropriations are offset by the amount of third-party collections Congress determines achievable. VA's billing and collection process has improved dramatically in recent years; however, it will never realize its true potential until it can collect from its largest customer – the Centers for Medicare and Medicaid Services (CMS).

Medicare-eligibility is not a factor in determining eligibility to enroll in either VA, Indian Health Services, or DOD's TRICARE, yet TRICARE providers do receive Medicare reimbursements and DOD serves as the supplemental insurer. Indian Health Services is authorized to bill and collect from CMS for the treatment of both Medicare-eligible and Medicaid-eligible beneficiaries. Both health care systems receive annual discretionary appropriations, just like VA. All three health care systems have eligible criteria that do not mention eligibility in any CMS program.

Recommendation 5.1: *The Federal Government should provide full funding to ensure that enrolled veterans in Priority Groups 1 through 7 are provided the current comprehensive benefit in accordance with VA's established access standards. Full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism, or by some other changes in the process that achieve the desired goal.*

The American Legion fully supports designating VA medical care as mandatory funding. The American Legion defines "full funding" or "guaranteed funding" as mandatory funding. Mandatory funding does not require any modifications to the current budget or appropriations process. The American Legion believes mandatory funding represents the ongoing cost of freedom.

Recommendation 5.2: *VA facilities should be held accountable to meet the VA's access standards for enrolled Priority Groups 1 through 7. In instances where an appointment cannot be offered within the access standards, VA should be required to arrange for care with a non-VA provider, unless the veteran elects to wait for an available appointment within VA.*

The American Legion fully supports this recommendation. The American Legion believes this is VA's moral, ethical, and legal obligation to its beneficiaries. No veteran should ever die, waiting for a medical appointment more than 30 days.

Since the PTF was tasked with "improving health care delivery between VA and DOD," The American Legion would strongly recommend that veterans be referred to TRICARE health care providers rather than non-VA providers as recommended in the **Report of the Congressional Commission on Servicemembers and Veterans Transition Assistance** in 1999, as *Issue III.F – Increase VA use of DOD's TRICARE for Selected VA Medical Services.* Since many VA

enrollees are also TRICARE-eligible, this would enhance collaboration and sharing of scarce resources.

Recommendation 5.3: *The present uncertain access status and funding of Priority Group 8 veterans is unacceptable. Individual veterans have not known from year to year if they will be granted access to VA care. The President and Congress should work together to solve this problem.*

The American Legion adamantly opposes this recommendation and views it as absolutely unconscionable! Veterans are taught to leave nobody behind on the battlefield – The American Legion believes that this same philosophy should be carried into the VA health care system. Veterans are in this together – not as individuals.

Dissenting Commission Members to this recommendation – the only dissent in the entire report – offered suggestions based on allowing Priority Group 8 veterans to enroll and receive timely access to quality VA health care. While Recommendations 5.1 and 5.2 direct Congress to provide adequate funding to cover the cost of health care for Priority Groups 1 through 7, some Commission Members offered an alternative that allows Priority Group 8 veterans choose from one of three health benefits just like TRICARE:

- All enrolled Priority Group 8 veterans would be required to identify their public/private health insurers.

This is similar to an initiative in the President's budget request for FY 2004.

- VA would be authorized as a Medicare provider for Priority Group 8 veterans and be permitted to bill, collect and retain all or some defined portion of third-party reimbursements from CMS for the treatment of non-service-connected medical conditions.

Just like participating private physicians are doing under TRICARE for Life.

- VA should be authorized to offer a premium-based health insurance policy to any enrolled Priority Group 8 veteran with no public/private health insurance.

Just like CMS does for Medicare.

- All enrolled Priority Group 8 veterans would be required to make co-payments for the treatment of non-service connected medical conditions and prescriptions.

Just like they are currently doing.

- All enrolled Priority Group 8 veterans with no public/private health insurance would agree to make co-payments and pay reasonable charges for treatment of non-service connected medical conditions.

Just like in the private sector.

Mr. Chairman and Members of the Committee, the vast majority of the veterans' population falls into Priority Group 8, yet the majority of the PTF voted against providing a substantive recommendation regarding Priority Group 8 veterans' eligibility for VA health care. They even described Priority Group 8 veterans as "*those veterans without compensable service-connected conditions whose incomes are above a geographically-adjusted means test*" as though that makes them different from any other veteran. In reality, the only difference between some Priority Group 7 and Priority Group 8 is their zip code.

A veteran is a veteran. There are Priority Group 1 veterans that never left the shores of the United States, yet there are Priority Group 8 veterans that served in theaters of armed conflicts. How the majority of the PTF Commission could leave so many members of the "Greatest Generation," the "Forgotten War," Vietnam War, the Persian Gulf War, and Bosnia "standing on the doorsteps" of VA without a single recommendation is irresponsible and a tremendous disappointment to the veterans' community.

The recommendations of the dissenting Commission members are fiscally responsible and, if enacted, should be scored as budget neutral. If a private sector health care provider were to treat them for nonservice-connected medical conditions, the Priority Group 8 veterans would be asked to comply with these same guidelines offered in the dissenting remarks, so why should VA hold them to the same requirements for treatment?

By not making any recommendations for Priority Group 8, the PTF sends a message to all Priority Group 8 veterans – to be granted timely access to VA health care -- consider other alternatives to qualify:

- Become financially destitute and qualify as a Priority Group 5 veteran.
- Become catastrophically disabled and qualify as a Priority Group 4 veteran.
- Move to a compatible HUD geographically indexed area and qualify as a Priority Group 7 veteran.

These are veterans of the armed forces being denied enrollment and timely access to quality health care in the VA integrated health care network even if they have a means to pay for their medical treatment. Some how The American Legion does not believe this represents the "thanks of a grateful Nation."

In the military upon successful conclusion of a task, it is customary to say: "Mission complete!" Mr. Chairman and Members of the Committee, although the PTF has published a final report, their mission is incomplete – they left about 20 million veterans behind.

Thank you for the opportunity to participate in this hearing. That concludes my testimony. I welcome any questions.

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STATEMENT OF
STEVE ROBERTSON, DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION
BEFORE THE
PRESIDENTIAL TASK FORCE TO IMPROVE HEALTH CARE DELIVERY TO OUR NATION'S VETERANS
ON
HEALTH CARE DELIVERY TO AMERICA'S VETERANS

JANUARY 15, 2002

Dr. Wilensky and Task Force Members:

The American Legion appreciates the opportunity to provide testimony to this Task Force. The American Legion mourns the death of former Task Force Co-Chair, the Honorable Gerald Solomon. In 1998, The American Legion's National Commander Daniel Ludwig chose Jerry Solomon to receive the Distinguished Public Service Award for his outstanding record of veterans' advocacy. His leadership and genuine concern for his fellow comrades-in-arms will be missed.

On Memorial Day 2001, President Bush established this Federal advisory committee in order to provide prompt and efficient access to consistently high quality health care for veterans. Initially, this Task Force had three major components:

- Identify ways to improve veterans' benefits and services through better coordination of the two departments;
- Review barriers and challenges that impede coordination and identify opportunities to improve business practices to ensure high quality and cost effective health care; and
- Identify opportunities for improved resource utilization between VA and DoD to maximize the use of resources.

The American Legion fully supports this initiative and welcomes the opportunity to assist you and your colleagues. This testimony will present the recommendations of the nation's largest veterans' service organization consisting solely of wartime veterans. The most common bond of Legionnaires is honorable military service during a period of armed conflict – they all answered the nation's call to arms. Legionnaires are included in the patient population in one or both of these Federal health care delivery systems.

In evaluating these health care delivery systems, one must first focus on the distinctive mission of each:

- The military medical departments support combat forces in both war and peacetime.
- The veterans' health care system serves the medical needs of America's veterans, especially those with service-connected disabilities.

The Military Health System (MHS) fully integrates its global medical readiness mission with its beneficiary obligations to military families – active-duty and retired. Three branches of the armed forces (Army, Navy and Air Force) must coordinate health care services with the for-profit regional TRICARE health care contractors. TRICARE offers MHS beneficiaries three health benefit options: fee-for-service, preferred providers, or health maintenance organizations. TRICARE consists of co-payments, deductibles, and premiums.

The Veterans Health Administration (VHA) provides specialized care, primary care, and related medical and social support services for eligible veterans. In addition, VHA serves as the Nation's largest trainer of health care professionals. VHA continues as a national research asset in all scientific disciplines. Finally, VHA is the contingency back-up to the MHS and, during national emergencies, supports the National Disaster Medical System.

Both independent integrated health care delivery systems continue to provide this nation with quality health care. With soaring costs in the health care industry, both VHA and MHS offer taxpayers the very best value for each health care dollar appropriated. The delivery of quality health care remains the top priority in both health care systems. Within VHA and MHS, health care decisions are based on the needs of each patient in the most appropriate setting.

The American Legion adamantly supports retaining the integrity of the two separate integrated health care delivery systems dedicated to their primary missions.

Both VHA and MHS have patient populations eligible for access to health care on a priority basis. In some cases, access is at no cost to the patient. For other patients, there are associated costs. However, we must never forget: access in each system is an earned benefit resulting from honorable military service. Although specialized care continues to be among the most expensive services, the medical conditions requiring such care are normally the most serious and debilitating. VHA's impressive list of specialized services includes blind rehabilitation, prosthetics services, long-term care, spinal cord injury care, Post Traumatic Stress Disorder care, and Readjustment Counseling just to name a few. Most of these services are unavailable through MHS. Specialized care treatment is generally labor intensive and extremely expensive. When faced with reducing expenditures, specialized services are tempting targets for budget-cutters. However, contracting for equitable quality of care in the private sector would be far more expensive.

The American Legion strongly recommends maintaining access for all beneficiaries, especially for specialized services, in both systems.

In meeting their obligations to America's veterans, both VHA and MHS have explored joint ventures with measured success. Clearly, there are barriers – some are tangible, but most appear more philosophical or cultural. Strong management at the local level can readily identify tangible barriers and offer creative solutions, but overcoming philosophical or cultural barriers will require focused leadership. Faced with the prospects of yet another round of the Base Realignment and Closure (BRAC) recommendations, DoD stands to lose additional military health facilities from its inventory. Since the first BRAC, DoD has lost over 50 percent of its military hospitals. VA is currently undergoing its own version of BRAC, the Capital Asset

Realignment for Enhanced Services (CARES). Each Department would be well advised to remain vigilant for the opportunity to enter into joint ventures. Neither downsizing program seems to give serious consideration to the adverse impact on the health care delivery of the veterans' community as a whole.

The American Legion advocates developing additional joint ventures where physically possible.

Most successful sharing agreements between VHA and MHS have been reached, at the local level, due to budgetary necessity. The key elements are quality communication and coordinated strategic planning. The principal objective is delivery of quality health care rather than pride of ownership. Maximum utilization of available Federal resources should be an element in annual individual performance evaluations. Positive reinforcement should be awarded for stellar performance. Again, with the real prospect of another BRAC, coupled with impending CARES recommendations, both Departments should seek sharing agreements to maximize available health services for their patient populations. American Legion representatives have visited several joint venture campuses and strongly encourages the Task Force to visit these locations in the near future. Each joint venture has its own strengths and weaknesses, but their ultimate goal is the same – delivery of quality health care to beneficiaries.

The American Legion continues to fully support maximizing utilization of sharing agreements between all regional VA and DoD health care providers.

One obvious common physical barrier between VA and DoD is the information technology communication gap. The information technology disconnect between Departments severely restricts seamless transmission of critical information. Current technology exists to establish and maintain electronic medical records capable of storing all data collected in a Federal health care facility. In theory, this technology could store the entire medical history of a patient receiving health care in any Federal health care facility on the back of an identification card. For instance, a military dependent born in a DoD health facility is raised as a military dependent until enlisting, serves in the military for over twenty years, retires, and eventually dies. Today's technology would allow that veteran's health care record to be posted on the back of his or her DoD or VA identification card and updated nearly instantaneously. Such information technology would help expedite VA's claims and adjudication process by making military medical records immediately available to provide documentation of service-connected injuries or medical conditions. Electronic medical records would also enhance the federalization and global deployment of National Guard personnel and Reservists.

The American Legion supports improving information technology to include electronic medical records.

Another information technology function commonly found throughout the health care industry is the billing and collection of third-party reimbursements. Yet, this fundamental process between VHA and DoD, especially its for-profit health care contractors – TRICARE is extremely problematic. Electronic billing and collection are routine transactions between health care providers and health insurance payers. VHA's inability to properly bill and collect from third-

party insurers continues to lag well behind the Federal discretionary budgetary expectations. This severe revenue shortfall adversely impacts on VHA's health care delivery capabilities and limits the cooperative opportunities for TRICARE's subcontracting options as well.

The American Legion recommends either providing enhanced information technology and training to improve VHA's billing and collection capabilities or purchasing this service from the private sector.

Currently, VHA is directed to bill and collect third-party reimbursements for the treatment and services provided to all veterans for nonservice-connected medical conditions. In VHA, the enrollment of Priority Group 7 veterans is contingent on their ability to pay for treatment and services received. However, if the Priority Group 7 veteran is Medicare-eligible, VHA is not authorized to bill Centers for Medicare and Medicaid Services (CMS) for the treatment of nonservice-connected medical conditions, even if the condition is normally covered by Medicare. The veteran is required to pay the co-payment. Any other third-party insurance coverage, including the Medicare supplemental insurer, will also be billed. Therefore, in essence, VHA subsidizes CMS.

The annual VA medical care discretionary appropriations are offset by the projected collections from such third-party insurers, yet no funding credit is awarded for the treatment of enrolled Priority Group 7, Medicare-eligible veterans treated for nonservice-connected conditions. In a joint venture facility, under the new TRICARE for Life provision, this creates internal billing problems for Medicare-eligible military retirees referred to VHA by TRICARE providers. Under the conditions of TRICARE for Life, the enrolled Medicare-eligible patient must purchase the Part B supplemental coverage. TRICARE subcontractor must bill Medicare, then the Medigap insurer, and finally DoD for any remaining charges. If VHA is a subcontractor for TRICARE and cannot bill Medicare, DoD has a disincentive to send Medicare-eligible patients to VHA facilities because of the additional cost to DoD. Access to VA and DoD health care is an earned benefit based on honorable military service – not age. Medicare coverage is based on a totally difference set of criteria. Both Medicare options (fee-for-service and Medicare+Choice) could be effectively administrated within VHA. Using Medicare's own performance standards for the treatment of certain health care conditions, VHA has repeatedly exceeded Medicare's expectations.

The American Legion adamantly supports allowing VHA Medicare subvention for all enrolled Priority Group 7 Medicare-eligible veterans and TRICARE for Life veterans being treated for nonservice-connected conditions.

Another opportunity for closer VA and DoD cooperation is joint purchasing ventures for pharmaceuticals, medical supplies, and equipment. Utilizing economy of scales would enhance the buying power of scarce Federal discretionary dollars. This initiative, coupled with joint ventures and sharing agreements, would enhance coordinated purchases of expensive equipment and help reduce incidents of excess regional purchases. Service-connected disabled veterans, active-duty military personnel, and military retirees deserve the best quality health care possible, to include medications, state-of-the-art medical equipment, and medical supplies.

The American Legion recommends VA and DoD continue participating in joint purchasing ventures for pharmaceuticals, medical supplies, and equipment.

VHA's reputation in medical and prosthetics research is world-renowned. VHA is also recognized as the largest trainer of health care professionals. This creates a logical opportunity for closer cooperation and coordination between VA and DoD to result in a win-win scenario. Through its affiliation with medical schools and academic medical centers, as well as other research institutions, VHA continues as a major national research asset. VHA conducts basic clinical, epidemiological and behavioral studies across the entire spectrum of scientific disciplines. In recent studies, VHA's patient safety procedures have received national recognition for excellence. In terms of nuclear, chemical, and biological warfare, MHS remains the nation's leading expert in casualty care. Both systems would benefit from shared expertise and best practices in these and other areas.

The American Legion advocates expanding joint medical education and training, as well as joint research and development opportunities.

The events of September 11, 2001 emphasize the national need for improved emergency preparedness for combat and civilian casualties. A major VHA mission is to serve as a contingency back-up for DoD medical services and support the National Disaster Medical System. Clearly, close cooperation between VHA and DoD on a daily basis, greatly enhances the knowledge of and confidence in the capabilities of each Department. Such insight would greatly enhance planning and coordination of national emergency response in support of Homeland Security. VHA's responses to the Twin Trade Towers and Pentagon attacks were instantaneous, but unfortunately, unilateral. If VHA were working in closer harmony with DoD's Total Force (active-duty and Reserve components) in planning, training, and execution of emergency preparedness, it would significantly improve aspects of national security.

The American Legion strongly recommends improving relations between VA and DoD in Homeland Security emergency preparedness.

Members of the Task Force, the following is a summary of The American Legion's recommendations. Each proposal addresses an independent component to improve veterans' benefits and services; opportunities to improve business practices; or improve resource utilization between two independent health care delivery systems designed to meet the health care needs of the true defenders of democracy – past, present, and future veterans:

- ✓ retain the integrity of the two separate integrated health care delivery systems dedicated to their primary missions;
- ✓ maintain access for all beneficiaries, especially for specialized services, in both systems;
- ✓ develop additional joint ventures, where physically possible;
- ✓ maximize utilization of sharing agreements between all regional VA and DoD health care providers;
- ✓ improve information technology to include electronic medical records;
- ✓ provide enhanced information technology and training to improve VHA's billing and collection capabilities or purchase this service from the private sector;

- ✓ allow VHA Medicare subvention for all enrolled Priority Group 7 Medicare-eligible veterans and TRICARE for Life veterans being treated for nonservice-connected conditions;
- ✓ participate in joint purchasing ventures for pharmaceuticals, medical supplies, and equipment;
- ✓ expand joint medical education and training, as well as joint research and development opportunities; and
- ✓ improve relations between VA and DoD in Homeland Security emergency preparedness.

Quality, accessible health care is a critical element of national security. In today's society, competition for the recruitment and retention of a military force second to none depends on an attractive quality of life not only for the service member, but also for his or her family. Many times, it is a young man or woman who is recruited, but a family that reenlists. Forward deployed soldiers, sailors, airmen, and Marines should not have to worry about whether or not the health care needs of their loved ones are being met back home. Service-connected disabled veterans must never have to wonder if their unique health care services will be available. Military retirees should not have to be concerned whether or not they and their eligible dependents will have access to quality health care. This is the ongoing cost of freedom. And it should be provide as the thanks of a grateful nation.

Third-Party Reimbursement Within
The Department of Veterans Affairs (VA)

When Congress calculates the fiscal year discretionary funding for VA medical care, a portion of that annual appropriations is dependent on collections from veterans in the form of first-party and third-party reimbursements. To date, the collection goal has never exceeded $1 billion.

Initally, VA was tasked for Medical Care Cost Recovery (MCCR) to collect reimbursements for the U.S. Treasury. The annual collections were minimal:

- FY 1994 VA collected $95 million;
- FY 1995 VA collected $103.7 million;
- FY 1996 VA collected $124.6 million;
- FY 1997 VA collected $107 million;
- FY 1998 VA collected $11.5 million; and
- FY 1999 VA collected $600 thousand.

Public Law 105-33, the Balanced Budget Act of 1997, established VA's Medical Care Collection Fund (MCCF) and requires that amounts collected or recovered after June 30, 1997, be deposited in this fund:

- FY 1998 VA collected $560.1 million, but the goal was $700 million;
- FY 1999 VA collected $637.5 million, but the goal was $637 million;
- FY 2000 VA collected $749.1 million, but the goal was $762 million; and
- FY 2001 VA collected $770.8 million, but the goal was $926 million.

This law also extended to September 30, 2002, the following Omnibus Budget Reconciliation Act provisions:

(1) authority to recover co-payments for outpatient medications, nursing home and health care;
(2) authority for certain income verification; and
(3) authority to recover third-party insurance payments from service-connected veterans for nonservice-connected conditions.

Whatever collection shortfalls occur, VA must absorb the loss.

Under the President's budget request, MCCF becomes even more complicated. MCCF now has a third-party collections goal ($529 million) and a first-party collection goal ($554.9 million) that totals $1.1 billion.

Plus an Extended Care Revolving Fund collection goal of $40 million. The Veterans Millennium Health Care and Benefits Act (P.L. 106-117) created this fund to collect per diems and co-pays from certain patients receiving extended care services.

Plus a Health Services Improvement Fund (HSIF) collection goal of $365 million. P.L. 106-117 also created this fund to collect pharmacy co-pays ($364 million), enhanced use-lease ($1 million), and VA's agreement with DoD for the proposed treatment of eligible military retirees (whatever that means, but no specific collection goal set in current budget).

White Paper on DoD's Medicare Subvention Demonstration Project

When DoD initially established TRICARE, Medicare-eligible, Military Health Services' (MHS) beneficiaries were prohibited from enrolling in TRICARE. Their only access to MHS health care was on a space available basis in MHS' medical treatment facilities (MTF).

About 1.5 million retired military personnel, dependents and survivors are Medicare-eligible. About 600,000 of these beneficiaries resided within 40 miles of a MTF. Due to the Base Realignment and Closure Commission (BRAC), DoD lost nearly 50 percent of its MTF, thus reducing space-available care.

Congress sought to improve health care delivery for Medicare-eligible MHS beneficiaries. DoD's Medicare Subvention Demonstration Project, established by the Balanced Budget Act of 1997 (BBA), was designed to test an alternative means of providing health care coverage through cooperation between DoD and the former Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (CMS).

The demonstration project allowed retirees to enroll in a DoD-run Medicare+Choice option called TRICARE Senior Prime at six demonstration sites. Senior Prime offered enrollees the full range of Medicare covered services, as well as additional TRICARE services -- with minimal co-payments. TRICARE Senior Prime gave enrollees improved access standards to MTF care. The demonstration authorized DoD to receive payment from Medicare if MTFs continued to spend as much on retirees as they had in the past -- thus establishing a unique requirement – meeting the "level of effort" or "maintenance of effort" before receiving any reimbursements from HCFA.

The demonstration began in 1998 and was originally authorized for a 3-year period. Subvention was expected to be beneficial for Medicare because, under the BBA, Medicare would pay DoD a discounted reimbursement rate – a fixed monthly payment for enrollees that would be less than that paid to private plans serving other Medicare beneficiaries.

During the demonstration period, new legislation altered the manner in which Medicare-eligible MHS beneficiaries would receive health care coverage from DoD. Under a provision of the Floyd D. Spence Authorization Act for FY 2001 (NDAA), Medicare-eligible MHS beneficiaries became eligible for enrollment in TRICARE for Life coverage as of October 1, 2001. This NDAA also extended Senior Prime for one-year through December 2001, although, DoD decided not to extend Senior Prime beyond this latter date due to the establishment of the TRICARE for Life program.

All MHS beneficiaries can obtain free prescriptions from MTFs, initially Medicare-eligible beneficiaries could not use TRICARE's National Mail Order Pharmacy or network of certain pharmacies. However, effective April 1, 2001, this policy was changed giving all MHS beneficiaries access to all three options: MTF, TRICARE National Mail Order Pharmacy, and certain pharmacy networks.

TRICARE Senior Prime required all enrollees to purchase their Medicare Part B coverage. An additional requirement to be eligible for enrollment in the TRICARE Senior Prime

demonstration, all beneficiaries must have used military care since becoming Medicare-eligible on a space-available basis. Although some 125,000 MHS beneficiaries were eligible for the demonstration, DoD limited enrollment to just 28,000 patients. TRICARE Prime enrollees were authorized to "age into" the Senior Prime Demonstration upon reaching 65 which eventually brought the total of demonstration participants to over 33,000.

TRICARE Senior Prime offered enrollees the full range of Medicare-covered services, as well as additional TRICARE services -- most notably prescription drugs. The demonstration gave higher priority of care for participating beneficiaries at MTFs than for other nonparticipating retirees. Only Medicare Part B was paid without any additional premiums. Care at MTFs was free of charge, but enrollees had to pay an applicable cost-sharing amount when MTFs referred them to certain networks for care. All primary care was provided by MTFs, but DoD purchased some hospital and specialty care from civilian networks for services not available at MTFs.

The six major demonstration sites were at Colorado Springs, CO; Dover, DE; Keesler AFB, MS; Madigan Army Hospital, WA; San Antonio, TX and San Diego, CA. A total of 10 MTF/Community Hospitals participated in the demonstration. Six of the ten MTFs reached their maximum enrollment and established waiting lists. The Balance Budget Amendment established rules for Medicare to follow in reimbursing DoD for TRICARE Senior Prime. It authorized Medicare to pay DoD similar to the way it pays similar civilian Medicare + Choice plans, with several major exceptions:

- TRICARE Senior Prime's reimbursement rate – a fixed monthly payment for each enrollee – differed in several ways from that received by civilian health care providers. TRICARE Senior Prime's reimbursement rate:
  1. Set at 95 percent of the rate that Medicare would pay Medicare + Choice plans, consistent with the belief that DoD could provide care at lower cost than the private sector.
  2. Further adjusted by excluding a percentage of the reimbursement rate for graduate medical education (GME).
  3. Further adjusted by excluding a percentage of the reimbursement rate for disproportionate share hospital payments (DSH).
  4. Further adjusted by excluding a percentage of the reimbursement rate for capital costs.
- TRICARE Senior Prime's reimbursement rate could be further adjusted, if there was "compelling" evidence that enrollees were healthier or sicker than their Medicare fee-for-service counterparts. The adjustment was intended to reflect whether TRICARE Senior Prime enrollees would be expected to be significantly more or less costly than the average Medicare beneficiary. HCFA and DoD agreed that if the difference between the adjusted and unadjusted payments equaled or exceeded 2.5 percent, then that would be compelling evidence that enrollees' health status differed from that of their nonmilitary Medicare counterparts. In that case, the Medicare payment would effect the adjustment.
- The BBA required that, before DoD could receive Medicare payments, participating MTFs must spend as much on care for Medicare-eligible beneficiaries as they did prior to the demonstration. This amount (termed DoD's "level of effort") was intended to prevent the Federal government from paying twice for the same care.
- The total amount that Medicare could pay DoD for the demonstration was capped at $50 million in 1998, $60 million in 1999, and $65 million in 2000.

In 1999, TRICARE Senior Prime cost DoD more than HCFA. This mostly resulted from beneficiaries' heavy use of medical services, including prescription drugs -- which did not qualify for Medicare coverage or reimbursements. TRICARE Senior Prime enrollees were not sicker than comparable Medicare beneficiaries, although they made heavy use of MTF services. Compared to similar Medicare fee-for-service beneficiaries, TRICARE Senior Prime enrollees were hospitalized 41 percent more often and had 58 percent more outpatient visits.

The BBA payment rules resulted in no Medicare payment to DoD in 1999. DoD monthly costs were $596 per person. Medicare would have paid DoD less than the reimbursement rate of $320 per person, because Medicare capped enrollees' payment at $60 million in 1999 – an amount that only averaged $196 per month for each enrollee. Although DoD could have charged enrollees a premium for TRICARE Senior Prime, as any Medicare+Choice organization can, DoD chose not to. Even if DoD had been paid the full Medicare+Choice rate, the monthly difference would still have been over $200 per person.

The demonstration illustrated retirees' interest in the quality and convenience of MTF care, as well as by the program's low cost sharing. Many military retirees, who had not enrolled in TRICARE Senior Prime, reported that they were satisfied with their existing health care options.

TRICARE Senior Prime also illustrated the tensions between MHS' commitment to care for active-duty personnel and its commitment to provide care to active duty family members and military retirees. TRICARE Senior Prime illustrated how seniors contributed to military medical readiness, but providing care to military retirees and family members could also interfere with an MTF's efforts to meet its military mission.

As TRICARE Senior Prime enrollment climbed, the amount of space-available care provided to nonenrolled seniors decreased. DoD funding purchased care centrally, thereby, reducing the sites' incentive to trim unnecessary network utilization. Enrollees paid no annual deductible and co-payments paid to network providers were minimal.

Data-related difficulties, such as segregating costs for groups of services, were pervasive and persistent.

The high costs generated by enrollees' care revealed the need to deliver and document care more effectively. Difficulties encountered in obtaining and managing data during the demonstration underscored problems that DoD generally faced in monitoring patient care and costs.

While TRICARE Senior Prime showed that DoD's health care coverage was attractive and satisfied military retirees, it also highlighted the following challenges that DoD encountered in doing so:

- The unique "level of effort" requirement placed on DoD appeared unreasonable. Military beneficiaries are eligible for DoD health care because of their military service, not their Medicare-eligibility. Many Medicare-eligible retirees in TRICARE Senior Prime used MTFs on a space-available basis before the demonstration project. Before DoD could receive Medicare payments, participating MTFs had to spend as much money on care for

non-TRICARE enrolled patients as they had before the demonstration. How was that space-available number and cost determined?

- Medicare is a Federally mandated, prepaid health insurance program. Beneficiaries are authorized to go to qualified health care providers of their choice. Not all beneficiaries are entitled to choose a Federal health care provider.
- CMS receives mandatory funding to cover the cost of allowable health care provided to all entitled beneficiaries. DoD receives limited discretionary funding for treating MHS-eligible beneficiaries.
- TRICARE Senior Prime was doomed to failure before it was implemented.

It is unclear as to why DoD did not choose to use another Federal health care provider as a model in delivering quality health care to Medicare-eligible beneficiaries. Since 1976, Indian Health Services (IHS) had the authority to bill HCFA (now CMS) for the treatment of their Medicare-eligible beneficiaries. The successful efforts of IHS in billing, collecting, and reinvesting third-party reimbursements has resulted in improve health care delivery to it patient population. In addition to billing private health insurance providers, IHS successfully bills Medicare and Medicaid. Like TRICARE Senior Prime, IHS does negotiate its reimbursement rate with CMS, but unlike TRICARE Senior Prime had no "level of effort" or "maintenance of effort" requirement.

Should VA attempt to seek Medicare reimbursements for the treatment of nonservice-connected medical conditions, the successful IHS model would appear to be the most logical approach.

White Paper on the Medical Care Collections Fund (MCCF)

Public Law 105-33, The Balanced Budget Act of 1997, established the Department of Veterans Affairs (VA) Medical Care Collections Fund (MCCF) and requires that amounts collected or recovered after June 30, 1997, be deposited in this fund. The MCCF is a depository for third-party insurance, outpatient prescription co-payments and other related medical collections and user fees. The funds collected and deposited into the MCCF may be used only for providing VA medical care and services during any fiscal year and for VA expenses for identification, billing, auditing, legal and collection of amounts owed the government.

All funds collected through MCCF are used as an offset rather than as a supplement to appropriations for the medical care budget. The American Legion adamantly opposes offsetting annual VA discretionary funding by the MCCF recovery.

Public Law 105-33 also granted VA the authority to begin billing reasonable charges. Reasonable charges are based on amounts that third parties pay for the same services furnished by private sector health care providers in the same geographic area rather than cost-based per diems.

Billing and collections is the final component of a process that includes patient registration, insurance identification and verification, documentation of care provided, inpatient and outpatient coding of care received, utilization review, and billing and accounts receivable. Although VA has automated much of the billing and collections process, their third party collections remain notoriously inefficient. While the amount recovered continues to increase to an estimated $1.4 billion in FY 2005, it is not a result of efficiencies in the process but rather, a result of being able to bill reasonable charges.

Aside from the inefficiencies of the billing and collections process, VA's method of distribution for these funds is rather unfair. Veterans Integrated Services Networks (VISNs) who are successful in collecting reimbursements often times are penalized for their success by having the funds they collected redirected to a poorer performing VISN.

Indian Health Service (IHS) has been very successful in billing and collecting third party reimbursements.

Key factors in the success of IHS' billing and collections are:

- The initial investment in training people, and there was a learning curve in the business process, where there is a deliberate billing process that requires attention and detail.
- Everybody in the process understands their role.
- Using only certified coders in the billing process. Pay grade of certified coders should be more comparable to the private sector for recruitment and retention purposes.

If the VA were to emulate some of these best practices, most notably the use of certified coders, their process would be much more efficient. By increasing the amount of collections, VISNs would have more funds to recycle back into the system for the care and treatment of veterans. Improvements in the efficiencies of billing and collecting third party insurers coupled with an adequate budget **not** offset by these increased collections will ensure VA's ability to provide quality health care well into the 21st Century.

White Paper on Medicare Reimbursement

Medicare is a Federal health insurance program. Nearly every person is mandated to make monthly contributions to Medicare throughout his or her working career. Employees must pay 1.45 percent of taxable wages. The employer must match that amount, yet unlike Social Security, there is no cap. Therefore, the majority of beneficiaries make significant monetary contributions to Medicare before becoming eligible for coverage. The more money made by an individual, the higher the combined payment to Medicare. Medicare is a pyramid-based funding scheme – spreading out the risk among its ***potential*** beneficiaries and those who are actually receiving coverage. Medicare is considered an entitlement; therefore, receives Federal mandatory appropriations.

Generally, any person is eligible for Medicare if:

- that person or their spouse worked for at least 10 years in a Medicare-covered employment,
- that person is 65 years of age or older, and
- that person is a citizen or permanent resident of the United States.

Others may qualify for coverage if:

- they are under age 65 with severe disabilities, or
- are diagnosed with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two basic components:

- Part A (Hospital Insurance) – basic coverage provided for allowable health care services.
- Part B (Medical Insurance) – additional coverage available on a premium basis for additional health care services.
- Supplemental Coverage – available through private insurance providers on a premium basis for charges not covered by Part A and Part B coverage.

Medicare offers certain choices to include:

- The original Medicare program, or
- Medicare+Choice including Medicare Managed Care Plans and Medicare Private Fee-for-Service Plans.

The Veterans Health Administration (VHA) is the largest Federal integrated health care delivery system. Eligibility for enrollment in VHA is based on honorable military service and limited by existing appropriations. Currently, there are 24 million veterans. Nearly 7 million are currently enrolled in VHA, but thousands of additional veterans are waiting to enroll. Currently, access to care is determined on a priority basis. Priority Group 1 has the highest priority to care, while Priority Group 7 has the lowest priority to care. Each Priority Group is clearly defined in Title 38, United States Code (USC).

Although access to VHA is an earned benefit, it is not considered an entitlement; therefore, funding is dependent upon annual discretionary appropriations. Title 38, USC, identifies which veterans shall receive care at no personal cost. VHA is authorized to bill, collect, and retain all co-payments and third-party reimbursements. Medicare is one of the Federal health insurance

programs VHA is prohibited from billing or collecting third-party reimbursements. There is no explanation or justification for this prohibition in Title 38, USC.

The Department of Veterans Affairs (VA) submits its annual budgetary needs to the Office of Management and Budget (OMB). There is no structure formula for justifying this budget recommendation. After reviewing VA budget request and comparing it with the overall Presidential budget request, OMB returns to VA OMB's budget recommendation. This is commonly referred to as the "passback" budget. At this point, VA can appeal OMB's recommendations. Once the President's budget request is finalized, the final budget recommendation is VA's official request. In this budget, mandatory and discretionary funding is clearly identified. Mandatory funding is prominently found in the Veterans Benefit Administration (VBA) to pay for disability compensation, pension, and other entitlements. No mandatory funding appears in any VHA appropriations.

After Congress finalizes the budget process, VA has a structured formula for the internal distribution of its annual discretionary appropriations called the Veterans Equitable Resource Allocation (VERA). This formula is based on specific components that determine exactly how much money will go to each of the 21 Veterans Integrated System Networks (VISN). The number of Medicare-eligible or Priority Group 7 veterans in the patient population is not a component in determining distribution. The components are based on:

- Number of veterans requiring basic care (vested and non-vested);
- Number of veterans requiring complex care;
- Geographic Price Adjustment;
- Research Support;
- Education Support;
- Equipment Support; and
- Nonrecurring Maintenance.

As a Medicare provider, VHA would be authorized to bill and collect allowable third-party reimbursements from the Medicare Trust Fund for the treatment of nonservice-connected medical conditions of enrolled Medicare-eligible veterans. There are logical reasons to justify Medicare reimbursements:

- Centers for Medicare and Medicaid Services (CMS) determine Medicare-eligibility.
- All Medicare-eligible beneficiaries are free to choose their health care providers.
- Only military service determines eligibility for enrollment in VHA – Medicare-eligibility is not a factor.
- VHA is mandated by law to bill and collect third-party reimbursements for the treatment of nonservice-connected medical conditions of enrolled veterans, except from Federal health insurance programs like Medicare.
- VHA is an integrated health care delivery system providing a full continuum of health care services and treatments.
- Indian Health Services (IHS) has successfully demonstrated how Medicare reimbursements can be successfully accomplished to improve the quality of care to beneficiaries.
- VHA does not receive adequate annual Federal discretionary appropriations to meet the health care needs of its growing patient population.

- Congressional oversight of CMS and VHA greatly reduces opportunities for fraud, waste, or abuse in billing or treatment of Medicare-eligible beneficiaries.
- The number of veterans enrolled in VHA is contingent upon existing appropriations, co-payments and third-party reimbursements.

The Medicare Trust Fund is funded to make reimbursements for quality health care delivered to beneficiaries by qualified Medicare providers. VHA, like IHS, provides quality health care to a unique patient population by using a combination of funding sources: discretionary appropriations and third-party reimbursements.

White Paper on Premium-Based Health Benefit Coverage

The American Legion continues to support allowing the Department of Veterans Affairs (VA) to offer premium-based health benefit coverage for eligible and enrolled VA beneficiaries. VA would offer four premium-based health benefit packages:

- Basic care;
- Comprehensive care;
- Medicare supplemental; and
- Specialized services.

Upon enrollment, veterans could choose the health benefit package or packages that best meets their individual health care needs. The Secretary for VA would establish premiums, deductibles, co-payments, and coinsurance charges. All premiums, deductibles, co-payments, and coinsurance charges would be paid directly to VA and retained at the assigned medical facility.

Basic care would include the following care and services:

- Hospital services, including mental health.
- Services of health care professionals.
- Women's health care services.
- Medical and surgical services.
- Outpatient services.
- 24-hour emergency services.
- Preventive health care services.
- Diagnostic services.

Comprehensive care would include the central elements of basic care, plus:

- Pediatric services.
- Hospice care.
- Home health care.
- Extended care services.
- Authorized transportation services.
- Durable medical equipment.
- Outpatient prescription drugs and biologicals.
- Investigational devices and treatments.
- Routine vision testing and eye care services.

Medicare Supplemental would cover those services not covered by Medicare Part A and Part B, but would only be recognized within VA.

Specialized Services would include:

- Prosthetic and orthotic services.
- Blind rehabilitation services.
- Services necessary for the rehabilitation of veterans with spinal cord dysfunction.
- Treatment for chronic psychiatric illnesses.
- Long-term care services.

White Paper on the Capital Asset Realignment for Enhanced Services (CARES)

VA's Capital Asset Realignment for Enhanced Service - CARES - is a national process to reorganize VA through a data driven assessment of veterans' health care needs. Through CARES, VA will evaluate the health services it provides, and identify possible changes that will help meet veterans current and future health care needs. Once these changes are identified, VA will develop proposals to "realign" its capital assets (buildings and land) to meet those needs.

An initial CARES pilot study (Phase I) was conducted in VISN 12 using a contractor to develop an assessment of veterans' health care needs and recommendations for improving service delivery. After one year of data collection, interviews and analysis, several questionable recommendations were made creating tremendous concern within the veterans' community. VA should involve the stakeholders-veterans-in the decision making process of CARES.

In the recently begun Phase II, the National CARES Program Office (NCPO), located in VA Headquarters, Washington, DC, is charged with managing and coordinating the CARES program. NCPO will review all collected data to determine which issues must be resolved within specific "health care markets." These issues become "planning initiatives" to be resolved at the local level. The solutions become the components of individual Network Market Plans, which form the National CARES Plan.

To ensure objectivity in the National CARES process, the Secretary of Veterans Affairs will appoint a CARES Commission, consisting of nine non-VA members. The Commission will review the National CARES Plan before making recommendations to the Secretary. The Commission is scheduled to hold hearings to allow stakeholders an opportunity to comment on the recommendations outlined in the study. The process will culminate with the Secretary's announcement of a final National CARES Plan, anticipated in late 2003.

The limited time frame for completion of the CARES process (attached) increases the need for true stakeholder involvement. It is important that veterans become involved in the CARES process in their local VISN for it will shape the future of the VA health care system.

The CARES initiative must occur in the context of a fully utilized VA health care system. It must take into consideration VA's role in emergency preparedness, organizational capacity for "special emphasis programs" like mental health, and Homeland Security.

Veterans must be informed and involved in the CARES process every step of the way. Veterans must be involved at the local, VISN and national levels to ensure that VHA's planning is responsive to their needs.

Veterans Equitable Resource Allocation (VERA)

Since April 1997, the Veterans Equitable Resource Allocation (VERA) has been the model used to allocate VA's medical care budget appropriated by Congress each fiscal year, to the now 21 Veterans Integrated Services Network (VISNs) that comprise the Veterans Health Administration (VHA). VERA was developed in response to Public Law 104-204, which was a mandate from Congress to improve the way VHA allocated resources across the entire VA health care system.

This mandate stemmed from years of documented, widespread disparity among the regions of the country with regard to historical budgets and the consumption of resources per veteran treated. Thus, VERA was created to address the problems and shortfalls of the other resource allocation systems that VA had implemented but had ultimately failed.

VERA allocates resources primarily on the basis of the number and types of patients within a network's patient workload. It attempts to adjust network resources for factors beyond the control of network management, such as health care needs of veterans and the geographical cost of living. By design, VERA has shifted substantial resources among regions to better reflect workload.

For example, in FY 2001, VISNs that saw the biggest increases were nearly all located in the south and southwest. That year, approximately $921 million was shifted among VISNs. VERA allocated $198 million to VISN 8 (Bay Pines), the most in VHA, and shifted the most resources out of VISN 3, (Bronx), which amounted to nearly $322 million. Moreover, 10 VISNs saw a smaller piece of VA's medical care appropriation in FY 2001 than in FY 1996, the year before VERA was implemented.

Of note is the fact that the VERA model excludes the "Priority Group 7" veteran workload in determining each VISN's allocation. Priority Group 7 veterans represent the largest segment of growth of new enrollees. In FY 00-FY 01, there was a 53 percent increase in the number of Priority Group 7 veterans. Also, the VERA model considers too few categories to accurately adjust for patient health care needs when deciding patient cost differences among networks.

Additionally, while much of the focus has been on VERA's allocation of resources from headquarters to VISNs, veterans would like to see an in depth examination of how each VISN in turn allocates comparable resources for comparable workloads to their medical facilities and programs. There is variance across VISNs in how resources are distributed locally and a review of this may prove beneficial.

Finally, there is concern about the process for providing supplemental resources to VISNs through VA's National Reserve Fund (NRF). Currently there is no study to analyze the effectiveness of the NRF or its impact on VERA's allocation, VISN inefficiency, or other factors. Currently, VA uses NRF as a financial *safety net* to bail out VISNs that cannot operate within their allocated budget – clearly, a subliminal message.

Veterans would like to see greater accountability at the VISN and local VA Medical Centers for budgetary responsibility.

White Paper on VA Disability Compensation and Workers' Compensation

VA disability compensation is payable to veterans who, during their period of active military service, suffered a work-related or nonwork-related injury or illness or who had a pre-service disability that became aggravated during this period. The injury or illness cannot have been due to willful misconduct. Compensation is based on the current severity of the service-connected disability or disabilities and is described in increments of 10% to 100%. The dollar amount for each percentage level is set by law and annually adjusted for the cost-of-living. VA disability compensation is not taxable and is not affected by the veteran's income from any other source.

Entitlement to service connection requires: 1) medical evidence of a current condition; 2) evidence of an injury or disease in service; 3) a medical opinion linking the experience in service to the current condition; 4) the disability cannot have been due to willful misconduct. Once service connected, the veteran is eligible for free VA medical care for that disability and can reopen the claim for an increased rating at any time the disability becomes worse. VA would then normally schedule an examination to reevaluate the condition(s) and a new rating prepared. Veterans should be cautious in reopening their claims, since a reevaluation can result in an increase, no change, or possibly a reduction rather than an increase in their compensation.

Workers' compensation is payable by the Department of Labor's Office of Workers' Compensation Programs, to non-military, Federal employees who suffer a work-related injury. Under workers' compensation, a disabled Federal employee is paid two-thirds of his or her normal monthly salary based on evidence of continuing disability. This program also covers medical expenses due to the disability and may require the employee to undergo job retraining. Certain benefits may be paid for permanent disability.

Eligibility for workers' compensation requires that the injury must have been sustained while in the performance of the employee's duties.

Current Situation

Who: Opened to all enrolled veterans and eligible CHAMPVA beneficiaries, within existing appropriations.

What: Basic care.
Complex care.

Where: In any VA medical facility or VA contracted facility.

When: Within VA's acceptable access standards; however, regionally these acceptable access standards are not being met as demand for services is well beyond VA's capability to deliver based on limited funding.

Basic Assumption

VA health care system was established to meet the health care needs of the eligible veterans' population.

Eligibility for enrollment is based solely on military service.

Far more veterans are enrolled in VA health care system than ever before for various reasons:

1. Quality of health care.
2. Cost of private health care.
3. Aging veterans' population.
4. VA's prescription drug program
   A. free for service-connected medical conditions
   B. a modest co-pay for nonservice-connected medical conditions.
5. VA's shift in focus from inpatient-care to outpatient-care.
6. VA's long-term care.
7. TRICARE.

VA's medical and prosthetics research continues to receive national recognition.

VA's patient safety record is among the best in the nation.

Funding Formula

VA's medical care funding is primarily based on annual discretionary appropriations, subject to supplemental appropriations, if appropriate.

VA is authorized to bill, collect, and reinvest copayments and third-party reimbursements; however, VA is prohibited from billing the nation's largest health insurance program, the Centers for Medicare and Medicaid Services (CMS).

Certain enrolled veterans are expected to make copayments for the treatment of and medications for nonservice-connected medical conditions.

VA is authorized to generate additional revenue through use-lease agreements.

Impact on Other Federal Health Programs

Medicare – about half of all enrolled veterans are also eligible for Medicare benefits. Medicare-eligibility is not a criteria for enrollment in the VA health care system. Since Medicare is a prepaid, Federal health care insurance program, no money from the Medicare mandatory appropriations is transferred to the VA medical care budget for the treatment of nonservice-connected medical conditions of Medicare-eligible beneficiaries. Therefore; every Medicare-eligible beneficiary treated by VA saves CMS mandatory appropriations. Nearly 3,000,000 Medicare-eligible veterans are currently enrolled in VA thus subsidizing CMS approximately $11,000,000,000 annually.

Medicaid – VA is prohibited from billing states for treatment of Medicaid-eligible veterans. VA's health care is far more comprehensive than that available through most state programs, thus subsidizing state Medicaid funding.

Federal Employees Health Benefit (FEHB) Program – as costs of health care coverage increases in the private sector, more veterans eligible for FEHB program seek VA as their primary health care provider.

TRICARE – all military retirees are eligible to enroll in both VA and TRICARE. Many (about 600,000) military retirees are service-connected disabled and entitled to VA health care at no cost, as opposed to the copayments and premiums required under TRICARE. VA offers specialized care not available under TRICARE or TRICARE for Life.

Indian Health Services – Native American veterans with health care needs beyond the capabilities of their local communities may find VA available to fill any gaps in coverage.

VA FY 2002 ENROLLMENT

Priority Group	Enrollees	Medicare Eligible	Cost per Enrollee	Expenditure
1	558,600	203,500	$8,100	$4,900,000,000
2	407,800	144,000	$3,750	$1,500,000,000
3	827,600	293,900	$2,800	$2,300,000,000
4	175,200	103,500	$16,000	$3,200,000,000
5	2,330,600	1,090,500	$3,800	$9,300,000,000
6	124,600	21,400	$1,000	$100,000,000
7	1,950,800	1,102,300	$1,370	$2,600,000,000
Totals	**6,375,200**	**2,959,200**	**Average cost $3,700**	**$23,900,000,000**
CHAMPVA	175,000		$1,371	$240,000,000

Full Mandatory Funding Model

Who: Opened to all enrolled veterans and eligible CHAMPVA beneficiaries.

What: Basic care.
Complex care.

Where: In any VA medical facility or VA contracted facility.

When: Within VA's acceptable access standards.

Basic Assumption

This model would replace annual discretionary appropriations with annual mandatory appropriations (direct spending) for VA's Medical Care account.

The quality of health care, prescription drug benefit program, and long-term care benefit would attract Medicare and Medicaid-eligible veterans and would result in significant savings to both CMS and states.

Funding Formula

This model would establish an annual funding formula for VA's Medical Care account.

Each fiscal year budget authority would be equal to the inflated per capita amount multiplied by the number of enrolled veterans to receive care for VHA as of July 1 of the previous fiscal year.

The per capita amount would be derived by dividing the fiscal year's budget authority by the number of enrolled veterans as of July 1 which is then inflated at the medical inflation rate published by BLS.

VA would continue health care copayments, pharmacy copayments, and third-party reimbursement policies, as appropriate.

Using VA's FY 2002 data, this model would require approximately **$46,000,000,000** for full coverage of all Priority Groups 1-8 without seeking any reimbursements from CMS.

Impact on Other Federal Health Programs

Medicare – about half of all enrolled veterans are also eligible for Medicare benefits. Medicare-eligibility is not a criteria for enrollment in the VA health care system. Since Medicare is a prepaid, Federal health care insurance program, no money from the Medicare mandatory appropriations is transferred to the VA medical care budget for the treatment of nonservice-connected medical conditions of Medicare-eligible beneficiaries. Therefore; every Medicare-eligible beneficiary treated by VA saves CMS mandatory

appropriations. Nearly 3,000,000 Medicare-eligible veterans are currently enrolled in VA thus subsidizing CMS approximately $11,000,000,000 annually.

Medicaid – VA would be especially attractive to Medicaid-eligible veterans, especially those veterans receiving VA pensions. These veterans lose a greater portion of their VA pension if they live in a Medicaid-approved nursing home, than those living in a VA-sponsored nursing home.

Federal Employees Health Benefit (FEHB) Program – as costs of health care coverage increases in the private sector, more veterans eligible for FEHB program may seek VA as their primary health care provider.

TRICARE – all military retirees are eligible to enroll in both VA and TRICARE. Many (about 600,000) military retirees are service-connected disabled and entitled to VA health care at no cost, as opposed to the copayments and premiums required under TRICARE. VA offers specialized care not available under TRICARE or TRICARE for Life.

Indian Health Services – Native American veterans with health care needs beyond the capabilities of their local communities may find VA available to fill any gaps in coverage.

VA Medical Care FY Appropriations Under This Model

Enrollees	Users	Revenue Source
7,000,000 Veterans	4,000,000 Veterans	Mandatory Appropriations, Copayments, and Third-Party Reimbursements (Priority Groups 1-8)
175,000 CHAMPVA		Mandatory Appropriations

Modified Version of Mandatory Funding

Who: Opened to all enrolled veterans and eligible CHAMPVA beneficiaries.

What: Basic care.
Complex care.

Where: In any VA medical facility or VA contracted facility.

When: Within VA's acceptable access standards.

Basic Assumption

Title 38, United States Code, clearly distinguishes those veterans that the VA Secretary "should" (Priority Groups 1-6) and "may" (Priority Groups 7-8) provide health care.

Consideration should be given to providing annual mandatory appropriations (direct spending) to cover the health care costs associated with enrolled veterans in Priority Groups 1-6.

Annual discretionary appropriations, copayments, and third-party reimbursements would still apply.

Funding Formula

This approach would provide VA with a balanced blend of annual discretionary appropriations, direct spending, copayments and third-party reimbursements.

VA would recommend to CBO the appropriate per capita rates based on the cost of care for enrolled veterans entitled to **basic care** and **complex care**.

CHAMPVA beneficiaries should be included in the direct spending calculations.

Other Federal Health Programs

Medicare reimbursement would be based on the fee-for-service basis for treatment and services for nonservice-connected medical conditions for enrolled Medicare-eligible veterans.

No Medicaid reimbursements would be pursued from the states.

Veterans enrolled in the Federal Employees Health Benefit (FEHB) Program are welcomed to enrolled in VA; however, will be subject to all of the applicable copayments.

All TRICARE-eligible veterans are also welcomed to enroll in VA; however, they will be subject to all of the applicable copayments.

All Native American veterans are welcomed to enroll; however, they will be subject to all of the applicable copayments.

VA FY 2002 ENROLLMENT

Priority Group	Enrollees	Medicare Eligible	Cost per Enrollee	Expenditure
1	558,600	203,500	$8,100	$4,900,000,000
2	407,800	144,000	$3,750	$1,500,000,000
3	827,600	293,900	$2,800	$2,300,000,000
4	175,200	103,500	$16,000	$3,200,000,000
5	2,330,600	1,090,500	$3,800	$9,300,000,000
6	124,600	21,400	$1,000	$100,000,000
7	1,950,800	1,102,300	$1,370	$2,600,000,000
Totals	**6,375,200**	**2,959,200**	**Average cost $3,700**	**$23,900,000,000**
CHAMPVA	175,000		$1,371	$240,000,000

VA Medical Care FY Appropriations Under This Modified Plan

Enrollees	Users	Revenue Source
5,000,000 Veterans	3,300,000 Veterans	Mandatory Appropriations
2,000,000 Veterans	1,100,000 Veterans	Discretionary Appropriations, Copayments, and Third-Party Reimbursements
175,000 CHAMPVA	175,000 CHAMPVA	Mandatory Appropriations

Modified Version of Mandatory Funding with Medicare

Who: Opened to all enrolled veterans and eligible CHAMPVA beneficiaries.

What: Basic care.
Complex care.

Where: In any VA medical facility or VA contracted facility.

When: Within VA's acceptable access standards.

Basic Assumption

Title 38, United States Code, clearly distinguishes those veterans that the VA Secretary "shall" (Priority Groups 1-6) and "may" (Priority Groups 7-8) provide health care.

Consideration should be given to providing annual mandatory appropriations (direct spending) to cover the health care costs associated with enrolled veterans in Priority Groups 1-6.

VA would collect Medicare reimbursements from priority groups 7-8.

Annual discretionary appropriations, copayments, and other third-party reimbursements would still apply.

Funding Formula

This approach would provide VA with a combination of annual discretionary appropriations, direct spending, copayments and third-party reimbursements to include Medicare.

VA would recommend to CBO the appropriate per capita rates based on the cost of care for enrolled veterans entitled to **basic care** and **complex care**.

CHAMPVA beneficiaries should be included in the direct spending calculations.

Using VA's FY 2002 data, this model would require approximately **$37,200,000,000** ($34,400,000,000 for basic care and $2,800,000,000 for complex care) without seeking any reimbursements from CMS for Priority Groups 1-6.

Using VA's FY 2002 data, this model would collect approximately $1,500,000,000 in Medicare reimbursements for treatment of priority groups 7-8.

Impact on Other Federal Health Programs

Medicare – about half of all enrolled veterans are also eligible for Medicare benefits. Medicare-eligibility is not a criteria for enrollment in the VA health care system. Since Medicare is a prepaid, Federal health care insurance program, no money from the Medicare mandatory appropriations is transferred to the VA medical care budget for the treatment of nonservice-connected medical conditions of Medicare-eligible beneficiaries. Nearly 1,100,000 Medicare-eligible veterans are currently enrolled in priority groups 7-8.

No Medicaid reimbursements would be pursued from the states.

Veterans enrolled in the Federal Employees Health Benefit (FEHB) Program are welcomed to enrolled in VA; however, will be subject to all of the applicable copayments.

All TRICARE-eligible veterans are also welcomed to enroll in VA; however, they will be subject to all of the applicable copayments.

All Native American veterans are welcomed to enroll; however, they will be subject to all of the applicable copayments.

VA Medical Care FY Appropriations Under This Modified Model with Medicare

Priority Group	Mandatory	Copayments	Medicare	Reimbursements
1-6	$37,200,000	0	0	0
7-8	0	TBD	$1,500,000	TBD
Totals	$37,200,000	TBD	$1,500,000	TBD
CHAMPVA	$650,000	0	0	0

Consolidated Funding Model

Who: Opened to all veterans and eligible dependents.

Entitled to Care: All Priority Group 1 veterans – enrolled or not enrolled
All enrolled CHAMPVA eligible dependents
All Priority Group 2 veterans* -- enrolled or not enrolled
All enrolled Priority Group 3 veterans *
All enrolled Priority Group 4 veterans *
All enrolled Priority Group 5 veterans *
All enrolled Priority Group 6 veterans *

Eligible for Care: All enrolled Priority Group 7 veterans * #
All enrolled Priority Group 8 veterans * #

* Enrolled veteran must identify any third-party insurers (public and private sector) for billing of treatment for nonservice-connected medical conditions.

\# Enrolled veteran must pay copayment for treatment of nonservice-connected medical conditions.

What: Basic health benefit package:

- At no cost for Priority Group 4
- Medicare Part A plus copayments
- TRICARE
- $840 per year plus copayments

Comprehensive health benefit package:

- At no cost for Priority Group 1 and CHAMPVA beneficiaries
- Medicare Part A, Part B, and Supplemental Coverage plus copayments
- TRICARE for Life plus copayments
- $960 per year plus copayments

Specialized Services benefit package:

- At no cost for Priority Group 1 and CHAMPVA beneficiaries
- At no cost for any veteran whose service-connected medical condition requires the specialized care
- $1200 per year plus copayments

Where: In any VA medical facility or VA contracted facility.

When: Within VA's acceptable access standards.

Basic Assumptions

VA would be authorized to bill and collect from the Centers for Medicare and Medicaid Services for the treatment of enrolled, Medicare-eligible veterans' nonservice-connected medical conditions. (***Requires Legislation***)

VA would be authorized to offer, on a premium-basis, health benefit package to veterans with no health care coverage. (***Requires Legislation***)

VA medical care appropriations would be mandatory rather than discretionary for Priority Groups 1-6 per capitated rates, based on VA's estimated cost of care for each group. (***Requires Legislation***)

During enrollment, all beneficiaries will identify how their health care costs will be covered -- by either public or private health insurance. (***Requires Legislation***)

TRICARE reimbursements for treatment in VA medical facilities. (***Requires contractual agreements between VA and TRICARE contractors***)

Funding Formula

This model would provide VA with a balanced blend of annual mandatory appropriations, discretionary appropriations, premiums, copayments and third-party reimbursements.

VA would recommend to CBO the appropriate per capita rates based on the cost of care for enrolled veterans entitled to **basic care**, **comprehensive care**, and **specialized care**.

CHAMPVA beneficiaries should be included in the direct spending calculations.

Using VA's FY 2002 data, this model would require approximately **$13,700,000,000**. VA would collect approximately **$8,900,000,000** from CMS for the treatment of nonservice-connected medical condition from enrolled Medicare-eligible veterans. The balance of VA medical care funding would come from premiums, copayments, and third-party reimbursements from Priority Groups 2-8.

Impact on Other Federal Health Programs

Medicare – about half of all enrolled veterans are also eligible for Medicare benefits. Medicare-eligibility is not a criteria for enrollment in the VA health care system. Under this model, CMS would reimburse VA for treatment of nonservice-connected medical conditions of Medicare-eligible veterans, except those in Priority Group 1. CMS should realize cost savings due to a managed-care approach to health care and a significant reduction in fraud, waste, and abuse.

No Medicaid reimbursements would be pursued from the states.

Veterans enrolled in the Federal Employees Health Benefit (FEHB) Program are welcomed to enrolled in VA; however, will be subject to all of the applicable copayments.

All TRICARE-eligible veterans are also welcomed to enroll in VA; however, they will be subject to all of the applicable copayments.

All Native American veterans are welcomed to enroll; however, they will be subject to all of the applicable copayments.

VA Medical Care FY Appropriations Under This Model

Priority Group	Enrollees	Revenue Source
1	600,000	Mandatory Appropriations ($8,100 Cost per Enrollee)
2	420,000	Mandatory Appropriations, Medicare Reimbursements, and Third-Party Reimbursements ($3,750 Cost per Enrollee)
3	840,000	Mandatory Appropriations, Medicare Reimbursements, and Third-Party Reimbursements ($2,800 Cost per Enrollee)
4	185,000	Mandatory Appropriations, Medicare Reimbursements, and Third-Party Reimbursements ($16,000 Cost per Enrollee)
5	2,300,000	Mandatory Appropriations, Medicare Reimbursements, and Third-Party Reimbursements ($3,800 Cost per Enrollee)
6	125,000	Mandatory Appropriations, Medicare Reimbursements, and Third-Party Reimbursements ($1,000 Cost per Enrollee)
7	1,500,000	Medicare Reimbursements, Copayments, Premiums, and Third-Party Reimbursements
8	500,000	Medicare Reimbursements, Copayments, Premiums, and Third-Party Reimbursements
Totals	6,450,000	Mandatory Appropriations, Medicare Reimbursements, Copayments, Premiums, and Third-Party Reimbursements
CHAMPVA	175,000	Mandatory Appropriations ($3,700 Avg Cost per Enrollee)

FY VA Appropriations

(dollar in thousands)

Priority Group	Mandatory	Copayments	Premiums	Medicare	Reimbursements
1	$4,900,000	0	0	0	0
2	$1,000,000	0	TBD	$550,000	TBD
3	$1,500,000	0	TBD	$1,000,000	TBD
4	$1,200,000	0	TBD	$1,700,000	TBD
5	$4,700,000	TBD	TBD	$4,100,000	TBD
6	$100,000	0	TBD	$21,000	TBD
7		TBD	TBD	$800,000	TBD
8		TBD	TBD	$700,000	TBD
Totals	$13,400,000	TBD	TBD	$8,900,000	TBD
CHAMPVA	$650,000	0	0		TBD

Recommendations

Who: Opened to all enrolled veterans and eligible CHAMPVA beneficiaries.

What: Basic care.
Complex care.

Where: In any VA medical facility or VA contracted facility.

When: Within VA's acceptable access standards.

Basic Assumption

Title 38, United States Code, clearly distinguishes those veterans that the VA Secretary "shall" (Priority Groups 1-6) and "may" (Priority Groups 7-8) provide health care.

Veterans seeking quality health care are willing to pay for timely access to quality health care from any health care provider.

Currently, VA's total annual budget consists of a variety of funding streams: **direct spending** (comp and pen), **discretionary** (medical care), **copayments** (medical and pharmacy), **premiums** (insurance), **fees** (indemnity fees and use-lease agreements), and **third-party reimbursements** (medical care).

To meet the growing demand for health care services, VA's medical care budget must also seek multiple funding sources.

Funding Formula

The Consolidated Funding Model is a logical, business-like approach to correct the current Demand/Resources mismatch.

Under the Consolidated Funding Model, VA is meeting its moral and ethical obligations to Priority Groups 1-6 and affording all other veterans access to a full continuum of quality health care at an affordable price.

This Consolidated Funding Model requires veterans to spend their personal health care dollars (public and private insurance plans) within their own health care system.

Impact on Other Federal Health Programs

Medicare is a prepaid, Federally mandated health insurance program – not a health care delivery system. Medicare-eligible veterans still have the option to vote with their feet. Until Medicare offers an affordable prescription program, VA will continue to attract more Medicare beneficiaries. Long-term care is another VA health care service attracting Medicare-eligible veterans. Currently, Medicare has several options, such as, fee-for-

service and Medicare+Choice – VA health care should be another earned benefit for America's veterans.

Medicaid is a Federal assistance program administered by each state -- not a health care delivery system. Medicaid-eligible veterans receiving VA health care have access to a full continuum of quality health care to include many expensive specialized services. No Medicaid reimbursements would be pursued from the states.

Veterans enrolled in the Federal Employees Health Benefit (FEHB) Program are welcomed to enroll in VA; however, will be subject to all of the applicable copayments.

All TRICARE-eligible veterans are also welcomed to enroll in VA; however, they will be subject to all of the applicable copayments.

All Native American veterans are welcomed to enroll; however, they will be subject to all of the applicable copayments.

VA health care remains a national resource.

MANDATORY FUNDING FOR VA MEDICAL CARE

Presentation to
President's Task Force
to
Improve Health Care Delivery for
Our Nation's Veterans

December 11, 2002

Current Situation

WHO: Opened to all enrolled veterans and eligible CHAMPVA beneficiaries, within existing appropriations

WHAT: Basic Care - Routine health care needs
Complex Care - Chronic health care needs

WHERE: In any VA medical facility or contracted facility.

WHEN: Within VA's acceptable access standards; demand for services is well beyond VA's capability to deliver.

Basic Assumptions

- VA health care system was established to meet the health care needs of eligible veterans
- Eligibility for enrollment is based solely on military service
- Far more veterans are now enrolled in VA health care system than in the past
- VA's patient safety record is among the best in the nation

Funding Formula

- VA's medical care funding is primarily based on discretionary appropriations
- VA is authorized to collect third-party reimbursements; **Medicare is the exception**
- Some veterans make co-payments
- VA creates revenue through use-lease agreements

Impact on Other Federal Health Programs

- Medicare: nearly 3,000,000 Medicare-eligible veterans are currently enrolled in VA
- Medicaid: VA is prohibited from billing states for treatment of Medicaid-eligible veterans
- FEHBP: More veterans eligible for FEHBP seek health care at VA
- TRICARE: Approximately 600,000 service-connected disabled military retirees are entitled to VA health care
- Indian Health Services: VA may provide access to specialized care unavailable through IHS

Full Mandatory Funding Proposal

WHO: Opened to all enrolled veterans and eligible CHAMPVA beneficiaries, within existing appropriations

WHAT: Basic Care - Routine health care needs
Complex Care - Chronic health care needs

WHERE: In any VA medical facility or contracted facility

WHEN: Within VA's acceptable access standards; current demand for services is well beyond VA's capability to deliver

Basic Assumptions

- This proposal would replace annual discretionary appropriations with mandatory appropriations for VA's medical care account.

- The quality of health care, prescription drug benefit program, and long-term care benefit would result in savings to CMS and states.

Funding Formula

- Would establish an annual funding formula for VA's medical care account

- Budget authority would equal the inflated per capita amount multiplied by the number of enrolled veterans to receive VHA as of July 1 of the previous year

- Collection of health care co-payments, pharmacy co-payments and third-party reimbursements would continue

Impact on Other Federal Health Programs

- Medicare: nearly 3,000,000 Medicare-eligible veterans are currently enrolled in VHA
- Medicaid: Medicaid-eligible veterans lose more of their VA pension living in a Medicaid-approved nursing home than living in a VA-sponsored nursing home
- FEHBP: As health care costs increase, more FEHBP-eligible veterans may seek VA as their primary provider
- TRICARE: Approximately 600,000 military retirees are entitled to VHA at minimal or no cost, as opposed to the co-payments and premiums under TRICARE

Modified Mandatory Funding Proposal

WHO: Opened to all enrolled veterans and eligible CHAMPVA beneficiaries, within existing appropriations

WHAT: Basic Care - Routine health care needs
Complex Care - Chronic health care needs

WHERE: In any VA medical facility or contracted facility

WHEN: Within VA's acceptable access standards; current demand for services is well beyond VA's capability to deliver

Basic Assumptions

- Title 38, U.S.C clearly distinguishes those veterans that the VA Secretary "shall" (1-6) or "may" (7-8) provide health care
- Formula-based direct spending should be provided VHA to cover health care costs for Priority Groups 1-6
- Discretionary appropriations, co-payments and reimbursements would also apply to Priority Groups 7-8

Funding Formula

- Provide VHA with discretionary funding, direct spending, co-payments and third-party reimbursements
- VHA recommends to OMB per capita rates based on the cost of care for enrolled veterans entitled to basic care and complex care
- CHAMPVA beneficiaries should be included in the direct spending calculations

Impact on Other Federal Health Programs

- **Medicare**-eligible veterans may enroll in VHA -- nearly 3 million are currently enrolled
- **Medicaid**-eligible veterans may enroll in VHA
- **FEHBP**-eligible veterans may enroll in VHA
- **TRICARE**-eligible veterans may enroll in VHA
- **IHS**-eligible beneficiaries may enroll in VHA

Modified Mandatory Funding Proposal with Medicare

WHO: Opened to all enrolled veterans and eligible CHAMPVA beneficiaries, within existing appropriations

WHAT: Basic Care - Routine health care needs
Complex Care - Chronic health care needs

WHERE: In any VA medical facility or contracted facility

WHEN: Within VA's acceptable access standards; current demand for services is well beyond VA's capability to deliver

Basic Assumptions

- Title 38, U.S.C clearly distinguishes those veterans that the VA Secretary "shall" (1-6) and "may" (7-8) provide health care
- Mandatory appropriations would be provided to cover health care costs for Priority Groups 1-6
- VHA would bill CMS for treatment of nonservice-connected medical conditions of Priority Groups 7-8
- Discretionary appropriations, co-payments, and third-party reimbursements would serve as revenue streams

Funding Formula

- VHA funding would consist of direct spending, discretionary funding, copayments, and third-party reimbursements from public and private health insurance sources (***requires legislation***)
- VHA recommends to OMB per capita rates based on the cost of care for veterans entitled to basic care and complex care
- CHAMPVA beneficiaries should be included in the direct spending calculations

Impact on Other Federal Health Programs

- **Medicare**-eligible veterans may enroll in VHA -- Approximately 1,100,000 of these veterans are currently enrolled in Priority Groups 7-8
- **Medicaid**-eligible veterans may enroll in VHA
- **FEHBP**-eligible veterans may enroll in VHA
- **TRICARE**-eligible veterans may enroll in VHA
- **IHS**-eligible veterans may enroll in VA

Consolidated Funding Proposal

WHO: Opened to all veterans and eligible dependents

Entitled to Care: All Priority Group 1 veterans - enrolled or not

All enrolled CHAMPVA eligible dependents

All Priority Group 2 veterans - enrolled or not

Consolidated Funding Proposal

Entitled to Care: All enrolled Priority Group 3
All enrolled Priority Group 4
All enrolled Priority Group 5
All enrolled Priority Group 6

Enrolled veterans must identify any third-party insurers for billing of treatment for non-service connected medical conditions

Consolidated Funding Proposal

Eligible for Care: All enrolled Priority Group 7
All enrolled Priority Group 8

Enrolled veterans must identify any third-party insurers for billing of treatment for non-service connected medical conditions

Enrolled veterans must pay co-payments for treatment of non-service connected medical conditions

Consolidated Funding Proposal

WHAT: VHA would offer three health benefit packages to meet the needs of enrolled veterans on a premium basis

BASIC HEALTH BENEFIT PACKAGE:

- No cost to Priority Group 4
- Medicare Part A plus co-payments
- TRICARE

Consolidated Funding Proposal

WHAT:

COMPREHENSIVE HEALTH BENEFIT PACKAGE:

- No cost to Priority Group 1 and CHAMPVA beneficiaries
- Medicare Part A, Part B and supplemental coverage plus co-payments
- TRICARE for life plus co-payments

Consolidated Funding Proposal

WHAT:

SPECIALIZED SERVICES BENEFIT PACKAGE:

- No cost to Priority Group 1 and CHAMPVA beneficiaries
- No cost for specialized care of service-connected medical conditions

WHERE: In any VA medical facility or contracted facility

WHEN: Within VA's acceptable access standards

Basic Assumptions

- VA would bill and collect from CMS for treatment of Medicare-eligible veterans' non service-connected medical conditions ***(requires legislation)***
- VA would offer premium-based health care benefit packages ***(requires legislation)***
- Upon enrollment, beneficiaries identify health insurance - either public or private ***(requires legislation)***

Basic Assumptions

- VA medical care would be mandatory for groups 1-6 per capitated rates, based on VA's estimated cost of care ***(requires legislation)***

- TRICARE reimbursements for treatment in VA medical facilities ***(requires contractual agreement between VA and TRICARE contractors)***

Funding Formula

- Would provide mandatory, discretionary, premiums, co-payments and third-party reimbursements
- VA would recommend to OMB the appropriate per capita rates for enrolled veterans entitled to basic care, comprehensive care, and specialized care
- VA would recommend to OMB the appropriate per capita rates for enrolled veterans entitled to basic care, and complex care
- CHAMPVA beneficiaries should be included in the direct spending calculations

Impact on Other Federal Health Programs

- Medicare: CMS would reimburse VA for treatment of non service-connected medical conditions except priority group 1.
- Medicaid: No Medicaid reimbursements sought
- FEHBP: Veterans eligible for FEHBP may enroll in VA under applicable co-payments
- TRICARE: All TRICARE-eligible veterans may enroll in VA under applicable co-payments
- IHS: All IHS eligible beneficiaries may enroll in VA under applicable co-payments

Recommendations

WHO: Opened to all enrolled veterans and eligible CHAMPVA beneficiaries, within existing appropriations

WHAT: Basic Care - Routine health care needs
Complex Care - Chronic health care needs

WHERE: In any VA medical facility or contracted facility

WHEN: Within VA's acceptable access standards; current demand for services is well beyond VA's capability to deliver

Basic Assumptions

- Title 38, U.S.C., clearly distinguishes those veterans that the VA Secretary "shall" (priority group 1-6) and "may" (priority group 7-8) provide health care
- Veterans are willing to pay for timely access to quality health care from any health care provider
- VA's budget consists of: direct spending, discretionary, co-payments, premiums, fees and third-party reimbursements
- To meet the growing demand for health care, VA's medical care budget must use multiple funding sources

Funding Formula

- The Consolidated Funding Proposal is a logical, business-like approach to correct the current Demand/Resources mismatch
- Under the Consolidated Funding Proposal, VA is meeting its moral and ethical obligations to priority group 1-6 and affording all other veterans access to a full continuum of quality care at an affordable price
- This proposal allows veterans to spend their personal health care dollars (public and private insurance plans) within their own health care system

Impact on Other Federal Health Programs

- Until Medicare offers an affordable prescription program, VA will continue to attract more Medicare beneficiaries. Currently, Medicare has several options, such as, fee-for-service and Medicare+Choice - VA health care should be another earned benefit for America's veterans

Impact on Other Federal Health Programs

- Medicaid is a Federal assistance program administered by each state -- not a health care delivery system. Medicaid-eligible veterans receiving VA health care have access to a full continuum of quality health care to include many expensive specialized services. No Medicaid reimbursements would be pursued from states

Impact on Other Federal Health Programs

- Veterans enrolled in FEHBP are eligible to enroll in VA; however, they will be subject to all of the applicable co-payments
- All TRICARE-eligible veterans are eligible to enroll in VA; however, they will be subject to all of the applicable co-payments.
- All Native American Veterans are eligible to enroll in VA; however, they will be subject to all of the applicable co-payments

STATEMENT OF
JOSEPH A. VIOLANTE
NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
JUNE 17, 2003

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to present the views of the Disabled American Veterans (DAV) on the final report of the President's Task Force To Improve Health Care Delivery For Our Nation's Veterans (Task Force or PTF).

As an organization of more than one million service-connected disabled veterans, DAV is concerned about the government's commitment to meet the health care needs of sick and disabled veterans through access to timely top quality medical care.

The Task Force was charged to identify ways to improve health care delivery to Department of Veterans Affairs (VA) and Department of Defense (DoD) beneficiaries through better coordination and improved business practices. The PTF's conclusions resulted in a series of 23 specific recommendations for action. Of most importance to DAV is the Task Force's recognition of a "growing dilemma" concerning VA health care. The PTF noted in its *Final Report* that, "...it became clear that there is a significant mismatch in VA between demand and available funding—an imbalance that not only impedes collaboration efforts with DoD but, if unresolved, will delay veterans' access to care and could threaten the quality of VA health care."

We are pleased that the PTF addressed the complex issue of a mismatch between demand for VA health care and available resources to meet that demand. We concur, in part, with the Task Force's findings and recommendation that the Federal Government should provide "full funding" to ensure that enrolled veterans in Priority Groups 1-7 (new) are provided the current comprehensive benefits in accordance with VA's established access standards by using a mandatory funding mechanism, or some other changes in the budget and appropriations process to achieve that goal. DAV, however, would apply the "full funding" approach to all enrolled veterans, not just group 1-7. For far too long, VA has had to cope with constrained resources even as it faced significantly increased demand for services and rising costs for medical care and pharmaceuticals. This Committee is well aware of the funding crisis VA health care is facing and its impact on sick and disabled veterans who depend on VA's specialized programs and services. In the years since open enrollment, VA has been forced to do more with less. Even though over the past two budget cycles Congress has increased discretionary appropriations for veterans health care, the funding levels have simply not kept pace with inflation or the significant increase in demand for services.

Secretary of Veterans Affairs Anthony J. Principi recently described the current state of veterans health care as "the perfect storm" gathering on the horizon. The best selling book, *The Perfect Storm* describes a rare metrological phenomena that occurred in 1991, when a cold front was building off Canada, a major tempest was brewing over the Great Lakes, and a hurricane developing near Bermuda collided and created one of the most devastating storms of the century trapping a small fishing boat working off the Grand Banks. The "storm systems" gathering over veterans health care are a dramatic increase in the number of veterans enrolling in the VA, skyrocketing medical costs, and decades of inadequate, inflation-eroded appropriations. Any one of these developments can be devastating in itself, but combined, spell disaster for the VA health care system and the thousands of veterans who rely on its specialized medical services and programs.

There is widespread agreement that the funding system, not the VA health care system, is in need of fundamental reform. The DAV, as part of *The Independent Budget*, supports a mandatory funding mechanism as a long-term solution to this problem. We are pleased with the recent introduction of the Assured Funding for Veterans Health Care Act of 2003 (H.R. 2318) by Lane Evans (D-IL), Ranking Democratic Member of the House Veterans' Affairs Committee. This measure would require the Secretary of the Treasury to annually provide funding for the VA health care system based on the number of enrollees in the system and the consumer price index for hospital and related services. We fully support H.R. 2318 and wholeheartedly agree with Congressman Evans' assessment that, "the price we pay as a Nation for assuring timely access to high-quality health care services is small in relation to the price we have asked [veterans] to pay in securing our freedom."

The other proposal made by the Task Force to address the mismatch in demand for care and available resources is to form an impartial board of experts from outside VA to identify the level of funding required for veterans health care including a requirement that the amount determined must be included in the discretionary budget request. The recommendation also proposed that the budget submission be protected from the customary budget guidance provided the Office of Management and Budget (OMB). We understand, Mr. Chairman, that you are considering a legislative measure similar to this PTF proposal and look forward to its introduction.

Everyone agrees that the current budget process is not working and that our nation's sick and disabled veterans deserve better than being asked to wait months or sometimes years for access to needed VA health care. We all agree the current situation is unacceptable. We see these proposals, of guaranteed full funding and an independent board, as two alternatives to VA's funding problems. We do have concerns about the latter proposal in that it might be a real challenge to select a truly independent board—free from political pressures and the watchful eye of OMB. It is possible that some hybrid of the two proposals may be a viable option. More importantly, we believe this sets the stage for a much needed debate on the issue of the crisis in the level of funding for VA health care and a workable solution to that problem. Our nation's sick and disabled veterans cannot wait any longer for the government to take action. Now is the perfect opportunity to move forward and resolve this untenable situation.

We too share the Task Force's vision of a veterans health care system that is no longer impaired by the mismatch between resources and demand for care. Therefore, it is essential that some type of practicable guaranteed funding measure be enacted this year to ensure that all eligible veterans—including those injured in Operation Iraqi Freedom and the war on Terror—have access to timely, quality health care now and in the future. We believe that guaranteed funding will close the gap identified by the Task Force between funding and demand for veterans health care. Anything short of guaranteed funding is unlikely to fully resolve the crisis. And like the tiny Andrea Gail caught in open waters, unable to weather the destructive forces bearing down on her, America's sick and disabled veterans may not survive the perfect storm that threatens the VA health care system.

We were however, disturbed by the statements made by the co-chair of Task Force, Gail R. Wilensky, Ph. D, during her testimony before this Committee on June 3, regarding the mismatch identified by the Task Force between VA demand and resources. Dr. Wilensky testified that, "although there has been a historical gap between demand for VA care and the funding available in any given year to meet that demand, the current mismatch is far greater...and its impact potentially far more detrimental." Yet later on in the hearing, she asserted that President Bush's fiscal year 2004 budget fully funds veterans' health care. The Task Force report and Dr. Wilinsky's statement about the President's budget don't match up. The Administration's budget falls short of "full funding" and would do little to solve the current veterans health care crisis. We have hundreds of thousand of sick and disabled veterans who are enrolled in the VA system but must wait in excess of six months to get care. Hundreds of thousands more have been turned away, unable to enroll because the VA does not have the resources it needs to treat them. Dr. Wilensky's statement is confounding as it is incredible given the current situation veterans are facing.

The Task Force report noted that the discretionary appropriations process has been a major contributor to the historic mismatch between available funding and demand for health care services. Clearly, to improve timely access to health care for our nation's sick and disabled veterans, the federal budget and appropriations process must be modified to ensure full funding for the veterans health care system. Until we can achieve a comprehensive long-term solution to this funding problem, DAV believes Congress needs to appropriate, at a minimum, $27.2 billion for VA health care for fiscal year 2004 to meet the needs of the nearly 5 million veterans expected to use VA services this year. The long-term solution must factor in how much it will cost to care for each veteran enrolled in the system and a guarantee that the full amount determined will be available to the VA to meet that need.

Two other key issues identified by the Task Force are VA's accountability for meeting its own access standards for timely care and the present uncertain access status and funding of Priority Group 8 veterans (veterans with non compensable 0% service-connected disabilities or nonservice-connected veterans with income and/or net worth above the VA means test threshold and the HUD geographic index.)

We agree that veterans must have access to timely health care and that VA must be held accountable for meeting their own access standards. We believe, however, that VA must have guaranteed full funding for all priority groups to meet this requirement. The Task Force

recommended that VA be held accountable for meeting its established access standards and when appointments cannot be offered within the standard, the Department should be required to offer an enrolled veteran an appointment with a non-VA provider. We are concerned about the precedent this sets in that VA would have to contract out for care if access standards cannot be met. If given proper funding, VA should be held accountable for meeting demand in a timely manner and only as a last resort would we want care to be contracted out. In theory, if VA receives a sufficient appropriation, it should be able to plan for the appropriate number of staff necessary to provide veterans care within VA facilities. As the Task Force pointed out, while mandatory funding does not guarantee access, it would likely eliminate a major impediment to providing access in a timely manner—unpredictable or subjectively developed budget requests.

We agree with the PTF's assessment that this increased demand has resulted in many of VA's traditional constituency—veterans with service-connected disabilities and indigent veterans—being unable to obtain health care within VA's established access time frames. Calling this situation "unacceptable" the Task Force recommends full funding for only Priority Groups 1-7 to meet demand and suggests the Congress and the President must "resolve the status of Priority Group 8 veterans."

As the Task Force found out through its deliberations, this remains a complex and controversial issue. DAV believes guaranteed funding should be provided for *all* enrolled veterans. Including Priority Group 8 veterans under a guaranteed funding mechanism is essential to ensuring viability of the system for its core users, preserving VA's specialized programs, and maintaining cost effectiveness. However, for years, VA continued to enroll veterans without adequate resources to treat them in a timely manner—hence the eventual rationing of care and unreasonably long waiting lists for access to care that we see today. We ask: Why should there only be an appropriation for veterans in Priority Groups 1-7 instead of all veterans enrolled for care by VA to date?

We believe that once VA enrolls a veteran for care there is a reasonable expectation that he or she will receive the full range of health care services available in VA's comprehensive benefits package. Since the VA accepted the currently enrolled veterans into the system, we believe VA has an obligation to provide them timely top quality health care and that Congress has an obligation to ensure that VA is provided sufficient funding to carry out that mission. The real problem, as the PTF aptly states in its report, is that, "the Federal Government has been more ambitious in authorizing veteran access to health care than it has been in providing the funding necessary to match declared intentions."

The PTF noted that under the Eligibility Reform Act, when annual funding is not sufficient for VA to furnish the established benefit to all veterans within access guidelines it has established for itself, the Secretary has authority to decide on an annual basis whether VA will continue offering enrollment to veterans in all priority groups. VA's authority to limit enrollment was intended as an equalizing mechanism to avoid a mismatch between funding and resources. Yet, until recently, despite years of inadequate health care funding VA elected to keep enrollment open for all priority groups. Secretary Principi's decision to stop enrollment for new Priority Group 8 veterans this year confirmed that the level of resources was not sufficient to continue open enrollment.

The alternate version proposed in the PTF's final report regarding the Priority Group 8 dilemma, suggested a variety of ways for VA to increase revenues to pay for this group of veterans. One recommendation was that VA would be authorized as a Medicare provider for Priority Group 8 veterans and be permitted to bill and retain reimbursements from Medicare for the treatment of nonservice-connected conditions.

In the past, we have been supportive of Medicare reimbursement as described above. Unfortunately, the Centers for Medicare and Medicaid Services (CMS) have been unwilling to consider this option and it is questionable, regardless if a contract was developed, if VA would be able to fulfill all the necessary requirements to collect on care provided to Medicare-eligible veterans. Even using the combination of other collection alternatives proposed, it is unclear if VA would receive sufficient funding to fully cover the cost of Priority Group 8 veterans' care. For these reasons, we believe that guaranteed full funding for all enrolled veterans is the most comprehensive solution to resolve this complex funding problem.

In general, we agree with the findings and recommendations of the PTF. The Task Force focused on collaboration between VA and DoD as a key component to improving access to quality health care and the need to hold senior leadership in both Departments accountable for outcomes. The PTF suggested that VA and DoD leaders need to send a clear message about the expected end state of collaboration and sharing and aggressive action must be taken to remove barriers to collaboration. The Task force also noted the need to create a seamless transition from military service to veteran or retiree status. We concur with the PTF's findings that there is a need for improving information sharing between the Departments, especially information relevant to a servicemember's deployments, occupational exposures, and health conditions. This data should follow a service member through his or her military career and be readily available to VA upon separation from the military. The PTF suggested expanded collaboration in order to identify, collect, and maintain specific data needed by both Departments to recognize, treat, and prevent illness and injury resulting from occupational exposures and hazards while serving in the Armed Forces. Clearly, standardization and compatibility of information systems and medical records between VA and DoD will provide lasting improvements in health care delivery to veterans. We agree that these improvements are necessary and essential to ensure the health and safety of our troops.

The Task Force concluded that, "our nation's commitment to those who have served should not waiver. Improving health care delivery to our nation's veterans will require action by the President, Congress, VA and DoD." As the Task Force pointed out a number of commissions, advisory panels, and government study groups have convened since 1991 and looked at many of the same issues addressed in its final report. These findings are well known and well documented. They are issues this Committee and the veterans service organizations (VSOs) have been trying to resolve for years. This past year DAV and the other major VSOs have been pressing Congress to take action on what the PTF considered one of its major recommendations—full funding for VA health care to ensure enrolled veterans are provided comprehensive benefits, according to VA's established access standards. Our nation's sick and disabled veterans should not have to wait any longer. The important question is: Is this Administration and this Congress willing to make our nation's veterans a top priority and resolve this untenable funding situation as recommended by the President's Task Force?

For the sake of our nation's sick and disabled veterans, I hope that our government is willing to make veterans a top priority and resolve the funding situation for VA health care.

STATEMENT
OF THE
FLEET RESERVE ASSOCIATION

Submitted for the Record
to the
House Veterans Affairs Committee on the
Presidential Task Force to Improve
Health Care Delivery for Our
Nation's Veterans Final Report

Robert Washington, Sr.
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June 17, 2003

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Introductory Comments

Mr. Chairman, and distinguished members of the Committee, I would like to thank you for the opportunity to comment on the views of my organization, the Fleet Reserve Association (FRA).

The FRA is the oldest and largest professional military enlisted association exclusively representing men and women of the United States Navy, Marine Corps, and Coast Guard. The majority of our members are retired from the three Sea Services with 20 or more years of honorable service in war and peace.

Military retirees are veterans too. And many of the enlisted retirees that FRA represents have limited resources, and are affected by base closures and realignments and no longer reside near a military treatment facility (MTF).

Access to Health Care

Access to health care is FRA's number one priority. TRICARE is DOD's triple-option, regionally managed health-care program. Military retirees have suffered since the implementation of TRICARE and sought better access, and high quality of care throughout the Military Health Care System. FRA believes Congress and DOD have delivered significantly improved access and quality of care.

VA should offer the same type of access standards as that of DOD. Quality of care is especially important in any sharing venture, and the current differences in the benefit packages are a major concern. The mission of the two systems differs in many ways, and is focused on serving different populations with diverse needs. FRA believes there are potential gains to be achieved from greater collaboration. The FRA is pleased with a March 2003 announcement by VA, DOD, and the Department of Health and Human Services of the first set of uniform standards for the electronic exchange of clinical health information is an important milestone in collaboration and serves as a model for all federal departments and agencies.

Pharmacy Cost Sharing

Both systems have robust pharmacy programs, but VA has a much broader formulary. Recent legislation has prompted DOD to increase the number of drugs on its basic core formulary. DOD and VA can work jointly, in opening VA Pharmacy outlets to DOD beneficiaries, and to improve the delivery of care particularly in areas where there is no DOD pharmacy network or MTF. FRA recommends that both departments remain committed to sustaining and building on the progress already made in jointly procuring pharmaceuticals. A joint national core formulary that provides for local flexibility would enhance the continuity of care for beneficiaries who access multiple points of pharmaceutical care within the two systems, and would likely provide additional opportunities for joint contracting between the departments.

Technology Sharing

DOD and DVA must also continue to collaborate on Information Technology (IT) sharing activities. It is important to our membership that technology-sharing ventures are in place so that both systems can deliver the highest quality of care. Joint planning and analysis improvement is needed to ensure that future resource sharing ventures are a success. This includes sharing of facilities, equipment, and personnel. A sustained commitment to developing interoperable IT systems that support or enable reengineered processes will be critical to many aspects of VA/DOD health care delivery. The interagency leadership committee should identify those functional areas where the Departments have similar information requirements so that they can work together to reengineer business processes and information technology in order to enhance interoperability and efficiency.

VA Facilities as Tricare Network Providers

Last year I visited a true DOD/DVA joint venture facility at Kirtland AFB, New Mexico. In this case, the two entities share a common structure, but maintain distinct health care operations. Contracts and agreements are defined with specified services and reimbursement rates, and they also have separate staffs and distinct areas of responsibility. This is an example of an effective sharing agreement. VA and DOD should declare that joint ventures are integral to the standard operations of both Departments. Through the interagency leadership committee, the Departments should articulate policy requiring that: (1) all major initiatives of each Department be designed and tested for effectiveness and suitability in joint venture sites; (2) lessons learned from successful joint ventures be shared with other joint ventures sites and also throughout the health care delivery systems of the two departments; (3) all proposed VA and DOD facility construction within a geographic area be evaluated as a potential joint venture.

Conclusion

There are significant opportunities for sharing agreements focused on improving or sustaining quality health care for all veterans, including military retirees. Consistent access standards must be established with beneficiary care as the highest priority.
The Association supports continued collaborative efforts between the DOD and VA to enhance the Defense Health System and provide the necessary care for a deserving population. Again thank you, Mr. Chairman, and members of this distinguished committee for the opportunity to present the Association's views.

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