RURAL VETERANS' ACCESS TO PRIMARY CARE: SUCCESSES AND CHALLENGES

FIELD HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON HEALTH

ONE HUNDRED NINTH CONGRESS

FIRST SESSION

AUGUST 22, 2005
HEARING HELD IN BANGOR, MAINE

Printed for the use of the Committee on Veterans' Affairs

Serial No. 109-21

23-330.PDF

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 2006

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2250 Mail: Stop SSOP, Washington, DC 20402-0001

AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

COMMITTEE ON VETERANS' AFFAIRS

STEVE BUYER, *Indiana, Chairman*

MICHAEL BILIRAKIS, *Florida*
TERRY EVERETT, *Alabama*
CLIFF STEARNS, *Florida*
DAN BURTON, *Indiana*
JERRY MORAN, KANSAS
RICHARD H. BAKER, *Louisiana*
HENRY E. BROWN, JR., *South Carolina*
JEFF MILLER, *Florida*
JOHN BOOZMAN, *Arkansas*
JEB BRADLEY, *New Hampshire*
GINNY BROWN-WAITE, *Florida*
MICHAEL R. TURNER, *Ohio*

LANE EVANS, *Illinois, Ranking*
BOB FILNER, *California*
LUIS V. GUTIERREZ, *Illinois*
CORRINE BROWN, *Florida*
VIC SNYDER, *Arkansas*
MICHAEL H. MICHAUD, *Maine*
STEPHANIE HERSETH, *South Dakota*
TED STRICKLAND, *Ohio*
DARLENE HOOLEY, *Oregon*
SILVESTRE REYES, *Texas*
SHELLEY BERKLEY, *Nevada*
TOM UDALL, *New Mexico*

JIM LARIVIERE, *Staff Director*

SUBCOMMITTEE ON HEALTH

HENRY E. BROWN, JR., *South Carolina, Chairman*
CLIFF STEARNS, *Florida, Vice Chairman*
RICHARD H. BAKER, *Louisiana*
JERRY MORAN, *Kansas*
JEFF MILLER, *Florida*
MICHAEL R. TURNER, *Ohio*

MICHAEL H. MICHAUD, *Maine Ranking*
BOB FILNER, *California*
LUIS V. GUTIERREZ, *Illinois*
CORRINE BROWN, *Florida*
VIC SNYDER, *Arkansas*

JEFFREY WEEKLY, *Subcommittee Staff Director*

CONTENTS

August 22, 2005

	Page
Rural Veterans' Access To Primary Care: Successes and Challenges	1

OPENING STATEMENTS

Chairman Brown	1
Hon. Michael H. Michaud, Ranking Democratic Member	2

WITNESSES

Chirico-Post, Jeannette, M.D., Network Director, VA New England Healthcare System	5
Prepared statement of Dr. Chirico-Post	40
Sims, John H., Jr., Director, Togus VA Medical Center	7
Prepared statement of Mr. Sims	45
Lessard, Roger, President, AFGE Local 2610	19
Prepared statement of Mr. Lessard	51
Simoneau, Don, Vice Commander, The Department of Maine American Legion	21
Prepared statement of Mr. Simoneau	55
Laweryson, Gary, Chairman, Maine Veterans Coordinating Committee	23
Prepared statement of Mr. Laweryson	64

STATEMENTS FOR THE RECORD

Hon. Thomas H. Allen, 1st Congressional District, Maine	33
Hon. Olympia J. Snowe, U.S. Senator, Maine	35
Ronald W. Brodeur, Adjutant, Department of Maine of the Disabled American Veterans	67
COL Edward L. Chase, USAF (Ret), Chairman, Legislative Committee, Pine Tree Chapter, Military Officers Association of America	71
Roger Landry, Former Maine State Representative, and Co-Chair of Maine's Task Force on Veterans' Health Services	76
Timothy J. Politis, Chief Executive Officer, Maine Veterans' Home	79
Peter W. Ogden, Director, Bureau of Veterans Services, State of Maine	87

INFORMATION FOR THE RECORD

"Most Wired 2005" USNews.com article by Josh Fischman 38
"Differences in Health-Related Quality of Life in Rural and Urban Veterans," American Journal of Public Health, October 2004 59
VA Health Care, Department of Veterans Affairs booklet 90
Cost Estimates for Maine CBOCs and Access Points 113

RURAL VETERANS' ACCESS TO PRIMARY CARE: SUCCESSES AND CHALLENGES

MONDAY, AUGUST 22, 2005

U.S. House of Representatives,
Subcommittee on Health,
Committee on Veterans' Affairs,
Washington, D.C.

The Subcommittee met, pursuant to call, at 9:06 a.m., at Eastern Maine Community College, Room 501, Rangeley Hall, 354 Hogan Road, Bangor, Maine, Hon. Henry E. Brown, Jr., [Chairman of the Subcommittee] Presiding.

Present: Representatives Brown and Michaud.

Mr. Brown of South Carolina. Good morning. My name is Henry Brown and I chair the Health Subcommittee of the Veterans Committee. I'm from South Carolina.

It is a real pleasure to be up in Maine. This is my first stop. And, you know, I left that 95 degree heat, it just came down from a hundred degrees. So, it's been a real pleasure this morning to wake up and enjoy the nice cool temperatures that you folks have here.

It's a real pleasure to be here. I know Mike Michaud and I serve together in Congress, and two years ago we served on the Veterans Benefits Subcommittee. And then I got to be Chairman of the Health Subcommittee, and Mike got to be Ranking Member on that Subcommittee, so it's been a real good working relationship. And our goal as the chair of the Health Committee is to try and improve the health care delivery for veterans. And we try to do some things to get us up with the 21st Century and deal with some other issues that we have.

And we're grateful today to come and listen to you, the veterans, and make absolutely sure that this is working; not just in South Carolina or in Texas, but in Chicago and also in Maine.

Rural healthcare is a big issue for us, because, in a state like Maine, and even some little areas in South Carolina, where accessability to good healthcare is a major concern.

We also have with us some staff members of the Senate. And I know Mark Kontio is here -- Mark, would you raise your hand -- thanks for

coming -- from Senator Olympia Snowe's office. Jon Ford from Senator Collins' office. Matt LaPointe from Thomas Allen's office.

Although the Senators and Congressman Allen were not able to come, I'm pleased that Congressman Allen asked us to submit his statement in the record, and we will certainly be happy to do that.

[The statement of Thomas Allen appears on p. 33]

Before delving into the subject of today's hearing, I would like to extend my heart-felt thanks to both my staff and Mr. Michaud's staff I would like to recognize Jeff Weekly and Dolores Dunn from my staff - - Mike, if you would recognize your staff --

MR. MICHAUD. Yes, Linda Bennett, from my staff, as well as my staff from the State of Maine, and several are here today.

I would like to thank them -- and your staff, Chairman Brown -- for coordinating this hearing. I appreciate all of the hard work.

MR. BROWN OF SOUTH CAROLINA. Well, I certainly appreciate the hospitality that you've shown, Mike, and your staff since we have been here together. And I look forward to going to Togus later today and see the medical facility up there.

Today we examine how the VA is providing primary care to veterans in rural Maine; what challenges the VA confronts in providing care for veterans in the state; and what unique and innovative measures serve as potential solutions to meet these challenges.

The panels we will hear from today, because of their roles inside and outside of VA, will help us better understand the current state of play for Mainers and the gaps that have developed due to the rural make-up of the state.

As Chairman, it is my hope that when gaps in treatment or clinical care are identified, we put significant effort behind developing new and innovative approaches to providing care for those who live long distances from VA medical centers or community-based outpatient clinics.

We must remember, however, Maine is not alone when it comes to providing rural care to our veterans. So, the solutions we consider as policymakers -- those already in use, or new ideas generated as a result of this hearing -- should be exportable to other states and localities in the United States, so that all eligible and enrolled veterans can benefit.

I now yield to my good friend, Mike Michaud.

MR. MICHAUD. Thank you very much, Mr. Chairman. And once again, I want to welcome you, your staff, and staffs from other lawmakers. I welcome you to the State of Maine, and hopefully you'll have an enjoyable stay while you are here. I want to thank Eastern Maine Community College for allowing us to use their facility here this morning, I really appreciate that.

I also want to thank all of the veterans who are here today. I know

a lot of them have traveled great distances to get here, several over three hours this morning, so I really appreciate your time and effort to come here this morning.

Mr. Chairman, I want to especially thank you for agreeing to hold this hearing in the State of Maine. And there's another hearing in South Carolina next month.

I know the Chairman and I are definitely united in a bipartisan effort to look at taking care of our veterans. It is a high priority for both of us.

It is a great honor to serve with you, Mr. Chairman, in a bipartisan effort over the last three years to make sure that the veterans get the services they need.

I'm also very pleased that the Democrats and Republicans came together earlier this year to correct the shortfall that we received in the original budget as it relates to veterans.

That bipartisan effort was put forth in a supplemental budget, that the President signed on August 2nd, and we're very pleased with the additional funding.

The budget shortfall definitely hurt the veterans' access to care and quality of care; it was put at risk.

In Maine, the VA had to put a hold on filling many staff positions until the new funds were released.

I must say I am surprised that the VA Central Office was caught by surprise by the shortfall in June. The Bangor Daily News had reported back in January that there was a 14 million dollar shortfall at the Togus VA Medical Center.

I hope that we can continue working in a bipartisan manner and keep the dialogue open to make sure that we find long-term solutions for VA funding.

I'm fully supportive of mandatory funding.

If members of Congress, the President and his Cabinet, and federal employees are guaranteed healthcare benefits, then I think veterans should be guaranteed their healthcare benefits as well.

As we tackle the underlying flaws that we find in the budget process, we also must look at how do we take care of Priority 8 veterans as well.

Mr. Chairman, we have a proud tradition here in Maine in answering the call to service. One in six Mainers are veterans. And we are very pleased with that.

We have a new generation of veterans who are risking their lives in Iraq and Afghanistan.

Americans from small rural towns, in your state and mine, have taken on more than their share of answering the call to serve their country.

I think it's important to the returning soldiers who need the help readjusting once they get back home, that we will provide that help.

We'll be looking at the need also for quick access for mental health services to prevent the chronic mental health problems that we are seeing.

We must not fail these heroes by ignoring that need. I look forward to hearing from Veterans Integrated Service Network, or VISN, 1 Director, Dr. Post; and Togus VAMC Director, Jack Sims -- looking forward to their testimony, and the efforts to expand the capacity to serve veterans in the state of Maine, which is definitely needed.

I'm also looking forward to hearing from them as well on the opening of CBOCs that were proposed under the CARES recommendations.

Veterans need these clinics. We must move forward to get these clinics up and running. Telemedicine is great. I believe telemedicine is important, but it's not the answer for all of the problems that we have.

We must make sure that we do not forget that, with telemedicine, we must have adequate staff -- whether it's psychiatrists or eye doctors to meet the demand. No amount of technology will make up that difference.

I'm also concerned about the way mental health patients are being integrated into primary care. Many veterans suffer from depression, post-traumatic stress disorder, and other mental health problems.

There simply are not enough mental health care specialists to meet the demand. We're looking forward to hearing about that issue.

If you look at the statistics, Mr. Chairman, last year VISN 1 spent only 60 percent of what it did nine years ago to treat veterans with serious mental illness.

Also, VISN 1 only had 78 percent of the mental health staff that it had back in 1996.

I am concerned that this means a reduction in the care for our veterans. I'm looking forward to hearing the testimony from the VISN 1 Director and Togus VAMC Director Jack Sims.

I want to thank you both for taking the time to come here this morning.

Thank you.

MR. BROWN OF SOUTH CAROLINA. Thank you very much, Mike.

At this time we'll call the first panel to come forward. Our first panel is Dr. Chirico-Post, appointed Director of the New England Healthcare System in 2000. She oversees a network of healthcare centers throughout the six New England states.

Mr. John Sims has served as the Director of the VA Medical Center for 15 years. His leadership has been instrumental in helping veterans in rural Maine access a broad range of medical services.

And let's start with you, Doctor.

STATEMENTS OF JEANNETTE CHIRICO-POST, M.D., NETWORK DIRECTOR, VA NEW ENGLAND HEALTHCARE SYSTEM; AND JOHN H. SIMS, JR., DIRECTOR, TOGUS VA MEDICAL CENTER

STATEMENT OF DR. JEANNETTE CHIRICO-POST

DR. CHIRICO-POST. Good morning. Mr. Chairman and members of the committee, thank you for the opportunity to appear today to discuss Rural Veterans Access to Primary Care: Successes and Challenges.

The New England Healthcare System is comprised of the six states in New England as an integrated health care delivery system to provide comprehensive quality, innovative care, in a compassionate manner to all veterans it serves.

We serve a population of 240,000 veterans with a total budget of over $1.4 billion dollars. Our eight medical centers operate approximately 1900 beds, and we have about 26,000 admissions to those beds.

The network is committed to provide the right care at the right time in the right place and at the right course.

We are committed to the unique healthcare challenges that Maine faces.

We are fortunate to be affiliated with premier medical schools in the country, including New England College of Osteopathic Medicine. And we are a leader in research and post-graduate education.

I'm pleased today to discuss the many areas in which VA is excelling in the state of Maine. Currently there are no significant waiting lists or backlog for new primary care patients in Maine. 71.6 percent of new patients are seen within 30 days, and 94 percent of the established patients are seen within 30 days.

We've had outstanding performance in Maine in high risk, high volume areas, such as cancer screening and diabetic care.

Access is enhanced in New England through a total of 38 operational community-based outpatient clinics, with the quality at the same standard as it is at the medical centers.

VHA has committed to the expansion of service and the transformation of mental health care, and the spectrum of services in Maine include both inpatient and outpatient services.

The network very successfully secured funding recently throughout the six states in support of those mental health services.

A grant recently received provides for the expansion of services to treat additional areas though substance abuse disorders, but not limited in that area.

We have a number of special programs that were initiated and flourished in support of the frail elderly in Maine. These home com-

munity-based care programs include other areas such as hospice-veteran partnerships that exist.

Telemedicine is a strategy to meet some of the rural healthcare needs in the network, including those veterans who need special services at a distance.

The goal is to provide an electronic network capable of supporting the veteran patient wherever they live by providing innovative means of communication between the patient and the healthcare provider on site.

Care coordination/Home Tele-health programs provide the tools to help patients self-manage their care, reducing hospitalizations and enabling them to live in the least restrictive environment.

A recent article from the US News and World Report entitled, House Calls, discusses telemedicine and the VA's use of this innovative medical tool.

And I would like to submit a copy of this for the record.

Advances in telemedicine and technology are included through the innovative implementation of My HealtheVet, which will allow the veteran access through the Internet for pharmacy refill functionality.

In addition to that, through the technology, we are able to establish consultation for our patients and additional referrals so the patients do not have to travel long distances.

We work collaboratively with the Department of Defense to insure a seamless transition for our returning service members. Our computerized patient record system provides a sharing of data in a secure fashion.

There are other areas in which telemedicine has provided enhanced access to the veterans of Maine, including dermatology, psychiatry, pathology, cardiac monitoring through electrocardiograms.

VA is committed to ensuring a seamless transition from active duty to civilian status for our newest veterans returning from conflict in Afghanistan and Iraq.

To date, over 5,000 veterans are enrolled in the network, including over 500 in Maine. These veterans are primarily seeking care through primary care, dental care, and mental health services.

Additionally, we have 18 Vet Centers located throughout the network, five in the state of Maine.

In summary, the VA has implemented numerous innovations to meet the rural health care challenges facing our Maine veterans. And today's veterans will know, in whatever setting they receive their healthcare, that they are receiving the highest quality of healthcare from the professionals who provide that care to our Nation's veterans.

Mr. Chairman, that concludes my statement. I truly appreciate the opportunity to share with you how VA New England Healthcare

System provides quality and compassionate healthcare to the veterans of New England.

MR. BROWN OF SOUTH CAROLINA. Thank you, Dr. Chirico-Post. At the conclusion of Mr. Sims' remarks, we'll then have some questions. Thank you.

[The attachment appears on p. 38]
[The statement of Dr. Chirico-Post appears on p. 40]

MR. BROWN OF SOUTH CAROLINA. Mr. Sims?

STATEMENT OF JOHN H. SIMS, JR.

MR. SIMS. Mr. Chairman, Congressman Michaud, thank you very much for the opportunity to speak to you today about Rural Veterans Access to Primary Care in Maine.

At Togus, as well as throughout the entire health care field, there is now a sustained emphasis on outpatient services, an emphasis that has significantly reduced hospitalization stays and more clearly focuses on outpatient clinics and their available services.

Although we have changed the manner in which we provide our care, we continue to provide the same broad range of services and high quality care that we have always provided to an ever increasing number of Maine veterans.

During my 15-year tenure as Director of the Togus VA Medical Center, there's been a remarkable and sustained shift in the delivery of health care services in Maine. In particular, the VA has been progressive in its attempt to provide rural health care access.

Today there are five full-time community-based outpatient clinics -- CBOCs -- in Maine, several of which have been expanded more than once to meet the increased demand.

These full-service CBOCs are located in Caribou, Bangor, Calais, Rumford and Saco. And, in addition, we have a part-time clinic located in Fort Kent which operates as a satellite of our Caribou CBOC. In addition to primary care, an essential part of that primary care at our CBOCs is the provision of preventive health services and health promotions as well, in addition to disease prevention programs.

We also have two VA mental health clinics located in Bangor and Portland.

To better serve the Maine veterans, four of these CBOCs were recently expanded or relocated, and the remaining CBOC in Calais will soon be in its new location. And we're hopeful that that will occur in October of this year. We're on schedule.

We've also been able to increase access to mental health throughout the state. The Bangor CBOC has adjacent mental health clinic which is fully staffed and operates on a full-time basis.

Mental health support for our Saco CBOC is provided by the newly

expanded and relocated mental health clinic in Portland.

Tele-mental health is in place in Caribou and is planned for Calais when that CBOC is relocated later this year.

Finally, the Rumford CBOC now has an onsite mental health clinician one day a week with plans to expand that service when additional resources become available.

One of the most significant changes in VA health care in Maine has been the extraordinary increase in the number of enrolled veterans selecting VA as their preferred choice for health care services.

In 1999, we had a total enrollment of 19,000 veterans in the State of Maine. 2004, the end of last fiscal year, that was up to 36,000 veterans seeking their care from VA.

The significant piece then with regards to rural health care is that, back in 1999, only one-third of the veterans, were getting their care at a CBOC. In 2004, half of our enrolled veterans are now getting their care out in the rural areas. Obviously, that shows that the veterans want to get their care closer to where they live.

The Togus Healthcare System has been coordinating very closely with the Maine National Guard and various reserve units to conduct outreach for the Operation Iraq Freedom/Operation Enduring Freedom veterans as they're returning.

The outreach efforts include healthcare and non- medical benefit briefings as well as information on readjustment counseling by the Vet Centers.

Currently, approximately 550 of these veterans have enrolled for VA healthcare, and about 80 percent of those are actively seeking some type of medical and/or mental health care.

At this point, the vast majority of veterans have only required outpatient health care.

In May 2004, the CARES Decision identified six additional sites of care throughout Maine, that were authorized pending the availability of resources and validation with the most current data.

To better meet the needs of the under served veteran populations, the majority of these newly authorized sites will be located in more rural areas of Maine, which would significantly further the attainment of a primary goal of providing veterans quality health care closer to their homes.

Togus will continue to closely monitor implementation of these sites of care.

To date we have about 69 patients receiving various stages of adjunctive care through tele-health devices. Our Home-based primary care unit has been using video phone devices for more than a year to provide follow-up and on-going care to patients in individual and residential home settings.

Physician assistants and nurses use these devices to review medications, look at wounds, complete psychosocial assessments, conduct

follow-up reviews for medication changes, and determine if there have been any other changes or medications have been changes.

To better serve the veterans of Maine, we must continue to monitor their needs and find ways to meet the challenges those needs present.

America's veterans have earned the best care we can possibly provide, and it's our distinct privilege to provide them with the highest levels of customer service.

We will continue to coordinate closely with Maine's veterans and with national and state Veterans Service Organizations, as we do our very best to address our veterans' concerns.

We certainly sincerely appreciate your interest and support in helping the VA to successfully accomplish our sacred mission of providing world-class care to all those who have so honorably served our great country.

Thank you very much.

[The statement of Mr. Sims appears on p. 45]

MR. BROWN OF SOUTH CAROLINA. Let me just say, I thank both of you for coming today. Also, let me thank you both for addressing the challenges that we have in rural America to find the veterans and find some adaptable services, that we are committed to support and sort of move away from the institutional type of setting in the hospitals we have in place and try to get needs and services closer.

I noticed, Dr. Post, in your testimony you talked about the wait time. I'm just wondering, how is the wait time for specialty-type performance?

DR. CHIRICO-POST. We continue to face significant challenges in meeting VHAs own standards in providing specialty services within 30 days.

And throughout the network, there's a variation, if you would, in those challenges, primarily depending on the availability of specialist.

We don't have significant delays in neurology -- I happen to be a neurologist -- but we do have significant delays in gastroenterology, eye care, orthopedic care.

There are those sub-specialities that are difficult to recruit in certain areas.

We have in place a system whereby there's a prioritization, if you would, for the veteran who needs that care, and how that care might be rendered.

If we can not provide the care in a timely fashion in one of our institutions, then we seek to do that for that veteran outside the VA on a fee basis.

MR. BROWN OF SOUTH CAROLINA. How about mental health.

DR. CHIRICO-POST. Let me speak to mental health as well.

We have an integrated model, if you would, of the delivery of services of mental health that run the gamut from simple things that may be managed through -- through a primary care office; like depression in the early stages can be managed by a primary care physician.

So, those who are seriously mentally ill, they may require services of a psychiatrist. I'm very proud, in New England, that one of the standards that VHA uses to measure how well we're doing in providing those services, is to look at the percentage of mental health care visits in our community-based outpatient clinics, where the enrollees total over 1500. And we do very well in that -- in that network. We're not perfect. We face challenges in several of the areas.

And, again, I'll go back to the issue of the principal resource of the provider being a scarce specialty to get enough of.

From an innovative point of view, what we have done in the network is two things. One is that, you're probably very well aware of our computerized patient records. There's no health care organization that has a computerized system like this, so that a veteran who is seen in Caribou, Maine, and has consulted with me in Massachusetts, I can pull up the record, as well as in California.

That serves as a basis, I think, for coordination continuity, especially in referrals.

That's one thing.

The other thing that we have done more recently is establish direct linkups through telemedicine that Mr. Sims talked briefly about, especially between Caribou and Togus.

When I was chief of staff at Providence, Mr. Sims and I established a relationship in dermatology between Providence and Togus.

The challenge that we faced in psychiatry, I think, is the gamut of illnesses that the individuals may have when they come to seek their care from us.

So, we attempt to better coordinate that care. We have other resources especially in the state of Maine that we tap into, called outreach centers or Vet Centers.

In all of New England, we have 18, and in Maine we have five.

Recently there's been separate funding for those Vet Centers. VA New England received a number of those in support of that, and we have worked very closely with our vet centers in outreach.

Because, sometimes the veteran doesn't want to come to the hospital, and is much more comfortable seeing a comrade at the Vet Center, and then can get referred into Togus.

Mr. Brown of South Carolina. Do you experience difficulty in seeing the transfer between the DOD and the VA as far as their medical records.

Dr. Chirico-Post. Seamless transition at this time in this country is the best it's ever been, I think.

The VHA has on the ground folks in Department of Defense to se-

cure a better coordination of those individuals once they get out.

We have an office in VHA for seamless transition. I have a person in the network, Mr. Sims has a person in the facility, that we rely on as the point person for just that issue.

The electronic medical record is a challenge. There are some incompatibilities that exist right now, but both Department of Defense and VHA are committed to enhancing those technical challenges that we face to improve the response that might exist there.

We have in the network a standardized system whereby, we go out to the reserve units, even before they go to discuss what will be available for them when they come back; we do the same thing when they come back.

We have readily accessible to them a specific place that they can call at any one of the medical centers when they call in, so that we can be there for them.

MR. BROWN OF SOUTH CAROLINA. I know that Mr. Michaud has some questions, too, but let me just ask one further question.

In the four major services, do you have any opportunities to coordinate services, like with the medical universities, in those eight regions that you're involved in?

I know in South Carolina, in our rural areas, we have, like, family health clinics for our newer vets. I'm hearing reports that they were recommended that we need more coordination between our county governments and state governments and the VAs.

Do you all have --

DR. CHIRICO-POST. On the network side, we're very fortunate to have relationships, whether it's through the state government or through the medical schools, and other healthcare partners that we can partner with.

Just here in the state of Maine, we have a wonderful relationship with our state veteran homes, from a long-term care point of view, where we work in conjunction with them.

For the last several years, I've been the co- chair of the homeless coordinated program through New England. And that brings to the table the state governments -- all of the New England states, the chairperson for Veterans' Affairs, for example, of the state; the VA, and Social Security, to interact and integrate and coordinate resources and services one with the other.

So, we do try to take advantage of that.

MR. BROWN OF SOUTH CAROLINA. In South Carolina we are looking at -- we also have a VA hospital in the same region or the same -- approximately in the same vicinity as a medical university hospital.

We're looking to replace both of those facilities, and move the VA hospital closer to the medical university, where so many of the offices are located. And that would help with the cost of the testing equipment, it would be a good mix to do that.

DR. CHIRICO-POST. At the present time, as a consequence of the original proposals and recommendations out of the CARES process, we're also looking at integrating, if you would, three of the facilities in Eastern Massachusetts. And part of the equation of that is the relationship with the schools. And part of the equation is, how do you best utilize that technology? How do you better integrate the research programs?

VA New England has received -- the largest number of dollars from all of the VHA research comes to New England.

So, we still have a number of those physicians and Ph.D. Individuals who do the research and observations, if you would, in the VHA.

But, in addition to that, provide quality care to the veterans.

MR. BROWN OF SOUTH CAROLINA. We also have some outpatient clinics, but we have a combination with DOD also, with an air force base in Charleston; and so that's another way of sharing.

Thank you for your patience in answering my questions. And I think Congressman Michaud may have some questions now.

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

Once again, I want to thank you, Dr. Post and Mr. Sims, for your testimony. We enjoyed it.

Dr. Chirico-Post, I want to congratulate you. I understand that you're going to receive the VHA Recognition Award, so I want to congratulate you.

DR. CHIRICO-POST. Thank you very much.

MR. MICHAUD. We are here to help you do whatever we can to make sure that we take care of the veterans.

I want to be more specific to the state of Maine. If you look at New England, you can practically fit all of New England inside the State of Maine. Maine's a very large state. We can drive another hour north of here, and that would be the center point for the State of Maine. So, it's a big state.

I'm concerned that, with this tight budget, that money for the clinics that have been recommended under the CARES process, and the timing to get those programs up and running. My concern is, whether or not that funding will come out of the existing budget of Togus VAMC facility. I definitely do not agree with that.

The VISN will need additional funding for these clinics. With the supplemental budget that was passed, will that help move these clinics forward?

Particularly, when you look at where these clinics are located, whether it's Dover-Foxcroft, Lincoln, Houlton, Lewiston-Auburn area -- a lot of these areas -- I know the VA has been working with local healthcare providers to move these clinics forward, and this will be great.

So, my question is, when will they be up and running?

The second part of that question is, have you estimated the cost

for each one of these clinics, what it will cost to get them up and running?

DR. CHIRICO-POST. Let me begin to answer that question, and some of the specifics of the resources required to open up the individual clinics, Mr. Sims may have those specific dollars associated with it.

Let me also thank you for the 1.5 supplemental that we have received. I think that -- I have given my professional career to veteran healthcare.

And to be recognized in that way, to receive the additional resources, I think demonstrated that, as good stewards of those resources, which I believe we are in the network, and Mr. Sims is in the State of Maine, that we will take those resources and do what's best for the veteran.

So, having said that, the supplemental clearly brings us closer to the implementation of the recommendation of the CARES program.

We go back in history to the foundation of the CARES program, which was to look at the capital assets that we had, and provide for enhanced services. That's what it was.

And the particular recommendation for -- that affects us and in our discussion today was, if you look out from a demographic point of view over the next ten and twenty years, you realize that the numbers, the sheer numbers that will come to us in VHA, would increase.

And New England, 25 years ago, we might not have said that. But, clearly, three years ago, when we started the process for CARES, and we keep updating our numbers.

And as Mr. Sims has said, in Maine, of the six New England states, the greatest market penetration is in Maine. So, on average, about 27 percent of our veterans in Maine come to receive their care through VHA.

CARES recognizes, given our definition of urban rural and highly rural, that we could -- I would say for the network, 97 percent of the veterans who seek their care have access to care within 30 minutes. That's not true of Maine. It's less than 60 percent. I think it's 56 or 57 percent.

So, the recommendations to open the clinics in Lincoln, and to speak out to those other areas, that probably will be outreach.

We originally, in the CARES proposal, started out looking at telemedicine throughout Maine. There were other opportunities. CARES was not saying that you have to do it in one way or the other.

I think the network, with the facility, will come forward and say, this is what we would like to do.

So, the first order of business, I think, is to open Lincoln. And then after that, to take a look at the other access points, if you would, and what's the best way of doing that.

Clearly, the CARES recommendation came out at the end of -- the middle to end of '04. In '05, the process of protocol we need to follow

is to go back into headquarters requesting to open it.

And one of the issues for us was the financial feasibility, which we could not do in '05.

We don't know what the budget's going to be for '06. Given the supplemental that we received in '05, we're fortunate that we're able to do a number of new things for the organization.

A new CAT scan for Maine. A mobile MRI unit on station in Togus at least two days a week. We would never have been able to do that.

I think the total dollars that came to Mr. Sims out of the supplemental was something like 13 million. And that includes both the equipment and the maintenance that's there.

To get back to your question. That obviously puts us in a better position to be able to put together the papers and the protocol, and we have to see what the budget's going to be for '06, to move forward in that regard.

Because, we want the same things that you want, and that's better access for the veterans.

MR. MICHAUD. This may call for Mr. Sims to answer. That 13 million, was that FY 05?

DR. CHIRICO-POST. Yes.

MR. MICHAUD. Now, that 11 million dollars that was borrowed, was that all for Togus, or was that part of VISN 1?

DR. CHIRICO-POST. Let me deal with the 11 million.

Before we got the supplemental back in the spring, we assessed that we needed 11 million dollars in capital to do what we considered high priority safety issues for the organization.

We never did borrow 11 million, we only borrowed five million. And that was to be paid back with the beginning of the next fiscal year.

So, the 11 million -- and I don't have that figure off the top of my head, how much of that were for projects here in Maine, but it was a fair share.

As I look at the budget across the network, the Maine budget is that it has increased over certainly the five years that I have been network director. And the apportionment that Maine receives in equipment and NRN has always been slightly greater, mostly because there's 36,000 veterans for us to take care of, and almost 1000 employees that we manage in the state of Maine.

MR. MICHAUD. The centers, Mr. Sims, how soon can they get up and running?

I know, it's the goal to come closer, but I don't know when they're going to be up and running, No. 1.

My next question is, I've been hearing a lot from the veterans in the Lewiston-Auburn area, and what are your thoughts about a Lewiston-Auburn CBOC?

MR. SIMS. First of all, we continue to, in anticipation of being able to get these up and running -- we've had ongoing discussion in many

of the communities already. They've been identified.

Certainly in Lincoln, with a local facility there. The CEO, we've had discussion about possibly -- about the possibility of space, and how we might do that.

In the Houlton area there's a definite interest on the part of veteran groups there to secure a building and have that be available for us.

So, there's ongoing planning in place, so that once the resources are available, we can move quickly and get these up in a reasonable time.

Now, once we have that final notification, there are other logistics that are required. Actually getting the equipment, getting the furniture in place, and having the space open and ready to work in.

Lewiston-Auburn is an area that I think, certainly now, is a large demographic area -- second largest population concentration in the state -- and it's far enough away from Togus and our other sites that I think that it makes sense for that to be a site for us in the future as we get to that point in the planning process.

Certainly, again, a fair amount of veteran interest in that area. We're working very closely with the various grassroots efforts that are in place there to get a suitable site when that comes.

MR. MICHAUD. I see my time's running out, Mr. Chairman. But, if I might, Mr. Sims, you testified -- or your testimony indicates that 22 percent of the newest veterans enrolled at Togus are using mental health services.

If this rate continues, will VA be able to provide mental health services without increasing the staff level?

I know Maine has had an increase in funding in the VA. But, when you also look at Maine, 16 percent of our population is veterans. Percentage-wise, we're one of the highest in the country.

Likewise, when you look at those who are actively serving in Iraq and Afghanistan, we are way up there in numbers. We need the services. Being a rural state, that makes it much more problematic.

So, do you think that the mental health resources will be there?

MR. SIMS. I absolutely do think so. We just recently added two new psychiatrists to our mental health department.

In fact, one of those just recently came off active duty, and had served in Iraq, and so is very well qualified to know some of the things that the returning soldiers are facing.

So, we've added new psychiatrists, other mental health staff. We are fully staffed in mental health at this time.

We have emphasis on the returning veterans, and the issues that they're facing, particularly within our PTSD program.

As Dr. Post mentioned, we have other programs coming online at our outbase clinic as well. And I think we're in a good position right now to be able to deal with any of those issues that would come up.

MR. MICHAUD. How is Togus integrating mental health services

into primary care?

MR. SIMS. Again, there is close coordination. With the computerized medical records, the primary care providers can see what's being done on the mental health side; and the mental health side can see the progress notes from the primary care providers. And it's just an integration of the whole services.

They're located at Togus in close proximity to each other, and so consultation as needed between the providers and -- again I think, they are very well coordinated, and mental health services are in good shape.

MR. MICHAUD. Would you be able to provide the cost for clinics as far as what it would cost to get clinics in Lincoln and Dover and all other recommended sites?

MR. SIMS. We could provide some preliminary costs. Again, it's going to depend on what the lease cost may be ultimately and, you know, the size of the clinic when we finally configure it. But, we could come up with some preliminary costs for you. We could get that to you, yes.

MR. MICHAUD. I would appreciate that.

[The information appears on p. 112]

MR. BROWN OF SOUTH CAROLINA. Thanks Mike. Let me follow up along with that same line of questioning. I think you proposed five new clinics in -- I think you said 2000, and your patient load was, like, what, 19,000; and I think in 2004 you had like 36,000.

Do you anticipate by adding these new health centers that those numbers will go up, or do you think those numbers will be just shifted around to the new locations?

MR. SIMS. We will do some shifting around, clearly that's our intent for some of these. But, we know from past experience that when we open up these outbase clinics, that there will be new enrollments as well.

And we've had some projections in some areas. And in Lincoln, for example, we're expecting maybe as many as 400 new enrollments initially, and then probably some growth from there.

But, certainly, there will be some new growth. As we put these CBOCs out in the rural areas, as Dr. Post mentioned, the market penetration greatly expands and grows in those areas because, when it's there, they come.

MR. BROWN OF SOUTH CAROLINA. Are you finding that the veterans are citizens of Maine, or are they migrating from some other regions in the United States.

MR. SIMS. Mostly it's Maine citizens, but certainly we get a wide variety. And we're here to take care of the veterans of the United States of America, and we do that.

MR. BROWN OF SOUTH CAROLINA. I represent the coast of South Caro-

lina and it's getting to be a destination of choice for retirees. In fact, I think it would be a good connector if we could spend winters in Myrtle Beach and summers up here.

Let me ask you one other question. Do you have an idea of how much you're spending for fee services now?

DR. CHIRICO-POST. The network spends over 70 million dollars in fee services.

MR. BROWN OF SOUTH CAROLINA. And how much of that is in Maine.

DR. CHIRICO-POST. About 20.

MR. SIMS. Probably about 20 million dollars, yes. It's a significant amount here in Maine --

MR. BROWN OF SOUTH CAROLINA. Do you see that that is costing VA health centers more money?

MR. SIMS. That again is our expectation, as we put these places closer to where the veterans live, because they'll get their healthcare from us rather than the fee --

MR. BROWN OF SOUTH CAROLINA. You understand that this is a cost saving --

MR. SIMS. Absolutely.

MR. BROWN OF SOUTH CAROLINA. Let me ask you just one other question and then we'll move on to the next panel. Do you have facility specific data in terms of the numbers seeking enrollment solely for the purposes of ordering or refilling prescriptions.

MR. SIMS. I'm not sure that we do, quite frankly. It's been significant, but I think it's tapered off some recently, so --

If we have it, I'll get it.

MR. BROWN OF SOUTH CAROLINA. Let me ask another question then to follow up on that.

I know, I think, in order to get a prescription filled or refilled, you must see your doctor.

MR. SIMS. Correct.

MR. BROWN OF SOUTH CAROLINA. How do you feel about filling the local doctor's prescriptions; would that help the patient load some.

MR. SIMS. Well --

MR. BROWN OF SOUTH CAROLINA. I know that, as a policy, that may be something that you'd want to take a look at, but I'm just curious to have you address that.

MR. SIMS. Well, the VA was established as a healthcare provider, not a pharmacy. And so, certainly anything that would deviate from that would require legislation to allow that sort of thing to happen.

And I think that would be the response. But, there certainly is a significant amount of co-managed care that does go on in the VA system, where some veterans prefer to stick with their local provider, and then come to the VA because of the prescription benefit.

I think that as we open up additional sites of care, if we're closer to where the veteran actually resides, that they'll be more apt to go to

VA care initially, and not seek out their local provider.

I know we have a significant number of veterans who, once they do come to VA, find out how good the care is, how wide the variety of care is, and have transferred their care entirely to VA. So --

DR. CHIRICO-POST. A final comment that I will make on that, VHA, through its extensive performance measurements system has demonstrated both on the inpatient and outpatient side of the house that we are a leader in quality, a benchmark for other healthcare organizations.

A recent study in preparation for this that I looked at was to compare -- the joint commission publishes a performance through ORECS and in Togus -- Togus is above other healthcare organizations in those inpatient performances.

That didn't happen by accident, it's by coordinating the care.

And for those of us who provide that care -- I think there has to be a different policy decision to support the prescription only in the VHA.

We don't have that policy yet.

MR. BROWN OF SOUTH CAROLINA. Right. And we've established that. I was just curious to know how you might feel about that.

I know you said that your mission is to take care of these veterans and, you know, prescriptions are part of their healthcare too. I don't know why they would separate that, but I was wondering if you would just have a response to that.

Thank you all. Mike, do you want to --

MR. MICHAUD. Yes. Mr. Chairman, I have, actually, several more questions, and I would request permission to submit the questions for the record so we could get the response from Dr. Post and Mr. Sims.

As well as I want to thank you both for coming today. And I definitely encourage Mr. Sims to try to get those numbers to us, and really work hard with the hospitals out there in the community. I know they're real anxious to do whatever they can to make sure that they can work with the VA to get the clinics up and running, because we definitely do need them.

MR. BROWN OF SOUTH CAROLINA. Thank you very much. Let's move up our next panel.

Our second panel is Don Simoneau, Vice Commander of the Department of Maine American Legion; Mr. Gary Laweryson, Chairman of the Maine Veterans Coordinating Committee; and Mr. Roger Lessard, President, of Local 2610 of the American Federation of Government Employees. And Mr. Lessard has been an employee of the VA for over 20 years.

And we welcome you guys and we'll ask Mr. Lessard to begin.

STATEMENTS OF ROGER LESSARD, PRESIDENT, AFGE LOCAL 2610; DON SIMONEAU, VICE COMMANDER, THE DEPARTMENT OF MAINE AMERICAN LEGION; AND GARY Laweryson, CHAIRMAN, MAINE VETERANS COORDINATING COMMITTEE

STATEMENT OF ROGER LESSARD

MR. LESSARD. Thank you, Mr. Chairman. It's my pleasure to be here today. Of course, I represent approximately 800 VA employees in professional and nonprofessional positions at the VA facilities affiliated with Togus; also including the Bangor, Calais and Caribou community clinics.

Rural healthcare markets face significant challenges as compared to urban markets, including a limited number of specialists, less access to expensive technologies, and a less affluent patient population.

At the same time, rural Americans are disproportionately represented in the military. Thus, it is no surprise that a disparity in healthcare exists between veterans living in rural areas and their urban and suburban counterparts.

A recent study by public health experts found that veterans living in rural areas experience a lower health-related quality of life. As a result, the veterans' health care costs are estimated to be as high as 11 percent greater in rural areas.

Here in Maine, we are very familiar with these healthcare challenges. Maine ranks fourth in the nation when it comes to the share of veterans living in rural areas.

Togus VA Director Jack Sims testified before the CARES Commission two years ago that only 59 percent of the enrollees have access to primary care services within the CARES travel time criteria, and only 52 percent have access to acute hospital care.

The Togus VAMC has experienced a dramatic growth in demand for services over the last four years. We average between 300 to 400 new enrollees per month.

Similarly, our community based outpatient clinics have experienced tremendous increases in demand in the past few years. As a result, our veterans are forced to wait longer for needed medical care.

For example, there is currently a four-month wait for ultrasounds in radiology, as well as a wait list for cardiology, urology, and other specialty care.

The CARES Commission warned the VA of this likely surge in demand in its February 2004 Report to Secretary. Specifically, the Commission recommended the addition of five CBOCs in Maine, including one in Lincoln.

However, due to lack of funding, and contrary to the CARES Com-

mission's recommendations, no new CBOCs have opened up to serve Maine's veterans more promptly and closer to home.

If and when we area able to open additional CBOCs, we will not be able to adequately staff them given the current hiring freeze.

Since the start of this year, we have only been able to hire one new employee for every two we lost. If the freeze continues, our only alternative will be to take staff away from another CBOCs, causing shortages and delays there instead.

Lack of funding and cuts in FTEs also affect our ability to deliver timely care in other ways. We have been forced by budget cuts to delay the implementation of important innovations such as our nurse case management system.

Also, we had to delay needed capital improvements and medical equipment purchases, including a much needed MRI machine as discussed below.

Despite years of short staffing, I am proud to represent a staff that has been continuously dedicated to the caring of our veterans. At the same time, I also have to care about our dedicated employees who become ill and stressed because of mandated overtime. Prolonged overtime and other pressures also are causing more or our older staff members to take early retirement, which further adds to the staffing problem.

These staff shortages have forced us to hire agency staff -- an unsatisfactory stopgap measure which ends up costing the taxpayer more, while affecting the quality and safety of the medical care we provide to our veterans.

The veterans in our state need new facilities and more staff to meet their medical needs. Additional CBOCs will allow us to provide more timely care and reduce the long distances that many veterans have to drive to see a doctor.

We will not help the rural veteran -- what will not help the rural veteran is an increased use of costly fee basis services.

Another VISN recently estimated that fee basis care costs 35 percent more than care provided by a VA facility. One must also consider the difference in quality in care delivered by an outside provider who lacks the training and resources available within the VA.

Finally, veterans and taxpayers in Maine will benefit from the acquisition of an MRI machine at Togus.

Currently, we have to pay high prices to outside providers because we do not have our own MRI or PET Scan machines, diverting scarce health care dollars from other needs.

If we had our own MRI machine, we could save close to a million dollars a year, even after including the cost of the purchase. In addition, our veterans would be able to get their screenings in- house.

This has changed, by the way, because now we are proposing to get an MRI machine and PET Scan in Togus.

We are grateful for the recent good news that the current shortfall in VA health care dollars has been partially addressed through supplemental funding. These additional dollars will enable us to undertake some of the capital improvements that we had to delay.

In the long term, there should be a better way to provide reliable funding for the medical needs of returning soldiers and other veterans.

Every budget cycle, our dedicated staff as well as the veterans we serve are left wondering whether there will be enough funding for hospital beds and doctor visits.

Uncertain funding also takes a toll on our ability to plan for the long-term needs of current and future veterans.

Thank you again for the opportunity to testify on behalf of the Maine veterans and thank you also for holding this hearing in Maine.

We at Togus will continue to provide the best care for our veterans. I am proud and grateful that as elected officials that you have recognized how this shortfall has hurt veterans and that measures are needed to rectify the problems that have resulted.

I pray that our veterans will never again have to experience these problems in accessing health care.

Thank you.

MR. BROWN OF SOUTH CAROLINA. Thank you, Mr. Lessard. And thank you for your service.

[The statement of Mr. Lessard appears on p. 51]

MR. BROWN OF SOUTH CAROLINA. At the conclusion of all three of these presentations, we'll have some questions.

STATEMENT OF DON SIMONEAU

MR. SIMONEAU. Chairman Brown, Congressman Michaud, I thank you for the opportunity to testify before you today on behalf of the American Legion, Department of Maine, regarding Access to Primary Care for Rural Veterans in the State of Maine.

According to the 2000 Census, many rural and non- metropolitan counties across the nation had the highest concentrations of veterans in the civilian population aged 18 and over from 1990 to 2000.

The State of Maine has the fourth highest proportion of veterans living in rural areas in the nation at 15.9 percent. Studies have further shown that veterans who live in rural areas are in poorer health than their urban counterparts.

And I present to you an article from the American Journal of Public Health, October 2004, to go on record to show that article and that study.

The Capital Asset Realignment for Enhanced Services, CARES Commission, report released February 2004 specifically mentioned

the Far North Market, which is Maine.

Only 59 percent of the veterans in Maine are presently within the CARES own guidelines, to access primary care services.

The subsequent CARES decision released in May 2004 identified 156 priority community based outpatient clinics, six of which are slated for Maine.

CBOCs were designed to bring health care closer to the veteran, and that means in the community where the veteran resides.

After a long, hard fought battle the final commission report and the CARES decision decided that, indeed, VISN1, and more importantly, Maine, needed these CBOCs to provide adequate primary care access to a mostly rural population.

The CARES decision of May 2004 directed that VISN begin immediate preparation of proposals for development of CBOCs for that same year. However, upon inquiry to the Veterans Administration Central Office, the American Legion has learned that business plans have not been submitted or revalidated during 2005, and are not anticipated until the final 2006 budget allocations are distributed and reviewed by VISNs.

The CBOCs of VISN 1 listed in the CARES decision are all designated for the State of Maine. The American Legion does not understand this delay. Nearly two years will have passed in preparing the proposals.

Additionally, establishing a CBOC is not a not a short process, and now the timeline has been considerably pushed back. The VA can ill afford a time lapse as lengthy as two years when it comes to providing health care to our rural veterans.

The nation is in the midst of a war on terror, and delaying the delivery of quality health care is not in the best interest of any veteran.

Of special note is the provision of mental health services within the CBOC setting. Mental health specialists within the VA all agree that CBOC should provide mental health services; however, they do not.

The committee on care of veterans with serious mental illness, has been monitoring this issue for years and has advocated in their annual report to Under Secretary of Health that CBOCs need to provide mental health services.

It has been reported that up to 30 percent of the returning veterans from Operations Enduring and Iraqi Freedom will have mental health problems to include post-traumatic stress disorder.

In 2005, Togus reported approximately 365 Operations Enduring Freedom and Iraqi Freedom veterans enrolled for healthcare with approximately 260 actively seeking medical and or mental health services.

While the VA does not believe returning veterans will have a major impact on Togus, they are continuing to monitor it.

The American Legion cautions the Togus facility on their optimis-

tic view of returning veterans and their impact on the system.

Let us not forget that the returning veteran suffers from multiple physical and mental wounds and is resource intensive to treat. Those that put their life on the line so that we may enjoy our carefree lifestyles deserve nothing but the best, and we can not deny them their deserve treatment.

What is of growing concern to the American Legion is the increasing number of veterans who are put on electronic wait lists. For example, in medical specialities, if a veteran is a service-connected at 50 to 100 percent, priority group 1, you can usually be seen within 30 to 45 days. However, if you are not in that priority group, you can wait up to year for specialties such as ophthalmology or orthopedics.

The VA budget woes are well documented, and the American Legion has played a key role in bringing these shortfalls to the forefront.

The American Legion has advocated for assured funding to ensure shortfalls such as that experienced by the VA this year does not happen in the future.

Again, I thank you for the opportunity -- for giving the American Legion this opportunity to express our views for the Department of Maine. We look forward to our continued work with Congress on these important issues.

Thank you, sir.

[Applause.]

[The statement of Mr. Simoneau appears on p. 55]
[The attachment appears on p. 59]

MR. BROWN OF SOUTH CAROLINA. I would also like to thank Mr. Simoneau for the help you put in for locating graves of the departed veterans.

And I was just curious as I read that last night, that there's an initiative in other states and other regions to do a similar thing.

MR. SIMONEAU. When I started that a few years ago, it was a local thing, because my Post said that we need to make sure that we flag the veterans.

And now I'm getting phone calls from all over the country. I mean, I've had people from Ohio and Florida contact me and say, how did you start this, and, you know, where do you go from there. So -- Thank you, sir.

MR. BROWN OF SOUTH CAROLINA. Okay. Mr. Laweryson.

STATEMENT OF GARY LAWERYSON

MR. LAWERYSON. Chairman Brown, Congressman Michaud, we appreciate testifying on behalf of the Maine Veterans Coordinating Committee. We represent 14 organizations and speak as a united

voice for the veterans of Maine.

The VA CARES program, short for Capital Asset Realignment Enhanced Services, studied the access to Maine's rural veteran population and concluded more Community Based Outpatient Clinics -- CBOCs -- were needed along Maine's North-South corridor and Western Maine.

These CBOCs would provide a greater number of Maine's rural veterans the much need access to quality outpatient and specialty care.

Every CBOC site within Maine is filled to capacity and are in need of expansion to be able to continue to provide the quality care Maine's veterans have come to expect. The CARES study shows Maine is greater in area and rural veteran population than the other entire VISN 1 areas.

In 2004, the VA's computer projections were 154,000 veterans in Maine that were eligible for care in the VA system.

These projections did not take into account the veterans who move to Maine's rural areas to escape the fast life, nor Maine's growing retired veteran population.

Through the efforts of the Maine Veterans Coordinating Committee and its subsidiary organizations, Togus VAMROC enrolled 500-700 new veterans each month for over two years.

Although this trend has slowed, Togus continues to enroll new veterans each month.

Now that Maine's National Guard and Reserve components are returning from Afghanistan and Iraq, many with wounds and illnesses requiring VA care, the need for access will again increase.

Maine's current VA system is stretched to the breaking point, and it is imperative that new CBOCs are made available to provide timely access to the services.

Due to Maine's unique geographical size, it is difficult for many of Maine's veterans to travel to the existing sites. Maine has no mass transit system. Maine's veterans rely on the DAV shuttle bus for transport to Togus and the CBOCs.

However, in the northern counties, there is only one bus available. Many of Maine's rural veterans are on a limited, fixed income and are unable to afford transportation to Togus or the nearest CBOC. Nor can these veterans afford health insurance or access to local care.

The Maine Veterans Coordinating Committee believes Togus should be expanded to become a full service VA Regional Medical Center, independent of Boston. Maine's rural veterans must now travel several hours one way to obtain care at Togus or a CBOC.

To require Maine's veterans to travel three to eight hours more to Boston for tertiary care is unacceptable. Maine has one of the top rated Cardiac Surgery Centers in the nation, and is leading the nation in long-term care and end-of-life care provided to our veterans.

Sending Maine's veterans to Boston removes the family and local

veteran support system sorely needed to effect recovery of its veterans.

While the majority of the nation is urban or metro, and have showed a slower growth, rural Maine has demonstrated a sustained growth pattern and will continue this trend.

Lastly, the Maine Veterans Coordinating Committee would urge the VA to open lines of communications to all veterans, not just in Maine. In the past, the veterans have not felt the VA was user friendly. As a result, many older veterans and those serving on active duty have failed to avail themselves of the quality care provided by the current VA system.

In Maine, the veterans are banding together to educate our veterans on the many services available to them. Operation I Served is a joint project initiated to provide information to Maine's veterans, their spouses and families on services through the VA system, educational benefits, tax relief, financial assistance, employment assistance, housing assistance, and long-term-care options through the VA and Maine's Veterans Homes systems.

Our program has received requests and been supplied to many other states.

Again, on behalf of the Maine Veterans Coordinating Committee and the Maine veterans we represent, thank you for allowing us the opportunity to speak to you.

The Maine Veterans Coordinating Committee looks forward to continuing to work with Congress to enable the VA to provide quality services to all veterans.

[Applause.]

Mr. Brown of South Carolina. Thank you very much. And thank you for that report.

[The statement of Mr. Laweryson appears on p. 64]

Mr. Brown of South Carolina. We'll continue the questions.

Mr. Simoneau, while this hearing is focused on primary care, do you think there's any utility in using new innovative technology such as telemedicine to help fill the current gap of specialized services you mentioned in your testimony, like tele-psychiatry?

Mr. Simoneau. Congressman, I guess my own -- my own gut instinct is that, if I'm suffering from PTSD, or I'm suffering from mental illness, I want to talk to a person. I don't want to sit in front of a telecommunication device and testify in front of something that scares the puppy out of me.

And I believe that a doctor or a therapist immediately for that patient needs to be there for that type of service.

Mr. Brown of South Carolina. Do you see any line of treatment where telemedicine might work, like eye examinations, blood sugar

checking, and many other different types of diagnostic testing situations that you believe it could fit.

MR. SIMONEAU. I believe there are places that tele-communication will work. But I think that we have to be real careful in placing what items in front of that type of situation.

If we're talking about a doctor being able to look at reports and do things with telecommunication with a patient that are paper-work intensive or such, yes.

But, when it gets down to an exam, where you're really talking about the nuts and bolts of what's going on with the patient -- a lot of these people have been through stresses already in their lives.

And to put them under the stress of a television camera I think is unfair. There are places they can be used, I agree. But, I think we have to be very careful in picking those areas.

MR. BROWN OF SOUTH CAROLINA. Mr. Laweryson, your written testimony suggested that VA is not notifying younger and older veterans of the services available through the VA. I know there's the American Legion and other avenues.

What type of outreaches would you like to see that aren't currently taking place in Maine or other regions of the nation?

MR. LAWERYSON. Well, sir, I think the VA has to overcome the past transgressions.

What I mean by that is, the communications. The VA right now is user friendly. From the Vietnam era on, it wasn't user friendly. And that stigma sat there for a long time. We have seen an increase of Vietnam veterans coming, and that's due to the fact that this -- we're used to working with the VA on that. Communication goes out, and then it's up to the service organizations to get the word out, and explain to them that this is a user-friendly system now.

And, as Mr. Sims eluded to, once they get in there they find out -- you know, it's like Christmas. This place is fantastic.

And then they come back out and spread the word again. But, it's a fact that we need to get that word to them, especially the older ones right now with the economy the way it is and the fuel. There's tough times ahead in the state of Maine, especially -- an hour north or here, either side of 95, is a bit lonely. There's not much out there.

And a lot of your combat veterans, not just from Maine, but from other states, gravitate to this solitude. There's a great number up there that are hiding.

The 154,000 veterans that we have, and -- we feel it is higher -- and our objective or goal is to notify as many of them as we can. That's why we went from 16,000 to 36,000. And we tend to make Jack earn his money up there, get another 10 to 15,000 enrolled.

MR. BROWN OF SOUTH CAROLINA. Mr. Simoneau, do you have any suggestions of how we might be able to reach the veterans and notify them of the services available.

MR. SIMONEAU. I believe part of our problem in the state of Maine is how rural we are.

You can go an hour from here and not have cell phone communication down the street. You can go across the street and not have communication on the Internet.

There's a lot of people within the state of Maine who don't have TV cable. There's a lot of access issues within the state of Maine that are really prevalent to the state of Maine because of the type of state we are.

Reaching those people is a full-time job, and I'm not sure how we can better do that.

The veteran organizations go out there, but you need to understand, some of these veterans are really skeptical about a veterans organization. You know, what do they want from me.

And they're afraid of the VA system. The VA turned me down when I got home from World War II. I went over to see them and they said, sorry, you're okay, go home. And that veteran in 1946 went home.

And now, when he's 80 years old, we try to tell them, you know, you need to go to Togus, you need to get some help.

He looks at me and he says, but they sent me away in 1946.

And you would be surprised how many veterans that are out there that are that way. And I'm talking 1946, World War II veterans.

But, we can do the same thing with the Korean veterans, and we can do the same thing with the Vietnam era veterans, and I'm sure down the road with the Iraqi Freedom veterans, we're going to have that same issue.

How do we do that? I'm not sure.

We've done local areas where we bring in people from the VA, people from the Maine Veteran Services, and we sit down and we ask veterans to come to the community to apply for help, to talk to people. Those fair-type systems work very well.

But, to put them on in a state as rural as Maine is tight skating.

MR. BROWN OF SOUTH CAROLINA. Do you have something like a mailing list? I know the post office gets to everybody, I would assume that, even up here --

Do you have up here a mailing list where you have everybody recorded?

MR. SIMONEAU. I believe, under the Freedom of Information Act, and all of the other requirements for protecting peoples' rights, that's one of the drawbacks of those rights, and that protection.

The names are out there, but we don't have access to them. We have access to the 26,000 members of the American Legion here in the state of Maine, but we don't have access to the 156,000 that are actually veterans.

MR. BROWN OF SOUTH CAROLINA. Okay. Mr. Michaud.

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

Mr. Laweryson, you talked about the Operation I Serve program. I was really intrigued by that. And living in the state of Maine all my life, I know how rural the state of Maine is, and it's problematic particularly when you look at the economic hardships which we have had over a number of years with mill closings and what have you.

Currently we're going through the BRAC process and we don't know how that's going to end up for bases in Maine.

In the program, Operation I Serve, how do veterans know about that program? I know it's difficult. We do have telecommunications here, but is there a website, or an 800 number that they can call in? Do you do mailings?

Can you tell us a little bit more about the program?

MR. LAWERYSON. The I Serve, we have a website, www.mainedvs.org. They get the information from there. The packets come out in the county where it's most rural up there.

Every town office gets a copy of this on CD as well as the paper one. And that was done through the coordinating committee. We got the funds ourselves, and we got a veteran up there, John Wallace, who's working on his own.

And we've got this as far south as North Carolina now. I retired from the Marine Corps down there. And when I went down there this summer, I dropped it off at the VA transition site at Camp Lejeune.

We also picked up the VA transitional list, and we're in the process of sending them all over the states, which is the major military installations.

[To Chairman Brown.] South Carolina will get theirs shortly.

But, the veterans returning from active duty, the ones in Maine, we got to let them know. Because when I decapped, we knew nothing about Maine. I grew up here, but I didn't know what the services were.

And I come back and worked through the system. So, what we did is put down the state commanders and the Maine Veterans Coordinating Committee the one with the BBS, and he's sit down and come up with a list of phone numbers, points of contact in the state, federal level.

We amend this every three to four months. We're putting on all of the elected officials now. The governor's on board with this. He made the announcement the 11th of November. He was kicking this off. He fully supports it.

We're grass roots. We're paying for it for ourselves. It isn't costing the state anything.

But, it's helpful to the state because we're getting the veterans in here. It's a slow process.

At town meetings I think would be the way to go.

The VA wasn't allowed to go up and actively enroll because they were shut down, because of the waiting list. Our philosophy was, if

you could get the numbers then you could justify them paying or getting the money to us. And it works.

And Jack Sims down there, at VA Togus, is doing a phenomenal job taking care of our veterans, and he wants to do a better job. That's why we're trying to get the veterans in there.

It's a challenge. And other states have asked us for it, and they're starting to -- I think the key word is you work together. All of the veteran organizations have to work together. Dance on the same sheet of music, and we're also building the VAs.

They get this out to the congressmen's offices and the senator's offices, and they're aware of this, because they're getting an influx of senior citizen centers, hospitals.

Get it out there and get it in front of them. Things are getting tight out there, and these people have got to make decisions. Do put heat in the house? Do I pay for the pills? And it's getting to the point where some of their kids bring them in to us.

It works. The CBOCs are critical. If they can't travel down to Bangor, we've got one in Lincoln, we got one in Houlton -- that's the North-South corridor. And the western corridor goes across Route 2 and goes over towards Rumford and that area. And, of course, Lewiston-Auburn is a large city for Maine.

Mr. Michaud. And don't forget Dover-Foxcroft.

Mr. Laweryson. Well, no, we can't forget that.

Mr. Michaud. How would you -- to follow up on that question.

What I've seen, particularly when Great Northern, where I worked for 30 years, shut down and filed bankruptcy, a lot of the workers there are veterans.

How do you convince someone who's working currently -- has good health care benefits, do not need them to go to the VA at all, how do you convince them to sign up to make sure that they're taken care of? Is there a lot of resistance?

Mr. Laweryson. It is and it's due to a lot of rumors up there. And the rumors are rampant.

You can come out here and say, you know, the VA is the way to go. And someone else is out there saying, you don't want to go to VA because -- they'll kill you, and it's slow, the waiting list is prenominal.

Well, in some cases it is and some cases it isn't. It's the education system. Again, this is part of it.

Category 8s, there's going to be a wait, Category 7s, there's a wait.

There's a priority list, and the priority list is there for a reason. There's a priority given your treatment for the VA.

They need to understand this. Once they're made aware of it, and what's available, there's not a problem. They feel that they can go down there and get into this.

But there are a lot of veterans out there who really need to be in there, they're just unaware.

And we need -- as the veterans that are active now, we have to communicate to them, and do so on a level that they will understand and are comfortable with, so they you can come to the VA and get proper treatment.

MR. MICHAUD. Mr. Simoneau, in your testimony, you raised concerns about electronic waiting lists. And, actually, I think the VA Inspector General came out with a report that says that the VA is under-reporting the number of veterans on the list, and that they're over-reporting the number of veterans who are receiving services within 30 days.

Can you elaborate more on the problems at Togus and at the clinics?

MR. SIMONEAU. I won't elaborate on numbers, because I guess, as you can see, numbers will tell whatever you want to say.

I'll elaborate on the fact of people that I know of within the system.

And people I knew within the system get very frustrated. They think they have an appointment. They think they're all set, and then all of a sudden they're on this list and, oh, by the way, your appointment isn't this month, it's not next month. We'll get back to you.

I get real nervous over electronic wait lists. I'm just not sure -- once again, we're taking a person out of the middle of that system.

MR. MICHAUD. To follow up on that question that's very similar, what would you recommend that we would do at the federal level, in the sense that there are waiting lists, and the veterans are waiting and going for services after retirement?

Is there something that we could do to help in the short term to help veterans?

MR. SIMONEAU. I believe that we need to come up with some sort of emergency funding for these veterans. I believe we need to come with some sort of pilot program where a veteran who applies for assistance in Togus, or Rumford, or Portland, wherever, when he applies for assistance, he needs assistance now. It's not six months from now.

But, he's also not eating well, he's not paying the rent well, he's not paying the electric bills well. He has no assistance out there to help him get by, until when he gets his paperwork done, that says, oh, yes, he's PTSD, a hundred percent, he should have been qualified for that two years ago.

But, there's no safety net out there for him. When he applies for it, from the time he applies until the time he actually sees somebody, where the system is kicking in, time goes by and the veteran is hanging out there on a thread.

And those are the veterans that sooner or later run away from the system because, well, gee, I can't do that, and I don't know where to go.

So, we need to come up with some sort of safety net, be it an emer-

gency-type funding mechanism, or something that can temporally get that veteran through a tough time that he finds himself in. And there's got to be a way to do that. And we need to be able to sit down and figure that out, because those veterans are walking away from the system that they need, but they're afraid they're going to starve to death before they get through it.

MR. MICHAUD. My last question is for Mr. Lessard.

Since Congress has provided additional funding--and the legislation was just signed recently--for the budget short-fall at the VA, has Togus started to fill some of the vacancies, or started to conduct some of the needed repairs at Togus?

MR. LESSARD. Congressman Michaud, not as of yet. We have tried to fill some of the gaps, but they're not fully staffed as of yet. And I'm sure that we will be working on that in the near future.

MR. MICHAUD. Can you give any examples of lack of adequate staff? What are they doing to veterans' access to care?

MR. LESSARD. It's delaying some of the clinics, I believe, in some of the areas where they're short- staffed.

It's also causing -- as I mentioned in my testimony, we are causing older nurses that would remain for another four or five years to retire early, due to the mandated overtime due to the short falls in staff.

It has a great demoralizing effect on the employees.

MR. MICHAUD. Thank you.

MR. BROWN OF SOUTH CAROLINA. Okay. Thank you very much, Gentlemen, for your testimony, and for what you do to support our veterans. I know I had the privilege this past Memorial Day to go to Normandy and be a guest speaker. And what a moving experience it is. We saw all those flags, over 9,000, of those Americans who never got a chance to come home; a lot of 17- and 18- and 19-year-old kids. The price of freedom of this nation is tremendous.

And I pledge to you, and Mr. Michaud certainly has been supportive, as part of the Health Subcommittee, assure you guys and you girls that you'll have support up here.

And it's been a real pleasure for me to come today and be part of this session.

And you can be absolutely sure that we try to find other ways to make the problems up here much better, and support the staff and the various operations around the nation.

But, it can't happen unless we have the feedback from folks like you. And we thank you for taking your time in coming and being with us today, and the preparations you made to make these presentations.

And I do thank you. Thank you all for coming and being part of this process.

Mr. Sims, I guess I have one other official thing -- I think you have something you wanted to submit for the record, and I'll also note that

at this time.

MR. MICHAUD. And I guess you have been reading my mind, Mr. Chairman, because we work so closely here, I was going to actually mention that Mr. Sims wanted that included for the record.

And, once again, Mr. Chairman, I want to thank you for taking the time to have one of the two hearings that we're having in the country as it relates to healthcare for veterans in Maine. And the State of Maine really appreciates that. And I want to thank all of the veteran organizations and veterans that came out this morning to be with us.

Thank you for your testimony, it definitely has been enlightening, and we'll be sitting down with the Chairman to move forward.

So, once again, thank you very much.

MR. BROWN OF SOUTH CAROLINA. This meeting stands adjourned. Thank you very much for coming.

[The statement of Senator Olympia Snowe appears on p. 35]

[The statement of Ronald W. Brodeur appears on p. 66]

[The statement of COL Edward L. Chase, USAF (Ret.) appears on p. 70]

[The statement of Roger Landry appears on p. 75]

[The statement of Timothy J. Politis appears on p. 78]

[The statement of Peter W. Ogden appears on p. 86]

[The information appears on p.89]

[Whereupon, at 10:39 a.m., the Subcommittee was adjourned.]

APPENDIX

THOMAS H. ALLEN
1ST DISTRICT OF MAINE

1127 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-6116

57 EXCHANGE STREET, SUITE 302
PORTLAND, ME 04101
(207) 774-5019

209 MAIN STREET, SUITE 103
SACO, ME 04072
(207) 283-8054

http://tomallen.house.gov

Congress of the United States
House of Representatives
Washington, DC 20515–1901

COMMITTEE ON THE BUDGET
COMMITTEE ON
ENERGY AND COMMERCE
SUBCOMMITTEES:
HEALTH
ENERGY AND AIR QUALITY
ENVIRONMENT AND HAZARDOUS MATERIALS
HOUSE OCEANS CAUCUS
CO-CHAIR
AFFORDABLE MEDICINES TASK FORCE
CO-CHAIR

August 22, 2005

Honorable Henry E. Brown, Chairman
Honorable Michael H. Michaud, Ranking Member
Subcommittee on Health
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, D.C.

Dear Congressmen Brown and Michaud:

Thank you for your generous invitation for me to attend today's hearing on "Rural Veterans' Access to Care: Successes and Challenges." I regret that I am unable to participate in person in this critically important forum.

The Veterans Administration (VA) health care system is currently in crisis. This crisis is particularly serious in rural states like Maine, where VA health care enrollment has grown steadily in recent years due in large measure to skyrocketing health care costs, especially for prescription drugs.

Jack Sims and the administrators and staff of the Veterans Hospital at Togus continue to provide the highest quality of care to Maine's veterans. Since more than half of Maine's veterans live more than two hours away from Togus, the services now provided by the VA's network of outpatient clinics have become critically important for meeting their health care needs. Representative Michaud and I fight continuously to secure the resources Togus needs to meet the increasing demand and to expand the services provided through outpatient care facilities. In fact, funding for these crucial programs is a top priority for Maine's entire congressional delegation.

Despite the outstanding services provided through Maine's Veterans Homes, we face critical shortages and increasing costs in providing access to quality long term care. Fortunately, Maine's veterans services organizations are tireless champions for the cause of veterans' health care.

Representative Michaud and I are co-sponsors of H.R. 515, The Assured Funding for Veterans' Health Care Act, legislation to move the Department of Veterans' Affairs (VA) health care system from "discretionary" to "mandatory" funding. The bill creates a formula by which veterans' health care would be funded every year, including an annual adjustment based on medical inflation and the number of veterans enrolled. Through

PRINTED ON RECYCLED PAPER

H.R. 515, we seek to establish a formula to assure that VA funding does not erode over time and that preserves the community of dedicated, experienced care-givers who understand veterans' health care issues.

In closing, thank you both for the tremendous job you do on behalf of Maine and America's veterans. Please call on me anytime to help in this vitally important mission.

Sincerely,

Tom Allen
Member of Congress

OLYMPIA J. SNOWE
MAINE
154 RUSSELL SENATE OFFICE BUILDING
(202) 224-5344
E-Mail: Olympia@snowe.senate.gov
Web Site: http://snowe.senate.gov

United States Senate

WASHINGTON, DC 20510-1903

COMMITTEES:
COMMERCE, SCIENCE, AND TRANSPORTATION
CHAIR, FISHERIES AND COAST GUARD SUBCOMMITTEE
FINANCE
INTELLIGENCE
CHAIR, SMALL BUSINESS

Statement of U.S. Senator Olympia J. Snowe
for
House Committee on Veterans' Affairs Field Hearing
on
Rural Veteran's Access to Care: Successes and Challenges

August 22, 2005

I want to commend the Chairman of the House Committee Veterans Affairs' Subcommittee on Health Representative Henry Brown and my colleague, Representative Mike Michaud for conducting this hearing of such tremendous importance to the State of Maine and the men and women who have served our nation so nobly as part of our military. I have long believed that if our soldiers are willing to make the ultimate sacrifice in service to our nation, then they should expect that their nation will give them the support they have rightly earned when they return home.

With our troops deployed overseas, our veteran health care system has come under increasing stress, threatening vital health care services our troops and our veterans depend on. For those of us in Congress who have long fought for our veterans, we were recently disappointed to learn that the Department of Veterans Affairs (VA) faced a massive shortfall in health care funding although just over four months ago, we were informed that the VA would not require emergency appropriations for the current fiscal year.

Congress immediately fixed the funding shortfall and passed legislation that would provide $1.5 billion to close the gap. I both co-sponsored and voted for this legislation as I feel it would be appalling to forget those who have bravely served our nation and put their lives on the line for our freedom. I also supported subsequent legislation to ensure that this funding is made available as soon as possible so that VA services will not be disrupted.

The veterans of Maine who currently travel to Togus for their health care must know that they will continue to get not only the standard of care they have been getting, but the quality that they deserve. We must ensure that all veterans and returning soldiers have the resources necessary to address their pressing health care needs especially in rural areas where veterans often must travel tremendous distances to gain access to the VA healthcare system.

AUBURN
TWO GREAT FALLS PLAZA
SUITE 7B
AUBURN, ME 04210
(207) 786-2451

AUGUSTA
40 WESTERN AVENUE, SUITE 408C
AUGUSTA, ME 04330
(207) 622-8292

BANGOR
ONE CUMBERLAND PLACE, SUITE 306
BANGOR, ME 04401
(207) 945-0432

BIDDEFORD
231 MAIN STREET, SUITE 2
BIDDEFORD, ME 04005
(207) 282-4144

PORTLAND
3 CANAL PLAZA, SUITE 601
PORTLAND, ME 04101
(207) 874-0883
MAINE RELAY SERVICE
TDD 1-855-3323

PRESQUE ISLE
169 ACADEMY STREET, SUITE 3
PRESQUE ISLE, ME 04769
(207) 764-5124

IN MAINE CALL TOLL-FREE 1-800-432-1599

PRINTED ON RECYCLED PAPER

As a rural state, a restructuring of the nation's veteran health care facilities is essential to recognize the realities that exist on the ground today. At a time when so many of our veterans receive their health care through the VA, I was encouraged last year when the CARES Commission recognized the obstacles of distance, time and travel conditions that Maine veterans face in trying to gain access to quality health care.

The Commission found that within the Far North (Maine) and North (New Hampshire and Vermont) Markets in the VA's New England Health Care system, fewer than 60 percent of enrolled veterans are currently within their standards for hospital care of 60 minutes travel time to hospitals for urban areas; 90 minutes in rural areas; and 120 minutes in highly rural areas.

Although the Commission clearly recognized the need to improve inpatient services for Maine's veterans, I believe the report fell short of advocating full solutions. I commend the forward thinking of the Togus leadership and the Commission to recognize the possibilities for telemedicine throughout the state, but it is a supplement, not a replacement for inpatient and outpatient care and I remain concerned that while the shortage of inpatient beds and the lack of physical access to care for rural veterans are acknowledged, they were not addressed.

The CARES report also recognized the necessity of community-based healthcare as a primary option for many veterans and authorizes plans for a new Community-Based Outpatient Clinic (CBOC) in Cumberland County. These community-based clinics provide easy access for veterans to get the approved services they need in order to take advantage of the VA healthcare system. We must remain aware that many rural veterans, sometimes residing four or more hours from the Togus VA Medical Center, have come to depend on resources like the clinic in Ft. Kent, Maine, which is available only one day a week. While the report also announced plans for CBOCs in Lincoln, Dover-Foxcroft, Houlton, South Paris, and Farmington, resources to actually open those facilities have not been definitively identified so those plans remain ambiguous and until we commit those resources, those facilities cannot be a part of the solution.

While increased outpatient care services in Maine and other underserved areas is a good step forward, it is only half of the equation. Veterans must be able to get to the facilities and while programs such as the Disabled American Veterans are to be commended, they simply cannot take care of all the transportation needs of all the patients who require care at Togus. According to Ron Brodeur, Adjutant of the Department of Maine Disabled American Veterans, the DAV Transportation Network in Maine drove 11,598 veterans over 811,579 miles to help their fellow veterans. I would like to thank them for such their heroic efforts. But they do need help.

That is why I am proud to be a co-sponsor of S. 1191, the VetsRide Act that will provide grants up to $50,000 for innovative transportation options in remote rural areas in order to help veterans travel to VA medical centers. This is just one area where relatively small investments can result in significantly better care for our nation's most vulnerable veterans.

Establishing new facilities and transportation networks in Maine would give rural veterans better access to the veteran healthcare system and deliver on the promise America has made to our men and women in uniform. But as rural veterans will tell you, there is a long way to go, and we must redouble our efforts to ensure that the VA secures the necessary resources for the region and that the Far North Market's priorities are appropriately considered. It is critical that these healthcare services are made available to veterans throughout Maine.

In this time of war and global unrest, each of us must certainly make many sacrifices. However, we must not sacrifice the safety and health of our nation's bravest men and women. Rather, we must do all we can to keep faith with those who have served and defended our nation. Providing them with adequate healthcare is only the beginning and I pledge to continue working to improve the lives of those who have sacrificed for our freedom.

USNews.com U.S.NEWS & WORLD REPORT

PENGAD-Bayonne, N. J.
EXHIBIT
No. 2
8-22-06

Most Wired 2005

8/1/05

House Calls

Remote monitors can be lifesavers for chronic disease patients

By Josh Fischman

An extra pound doesn't seem like much. But for George Grande, that little quiver on the bathroom scale could signal that his heart is drowning. Grande, 82, has heart failure, and what used to be a strong, muscular pump now lets blood and fluid pool in his lungs, adding an extra pound or two. More fluid and he'll end up unable to breathe, fighting for his life.

That's the last thing he wants. "I've been to the hospital so many times," says Grande, who lives in the small town of Boxford, Mass., about 20 miles from Boston. His voice sounds tired as he recites the litany: "Three open-heart surgeries, an aorta problem, a leaky heart valve." To keep him safe at home, any weight change needs to be spotted quickly.

It is. About three months ago, Grande's nurse gave him a little device called a monitoring station, which let him input his vital signs. "Every morning it reminds me to check myself," says Grande. "I plug in a blood pressure cuff and a scale, and it sends that stuff over the phone, right to my nurse. A few weeks ago, it picked up a weight gain, and they called me right away and told me to adjust the dose of my medication. That's very reassuring, to know someone is always watching out for me."

Daily care. More healthcare professionals are watching out for patients with chronic conditions like Grande using this kind of remote monitoring. Heathcare agencies spent about $55 million in 2003 on telehealth and expect to spend $260 million in 2010. The key is the daily check of vital signs, a drill that can catch problems much faster than a monthly clinic visit. The technology is easy to use for senior citizens and for kids and adaptable to a wide range of illnesses. Study after study has shown that it helps keep people healthy and out of the hospital and allows scarce medical resources to be stretched over a wider area for a longer period. "It's been great for our patients and great for our agency," says Rhonda Chetney, director of clinical operations for Sentara Home Care Services in Chesapeake, Va. "These are very brittle patients who go in and out of the hospital a lot. With these units in the home, that stops."

Partners HealthCare, Grande's health plan, has placed American TeleCare Monitoring Stations in hundreds of homes and cut hospital readmissions for its heart failure patients by 33 percent. In Brooklyn, N.Y., Coney Island Hospital gave similar devices to 69 asthmatic kids who had been hospitalized at least once a month during the previous winter, and during the next winter all but one avoided the hospital completely. Across the country, the Department of Veterans Affairs has been testing these appliances in the homes of patients with diabetes and lung diseases as well as heart failure; it has found a 35 percent reduction in readmissions and a 60 percent drop in emergency visits. "Plus we get 90 percent patient satisfaction ratings," says physician Adam Darkins, the VA's chief consultant for care coordination. "That's why we'll have these devices in 12,500 homes by the end of this year."

The monitors are hooked up to patients' telephone lines. Using buttons or a touch-screen, the devices engage people in a dialogue about their condition by asking how they feel and if they took their medications. "It will ask a question like 'Are you short of breath?' " says Lisa Canterbury, a nurse and director of a branch of Deaconess Home Care in the small town of Magee, Miss. Her agency uses a four-button device called a Health Buddy. "Then it will follow up with 'Is this *unusual* shortness of breath?' because a lot of our patients are short of breath anyway."

U.S.NEWS & WORLD REPORT
USNews.com

Most Wired 2005

8/1/05

House Calls

Better behavior. Some of the monitors also have plug-in gizmos that measure pulse, blood pressure, and weight automatically. The patients' answers and the medical data are zapped to the home care agency, where clinicians can immediately review them. Anything that seems out of whack triggers an alert and a phone call. "It keeps me on my toes," says Charles Thomas, 82, a pulmonary disease patient in Downingtown, Pa. "The other day I missed a question, and my nurse was on the phone, asking why."

The daily back-and-forth helps change patient behavior, and that is crucial. Nothing is as effective as a motivated patient. A nurse or doctor can remind a patient to do something during a weekly or monthly visit, but patients often forget the advice in a few days. "Once you put these units in the home, patients actually start taking better care of themselves," says Chetney. "They get on a scale and see 2 extra pounds and can relate that to yesterday's hot dogs at the Fourth of July picnic and go, 'Whoa!' "

Chetney, whose service uses a touch-screen device called the Vitel Net's Turtle, likes the ability to customize the virtual chat. If she has a question she wants to ask a specific person say, whether the patient's spouse is around or away--she can easily do that herself.

On the clinical side, telehealth lets agencies spread expertise further than ever before. At Partners, for instance, the agency has several patients with open wounds, from operations or recurring diabetic ulcers. But the agency has only four wound-care nurse specialists. It could take several weeks for the four nurses to visit all the patients, during which time the wound could get infected. Yet a staff nurse can get there in a few days, take photos of the wound with a digital camera, and send them to a wound specialist, who can provide specific instructions on care. "A telehealth visit costs me one third of what it costs to send a nurse out," says Chetney. "When insurance, like Medicare, only gives you a lump sum for home care, you can rip through that really fast with daily visits." Deaconess, in Mississippi, charges patients $9 per day for telehealth monitoring, while a nurse visit costs at least $100 per day.

The VA's Darkins cautions that the technology, though alluring, is not appropriate for every illness. Alzheimer's patients, for instance, may not have the cognitive ability to use the monitors. Yet for people with mild cognitive impairment or stroke, the devices might work quite well, reminding them to take their medications.

Another concern is that the monitors won't be effective without trained nurses and doctors behind them. Agencies can't simply buy the technology and expect miracles, Darkins says. Telehealth works because it provides continuous care, and if the staff doesn't know how to use the machines correctly, there will be gaps in care. But when the monitors are employed with training and commitment, that is exactly what telehealth will prevent: having patients fall through the gaps.

Statement of

Jeannette Chirico-Post, M.D.

Network Director, VISN 1

Before the

House Committee on Veterans' Affairs, Subcommittee on Health

August 22, 2005

****

Mr. Chairman and Members of the Committee, thank you for the opportunity to appear today to discuss "Rural Veterans' Access to Primary Care: Successes and Challenges."

The VA New England Healthcare System (Network), which includes Maine, is an integrated health care delivery system that provides comprehensive, high quality, and innovative care, in a compassionate manner to all veterans it serves. The Network serves over 237,000 veterans with a total budget of over $1.4 billion. Medical centers currently operate 1,915 inpatient beds for acute medical/surgical, mental health, nursing home, and domiciliary care. Annually, the Network has 26,000 admissions and over 2.3 million outpatient visits. Maine, like the five other states in this Network, has unique requirements and health care challenges.

Today, I am pleased to discuss the many areas in which VA is excelling in the state of Maine. Currently Maine has no waiting lists or backlog for new primary care patients; 71.6% of new patients are seen within 30 days; and 94% of established patients are seen within 30 days of desired date. In a national survey, 86% of Maine veterans reported high satisfaction with the timeliness of their appointments. Recent outstanding performance in Maine also includes: screening patients for cervical cancer, monitoring patients with congestive heart failure (CHF), improving diabetic care with good blood sugar control, administering influenza immunizations and screenings for alcohol use problems.

Currently in 2005, the Network is treating over 237,000 unique patients with a total of 38 operational Community Based Outpatient Clinics (CBOCs). In the last five years, VA New England Healthcare has renovated, expanded and opened new CBOCs in rural Maine to improve

access. In 2001, Maine opened a CBOC in Saco; in 2002, we opened an "outreach clinic" in Fort Kent which operates as a part-time satellite clinic and is affiliated with the existing CBOC in Caribou; in 2004, Caribou and Bangor CBOCs completed major expansions and renovations of existing CBOCs; in 2005, Rumford completed relocation and expansion of a CBOC; and Calais will complete their relocation and expansion of a CBOC in October, 2005. Repeated studies have demonstrated that quality of care at New England CBOCs is the same high standard as that of VA's Medical Centers.

VA mental health services in Maine also demonstrate excellence and include both inpatient and outpatient services. A grant was recently received for an expansion of these services to treat a full range of substance use disorders, including but not limited to opiate dependence. VA will also begin to offer Buprenorphine as an opiate substitution intervention.

VA recognizes the importance and benefit of several special programs for the continuum of the frail elderly that abound in Maine, as well as identified unique end of life needs. More patients are enrolled in Maine's Home and Community-Based Care program than in any other facility in the Network. The Togus VAMC was one of the first Medical Centers in the nation to establish a Hospice-Veteran Partnership with the state of Maine. Hospice care is provided by our community partners under either the Hospice Medicare Benefit or VA's Purchased Skilled Home Care program. Hospice is also provided in the Community Nursing Home program. Expansion of the Hospice program is being planned for FY 2006. Long-term care in Maine is provided through the facility's Nursing Home Program, partnerships with the five State Veteran's Homes, and in the Community. Approximately 500 veterans are cared for outside of the Medical Center.

One of the four strategic goals for VISN 1 in 2005 has been the expansion of telemedicine and home telehealth. Telemedicine is a prime strategy for meeting rural health care needs in this Network, including those veterans who need specialty services at a distance. The goal is to provide an electronic network capable of supporting the veteran patient wherever they live by providing an innovative means of communication between the veteran patient and the health care provider. There are a total of 102 videophones located throughout the VISN to provide a means of communication between veterans and their health care providers. Twenty-

eight videophones are located at Togus. We are among the leaders, nationally, in several areas with key successes in dermatology, mental health, and eye care. I would like to share some of the ways in which telemedicine is enabling VA to meet the needs of Maine's veterans.

The Care Coordination/Home Tele-health program provides the tools to help patients self-manage their care thus reducing hospitalizations and enabling them to live in the least restrictive environment. Simple electronic devices placed in the patient's home and connecting through existing telephone lines allow patients to send and receive information from their health care team. Currently there are 108 of these devices located throughout the VISN and 24 of them are located at Togus. As of June 2005, there are 555 unique patients participating in the program throughout the Network. 69 of those patients reside in Maine. A recent article from "US News and World Report" entitled *House Calls* discusses telemedicine and the VA's use of this innovative medical tool. I'd like to submit a copy of this for the record. Tele-monitoring, rather than weekly or monthly clinic visits improves the quality of care and reduces the need for patient travel, especially over long distances. Expanding home care and community-based programs, emphasizing health promotion, wellness, and prevention will assist in reducing the cost of care and enable the Network to treat more veterans.

Another technology under telemedicine, My Health*e*Vet, will be significantly enhanced with the advent of pharmacy refill functionality. VISN 1 is expecting to launch an initiative to inform patients and their care-givers of the ability to log onto their personal web health information system, to obtain health information, to enter their own health information (such as blood pressure, blood sugar, and weight), thus sharing that information with their providers. The pharmacy refill functionality will allow them to see and order their medicine refills and thereby eliminate the need to travel long distances.

Telemedicine is helping VA to work collaboratively with DoD to ensure a seamless transition for our returning service members. The Computerized Patient Record System (CPRS) provides sharing of patient data in a secure fashion. This allows users in one location to view health information of a patient whose "home record' is based in another location. The latest iteration of this software is VistA-Web. This iteration has enhanced the ability to view DoD

health data for veteran-patients recently discharged from active duty. This moves VHA closer to its goal of seamless integration of healthcare across a continuum of care.

When specialist referrals are required, CPRS information may be transmitted between providers locally and elsewhere through interfacility consults. The Network has implemented and deployed several specific high-volume remote consults for the veterans in Maine including Tele-dermatology and Tele-psychiatry. An integrated VISN-wide approach to EKGs was implemented several years ago to remotely read and access EKGs by cardiology anywhere in New England. The Network 1 has received resources and support for new retinal imaging cameras, including new equipment for Maine, to support the screening requirements of diabetic eye care. Telemedicine plans for fiscal year 2006 include VISN-wide deployment of tele-pathology and tele-radiology for computerized tomography (CT) and magnetic resonance imaging (MRI).

In addition, a Primary Care Tele-care call center was established at each medical center in New England starting in 2002. The goal of the program was to allow veterans to dial a toll-free number for access to their primary care team. This has allowed them to cut directly through VA Medical Center phone systems and reach a call center staff trained to handle their needs. In 2004 – over 600,000 calls were handled throughout New England. Support ranges from medicine refills and appointment scheduling to requests for test result information and more.

VA recognizes, authorizes, and provides non-VA services in those appropriate instances of need and request. For eligible veterans both inpatient and outpatient care is provided. The network has established processes for enhanced access through this program. A case management system exists for monitoring non-VA health care in all facilities including Maine. VISN 1 has witnessed significant expenditures network-wide in the fee program. There are more veterans seeking care in New England and especially in Maine. The network is committed to providing timely quality care. Over 30% of the resources identified in this program are expended in Maine to meet the needs of those veterans. These are provided in a number of settings in outpatient care including diagnostic testing such as MRI and mammography, mental health,

inpatient hospitalization, and home health. Continuity of care is supported through the electronic medical record and case management system.

VA is committed to ensuring a seamless transition from active duty to civilian status for our newest veterans returning from conflict in Afghanistan and Iraq. To-date, over 5,000 veterans are enrolled in the Network, including 524 in Maine. Those returning veterans, in Maine, are seeking care from VA specifically for primary care (387 veterans), dental (325 veterans), and mental health (114 veterans). Additionally, there are 18 Vet Centers located throughout the Network where returning veterans may seek readjustment counseling and other related services. Five of those Vet Centers are located in Maine.

In summary, VA has implemented numerous innovations to meet the rural health care challenges facing our Maine veterans. Today's veterans will know, in whatever setting they receive their healthcare, that they are receiving the highest quality of health care from professionals who are proud to serve our Nation's veterans.

Mr. Chairperson, this concludes my statement. I truly appreciate the opportunity to share with you how VA New England Healthcare System provides quality and compassionate healthcare to veterans in the state of Maine.

Statement of

John H. Sims, Jr.

Center Director

Togus VA Medical Center

Augusta, Maine

Before the Subcommittee on Health

of the

House Committee on Veterans' Affairs

August 22, 2005

**

Thank you for the opportunity to speak today about "Rural Veterans' Access to Primary Care" in Maine. There have been many changes in recent years in the delivery of healthcare services in the Department of Veterans Affairs in general and Maine in particular.

At Togus, as well as throughout the entire health care field, there is now a sustained emphasis on outpatient services—an emphasis that has significantly reduced hospitalization stays and more clearly focuses on outpatient clinics and their available services. Although we have changed the manner in which we provide our care, we continue to provide the same broad range of services and high quality care that we have always provided to an ever increasing number of Maine veterans.

As our healthcare delivery system continues to evolve, it is critical that we continue to monitor our services through internal and external audits to ensure the quality of our services. Our various monitoring processes indicate we have maintained, and in many cases improved, the quality of medical services.

VA ACCESS TO PRIMARY CARE FOR RURAL MAINE VETERANS

During my 15 year tenure as Director of the Togus VA Medical Center, there has been a remarkable and sustained shift in the delivery of healthcare services in Maine. In particular, VA has been progressive in its attempt to provide rural healthcare access. Today, there are five full-time Community-Based Outpatient Clinics (CBOC) in Maine, several of which have been expanded more than once to meet increased demand. These full-service CBOCs are located in Bangor, Calais, Rumford, Caribou, and Saco.

As an essential part of primary care, all existing CBOCs also provide preventive health services and health promotion and disease prevention programs. Additionally, a part-time primary care access point is located in Fort Kent, which is a satellite of the Caribou CBOC. There are also two VA mental health clinics located in Bangor and Portland. In addition, there are 18 vet centers in VISN 1, five of which are located in Maine.

To better serve Maine veterans, four of these CBOCs were recently expanded or relocated, and the remaining CBOC in Calais will soon be in its new location. The anticipated moving date is October, 2005.

The larger spaces we have obtained has allowed us to increase staffing levels and offer additional services for the benefit of Maine veterans. Four of our five CBOCs now offer on-site phlebotomy services and all CBOCs have VA contracts locally to provide X-rays and stat lab services.

We've also been able to increase access to Mental Health care throughout the state. The Bangor CBOC has an adjacent Mental Health Clinic which is fully staffed and full-time. Mental health support for the Saco CBOC is provided by the newly expanded and relocated Mental Health Clinic in Portland. Tele-mental health is in place in Caribou and is planned for Calais when the CBOC is relocated later this year. Finally, the Rumford CBOC now has an on-site Mental Health clinician one day a week with plans to expand services when additional resources become available.

One of the most significant changes in VA healthcare in Maine has been the extraordinary increase in the number of enrolled veterans selecting VA as their preferred choice for healthcare services and support. In 1999, total enrollment for VA healthcare was 19,000 veterans. A short five years later in 2004, enrollment had increased to over 36,000, nearly double the numbers of five years ago.

Equally interesting is that in 1999, only a third of enrolled veterans sought their primary care at the CBOCs. In 2004, half of our enrolled veterans did so—and the percentage continues to increase. These statistics clearly indicate that veterans prefer to receive their VA healthcare closer to home, whenever that is possible.

The Togus VA Healthcare System has been coordinating closely with the Maine National Guard and various Reserve units to conduct outreach for OIF/OEF returning service members. The outreach efforts include healthcare and non-medical benefits briefings as well as information on readjustment counseling by the Vet Centers. Currently, approximately 550 OIF/OEF veterans have enrolled for VA healthcare and about 80% of those enrolled are actively seeking some type of medical and/or mental health care. At this point, the vast majority of OIF/OEF veterans have only required outpatient healthcare.

VA PLANS TO MEET THE CHALLENGE

In the May, 2004 CARES Decision six additional sites of care throughout Maine were authorized pending availability of resources and validation with the most current data available. To better meet the needs of underserved veteran populations, the majority of these newly authorized sites will be located in more rural areas of Maine which would significantly further the attainment of a primary goal of providing veterans quality healthcare closer to their homes. Togus will continue to closely monitor implementation of these additional sites of care as resources become available.

Based on the burgeoning veteran population seeking care at the current CBOCs, Togus will also continue to monitor the growth at the existing sites of care and provide additional resources and providers as necessitated by demand.

To help meet the emotional and medical support needs of the widely dispersed veterans in the huge area of far northern Maine, Togus has positioned two social workers in Aroostook County. While one social worker has more specific training in mental health issues and the other in medical issues, they both work at the Caribou CBOC and in the field addressing both kinds of problems and providing care to veterans in whatever setting is most beneficial. Both consistently receive positive and enthusiastic comments from the many veterans who are cared for by them.

Togus will also continue to be a leader in health care by identifying and employing new technologies such as the latest improvements in home healthcare monitoring.

To date, we have 69 patients receiving varying stages of adjunctive care through tele-health devices. A recent article from "US News and World Report" entitled *House Calls* discusses telemedicine and the VA's use of this innovative medical tool. Currently, there are 102 total videophones located throughout the VISN and 28 of those are at Togus. Simple electronic devices, called Health Buddies, are placed in the patient's home and connect through existing telephone lines to allow patients to send and receive information from their health care team. There are currently 108 of these devices located throughout the VISN and 24 of those are at Togus. Our Home-based primary care unit has been using video phone devices for more than a year to provide follow-up and on-going care to patients in individual and residential home settings. Physician assistants and nurses use these devices to review medications, look at wounds, complete psychosocial assessments, conduct follow-up reviews for medication changes, and to determine if there have been any changes in health status when medications have been changed.

Our spinal cord injury unit has been providing care through use of interactive tele-video devices for some time. These devices include cameras and video conferencing

capabilities, and have the ability to measure blood pressure, blood sugar, pulse oximetry and weight. Patients can talk face-to-face with providers, show the status of wounds by moving the camera over the affected area, provide daily information on blood sugar readings, and provide other important information, so that areas of concern can be addressed without the patient having to travel to Togus.

Our Women's clinic recently began to use an in-home messaging device to provide medication reminders, instructions on various home care needs, and general health improvement questions to provide support to this veteran group. These devices have a set series of questions designed specifically for the diagnosis being treated set in the machine with the patient going through the prompts and answering "yes" or "no" to questions.

The information is sent to the patient's care coordinator who reviews the information daily. If an answer is not within the established norms, the coordinator contacts the patient to determine the type of intervention necessary. This methodology also allows patients to indicate if they need to be contacted because of a question that they might have and allows them to do so without having to be concerned that they are interrupting another patient's care.

Togus VAMC was one of the first VA Medical Centers in the nation to establish a Hospice-Veterans Partnership with the state. Hospice care is provided by community partners under the Hospice Medicare Benefit or paid for out of the Purchased Skilled Home Care program under the VA fee basis package. Hospice care is also provided under the Community Nursing Home Program.

We are using tele-psychiatry and other methods to help meet our mental health needs. And we will continue to review and approve providing fee-basis healthcare in local communities on a case-by-case basis as appropriate and in accordance with governing law and directives.

Mr. Chairman, to better serve the veterans of Maine, we must continue to monitor and meet their needs. America's veterans have earned the best care we can possibly provide, and it is our distinct privilege to provide them with the highest levels of customer service.

We will continue to coordinate closely with Maine's veterans and with national and state Veterans Service Organizations, as we do our very best to address our veterans' concerns. We sincerely appreciate your interest and support in helping VA to successfully accomplish our sacred mission of providing world-class care to all those who have so honorably served our great country.

STATEMENT BY

ROGER LESSARD
PRESIDENT, LOCAL 2610
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

BEFORE

THE SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON VETERANS' AFFAIRS
REGARDING
RURAL VETERANS' ACCESS TO PRIMARY CARE:
SUCCESSES AND CHALLENGES

AUGUST 22, 2005

INTRODUCTION

My name is Roger Lessard, and I am the President of Local 2610 of the American Federation of Government Employees (AFGE) inTogus, Maine. AFGE represents more than 600,000 federal employees who serve the American people across the nation and around the world, including more than 150,000 employees of the Department of Veterans Affairs (VA). AFGE Local 2610 represents approximately 800 VA employees in professional and nonprofessional positions in all the VA facilities affiliated with the Togus VAMC, including the Bangor, Calais and Caribou Community Based Outpatient Clinics (CBOCs) I want to extend my gratitude to Chairman Brown for the opportunity to discuss our concerns about providing health care to veterans in rural Maine, Ranking Member Evans, and other distinguished members of the House Veterans' Affairs Subcommittee on Health.

THE CHALLENGES OF DELIVERING HEALTH CARE TO VETERANS IN MAINE

Rural health care markets face significant challenges as compared to urban markets, including a limited number of specialists, less access to expensive technologies and a less affluent patient population. At the same time, rural Americans are disproportionately represented in the military. Thus, it is no surprise that a disparity in health care exists between veterans living in rural areas and their urban and suburban counterparts. A recent study by public health experts found that veterans living in rural areas experience a lower

"health-related quality of life". As a result, the veterans' health care costs are estimated to be as high as 11% greater in rural areas.[1]

Here in Maine, we are very familiar with these health care challenges. Maine ranks fourth in the nation when in comes to the share of veterans living in rural areas.[2] Togus VAMC Director John H. Sims, Jr. testified before the CARES Commission two years ago that only 59% of enrollees have access to primary care services within the CARES travel time criteria, and only 52% have access to acute hospital care.

GROWING DEMAND, SHRINKING RESOURCES

The Togus VAMC has experienced a dramatic growth in demand for services over the last four years. We average between 300 to 400 new enrollees per month. Similarly, our community based outpatient clinics (CBOCs) have experienced tremendous increases in demand in the past few years. As a result, our veterans are forced to wait longer for needed medical care. For example, there is currently a four month wait for ultrasounds in Radiology, as well as wait lists for Cardiology, Urology, and other specialty care.

The CARES Commission warned the VA of this likely surge in demand in its February 2004 Report to Secretary.[3] Specifically, the Commission recommended the addition of five CBOCs in Maine, including one in Lincoln. However, due to lack of funding, and contrary to the CARES Commission's recommendations, no new CBOCs have opened up to serve Maine's veterans more promptly and closer to home.

If and when we are able to open additional CBOCs, we will not be able to adequately staff them given the current hiring freeze. Since the start of this year, we have only been able to hire one new employee for every two we lost. If the freeze continues, our only alternative will be to take staff away from another facility, causing shortages and delays there instead.

Lack of funding and cuts in FTEs also affect our ability to deliver timely care in other ways. We have been forced by budget cuts to delay the implementation of important innovations such as our nurse case management system. Also, we had to delay needed capital improvements and medical equipment purchases, including a much needed MRI machine as discussed below.

---

[1] William Weeks, et al, "Differences in Health-Related Quality of Life in Rural and Urban Veterans," *American Journal of Public Health*, October 2004.

[2] 15.9% of veterans in Maine live in rural areas, as compared to the national average of 12.7%. National Rural Health Care Association, *Rural Veterans: A Special Concern for Rural Health Advocates,* July 2004.

[3] During the period 2001-2012, inpatient care in the Far North Market was projected to increase 209%, primary care by 59%, specialty care by 136% and mental health care by 38%. CARES Commission, *Report to the Secretary of Veterans Affairs*, February 2004.

Despite years of short staffing, I am proud to represent a staff that has been continuously dedicated to the caring of our veterans. At the same time, I also have to care about our dedicated employees who become ill and stressed because of mandated overtime. Prolonged overtime and other pressures also are causing more of our older staff members to take early retirement, which further adds to the staffing problem.

These staff shortages have forced us to hire agency staff – an unsatisfactory stopgap measure which ends up costing the taxpayer more, while affecting the quality and safety of the medical care we provide to our veterans.

RECOMMENDATIONS FOR ADDRESSING THE HEALTH CARE NEEDS OF VETERANS IN RURAL MAINE

The veterans in our state need new facilities and more staff to meet their medical needs. Additional CBOCs will allow us to provide more timely care and reduce the long distances that many veterans have to drive to see a doctor.

What will *not* help the rural veteran is an increased use of costly fee basis services. Another VISN recently estimated that fee basis care costs 35% more than care provided by a VA facility. One must also consider the difference in quality of care delivered by an outside provider who lacks the training and resources available within the VA.

Finally, veterans and taxpayers in Maine will benefit from the acquisition of an MRI machine at Togus VAMC. Currently, we have to pay high prices to outside providers because we do not have our own MRI or PET Scan machines, diverting scarce health care dollars from other needs. If we had our own MRI machine, we could save close to a million dollars a year, even after including the cost of the purchase. In addition, our veterans would be able to get their screenings in-house.

CONCLUSION

We are grateful for the recent good news that the current shortfall in VA health care dollars has been partially addressed through supplemental funding. These additional dollars will enable us to undertake some of the capital improvements that we had to delay. In the long term, there should be a better way to provide reliable funding for the medical needs of returning soldiers and other veterans. Every budget cycle, our dedicated staff as well as the veterans we serve are left wondering whether there will enough funding for hospital beds and doctor visits. Uncertain funding also takes a toll on our ability to plan for the long term needs of current and future veterans.

Thank you again for the opportunity to testify on behalf of Maine's veterans and thank you also for holding this hearing in Maine. We at Togus will continue to provide the best of care for our veterans. I am proud and grateful that as elected officials that you have recognized how this shortfall has hurt veterans and that measures are needed to rectify the problems that have resulted. I pray that our veterans will never again have to experience these problems in accessing health care.

Donald A. Simoneau
First Vice Commander
The American Legion
Department of Maine

Representative Henry E. Brown Jr.
Chairman, Veterans Affairs Subcommittee on Health
335 Cannon House Office Building
Washington, DC 20515

Mr. Chairman and Members of the Veterans Affairs Sub Committee on Health, I thank you for the opportunity to testify before you today on behalf of The American Legion, Department of Maine, regarding Access to Primary Care for rural Veterans in the State of Maine.

According to the 2000 Census, many rural and non-metropolitan counties across the nation had the highest concentrations of veterans in the civilian population aged 18 and over from 1990-2000. The State of Maine has the fourth highest proportion of veterans living in rural areas in the nation at 15.9 percent. Studies have further shown that veterans who live in rural areas are in poorer health than their urban counterparts.

The Capital Asset Realignment for Enhanced Services (CARES) Commission report released February 2004 specifically mentioned the Far North Market, which is Maine. Only 59 percent of the veterans in Maine are presently within the CARES own guidelines, set for access to primary care services.

The subsequent CARES Decision released in May 2004 identified 156 priority Community Based Outpatient Clinics (CBOC's), six of which are slated for Maine. CBOC's were designed to bring health care closer to the veteran and that means in the community where the veteran resides.

After a long, hard fought battle the final commission report and the CARES decision decided that indeed VISN 1, and more importantly Maine, needed these CBOC's to provide adequate primary care access to a mostly rural population.

The CARES decision of May 2004 directed that VISN's begin immediate preparation of proposals for development of CBOC's for that same year. However, upon inquiry to Veterans Administration Central Office (VACO), The American Legion has learned that business plans have not been submitted or revalidated during 2005 and are not anticipated until the final 2006 budget allocations are distributed and reviewed by the VISN's. The CBOCS for VISN 1 listed in the CARES decision are all designated for the State of Maine. The American Legion does not understand this delay. Nearly two years will have passed in preparing the proposals.

Additionally, establishing a CBOC is not a short process and now the timeline has been considerably pushed back. The VA can ill afford a time lapse as lengthy as two years when it comes to providing health care to rural veterans. The nation is in the midst of a War on Terror and delaying the delivery of quality health care is not in the best interest of any veteran.

Of special note is the provision of mental health services within the CBOC setting. Mental health specialists within the VA all agree that all CBOCs should provide mental health services; however, they do not. The committee on care of veterans with Serious Mental Illness (SMI) has been monitoring this issue for years and has advocated in their annual reports to the Under Secretary For Health that CBOCs need to provide mental health services.

It has been reported that up to 30 percent of the returning veterans from Operations Enduring and Iraqi Freedom (OEF/OIF) will have mental health problems to include Post Traumatic Stress Disorder (PTSD). In 2005 Togus reported approximately 365 Operations Enduring and Iraqi Freedom (OEF/OIF) veterans enrolled for healthcare with approximately 260 actively seeking medical and or mental health services. While the VA does not believe returning veterans will have a major impact on Togus they are continuing to monitor it. The American Legion cautions the Togus facility on their optimistic view of returning veterans and their impact on the system. Let us not forget that the returning veteran suffers from multiple physical and mental wounds and is resource intensive to treat. Those that put their life on the line so that we may enjoy our carefree lifestyles deserve nothing but the best, and we can not deny them their deserved treatment.

What is of growing concern to The American Legion is the increasing number of veterans who are put on an Electronic Wait List (EWL). For example, in medical specialties if a veteran is service connected at 50-100 percent (priority group 1) you can usually be seen within 30-45 days, however, if you are not in that priority group you can wait up to a year for specialties such as ophthalmology or orthopedics.

VA's budget woes are well documented and The American Legion has played a key role in bringing these shortfalls to the forefront.

The American Legion has advocated for assured funding to ensure shortfalls such as that experienced by VA this year does not happen in the future.

Again, thank you for giving The American Legion this opportunity to express the views of the Department of Maine. We look forward to continue to work with Congress on these important issues.

For God and Country,
Donald A. Simoneau
Donald A. Simoneau
First Vice Commander

Differences in Health-Related Quality of Life in Rural and Urban Veterans

William B. Weeks, MD, MBA, Lewis E. Kazis, ScD, Yujing Shen, PhD, Zhongxiao Cong, MA, MS, Xinhua S. Ren, PhD, Donald Miller, ScD, Austin Lee, PhD, and Jonathan B. Perlin, MD, PhD

Objectives. We sought to determine whether disparities in health-related quality of life exist between veterans who live in rural settings and their suburban or urban counterparts.

Methods. We determined health-related quality-of-life scores (physical and mental health component summaries) for 767 109 veterans who had used Veterans Health Administration services within the past 3 years. We used rural/urban commuting area codes to categorize veterans into rural, suburban, or urban residence.

Results. Health-related quality-of-life scores were significantly lower for veterans who lived in rural settings than for those who lived in suburban or urban settings. Rural veterans had significantly more physical health comorbidities, but fewer mental health comorbidities, than their suburban and urban counterparts. Rural–urban disparities persisted in all survey subscales, across regional delivery networks, and after we controlled for sociodemographic factors.

Conclusions. When compared with their urban and suburban counterparts, veterans who live in a rural setting have worse health-related quality-of-life scores. Policymakers, within and outside the Veterans Health Administration, should anticipate greater health care demands from rural populations. (*Am J Public Health.* 2004;94:1762–1767)

Vulnerable patient populations that live in rural settings, such as veterans,[1] the poor,[2] and the elderly[3,4] have health care needs similar to those of their urban counterparts in several studies. But providing access to a full spectrum of health care services in a rural setting is a difficult undertaking. Access to expensive technologies[5] and specialty care[6,7] may be limited by the high costs to the health care system associated with providing that care. Although funded federal[8] and nonfederal[9] programs have been effective at improving primary care access in rural settings, physicians may be reluctant to locate their practices in rural settings.[10–12] The combination of limited numbers of specialists (who for economic reasons need large patient populations to thrive), similar service needs of rural and urban populations, and patients' tendency to be loyal to local care (preferring their local secondary hospital) in rural settings may result in greater demand for primary care services and may influence primary care practice management.[13] Limitations in resources other than health care in rural settings, such as personal finances,[14,15] may further restrict access to health care and influence the quality of life of patients.

The Veterans Health Administration (VHA) provides comprehensive health care services to veterans across the United States through regional delivery networks. Because of its relatively small service population, regionalizing services within the VHA has required establishing large referral regions, with all VHA tertiary care referral centers located in urban areas. Travel distances for rural veterans who are remote from referral centers may implicitly restrict veterans' access to these services, and restricted access may result in underutilization of services.[16,17]

If rural veterans have a lower health-related quality of life than their urban counterparts, the cost-efficient strategy of regionalization may concentrate services far away from where the greatest needs exist; such disparities would have important implications for redirecting health care resources. We therefore sought to determine whether there are disparities in the health-related quality of life between veterans who live in rural settings and their suburban or urban counterparts, nationally and at the level of coordination of health care delivery.

METHODS

Measures

We conducted a cross-sectional study of health-related quality-of-life scores using the 1999 Large Health Survey of Veteran Enrollees.[18] That survey used a modification of the Medical Outcomes Study (MOS) Short Form 36 called the Veterans SF-36.[19] The Veterans SF-36 has been widely used, disseminated, and documented as reliable and valid in the veteran population that uses the VHA.[20] Like the MOS SF-36, the Veterans SF-36 measures 8 concepts of health: physical functioning, role limitations owing to physical problems, bodily pain, general health perceptions, energy/vitality, social functioning, role limitations owing to emotional problems, and mental health. In veterans, the physical health component summary (PCS) and mental health component summary (MCS) scores, weighted summaries of the 8 scales, demonstrate increased precision over the MOS version.[21,22] In late 1999, the survey was administered to a random sample of 1.4 million veterans enrolled in the VHA system who had used VHA services within the prior 3 years or who had enrolled in the VHA, anticipating future service use. Of those, 877 775 responded to the survey and 805 422 responded with usable Veterans SF-36 data. Zip code data were not available for 38 313 veterans, or 4.4% of the total respondents, leaving 767 109 veteran respondents in the analysis. From Veterans SF-36 responses, we calculated PCS and MCS scores and 8 subscale scores.

PCS and MCS scores are standardized with a norm of 50 and a standard deviation of 10 in a general US population. Lower

scores denote worse health for the summaries and subscales, and differences in Veterans SF-36 of 2.5 points have been associated with increased morbidity.[21] For example, when other diseases are controlled, angina is associated with a 2.5-point-lower PCS score, chronic lung disease with a 3.6-point-lower score, and chronic low back pain with a 5.5-point-lower score. Similarly, when other diseases are controlled, depression is associated with an 8.0-point-lower MCS score, alcohol disorders with a 6.6-point-lower score, and chronic low back pain with a 2.8-point-lower score. Lower scores have also been associated with increased health services utilization. For veterans, a 1-point decrease in PCS is associated with an annual $148.20, or 3.2%, increased cost of care over the average cost of $4632 per patient; and a 1-point decrease in MCS, with an independent annual $86.40, or 1.9%, increase in costs of care per patient when age, gender, and *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM)-defined comorbidities are controlled.[23,24] Therefore, population differences in Veterans SF-36 scores can be used to anticipate population differences in morbidity, health care needs, and anticipated health care expenditures.

The survey also collected social security number, self-reported demographic data (age, gender, race, maximal educational attainment, and employment status), and zip code of residence. We linked respondents' social security numbers to VHA administrative databases to determine the following:

1. *Veterans' VHA priority levels.* Priority levels range from 1 to 7, are specific to an individual veteran, and are associated with the severity of service-related disabilities, special status, and income level. Veterans with priority levels 1 through 6 tend to be more disabled, poorer, and more reliant on the VHA for health care services and have lower mean MCS and PCS scores.[20]
2. *Comorbidity indices.* Measures of comorbidity were obtained by linking social security numbers to veterans' VHA utilization record. Mental and physical health comorbidity indices were calculated as the sum of ICD-9-CM codes for 6 mental health and 30 medical diagnoses recorded in outpatient or inpatient treatment for the 3 years before the survey. The indices range from 0 to 6 for mental health and 0 to 30 for physical health.[25] For example, a patient who had ICD-9-CM codes for 2 mental health and 4 physical health conditions would have a mental health comorbidity index of 2 and a physical health comorbidity index of 4.

We used zip code of residence to calculate 3 variables:

1. *Degree of rurality.* To identify veterans as living in a rural, suburban, or urban setting, we used the US Department of Agriculture's rural–urban commuting area (RUCA) designation,[26] a 10-point designation of rural and urban status, based on travel and shopping patterns, and designated at the county level. We then used the University of Washington's probabilistic zip code–to–county crosswalk file, wherein zip codes are designated with RUCA codes, to assign veterans' zip codes to their RUCA designations.[27] We defined 3 comparison groups: urban (RUCA code 1), suburban (RUCA codes 2 through 6), and rural (RUCA codes 7 through 10). RUCA category definitions, the groupings that we used, the proportion of the general US population in each category, the number of survey respondents in each category, and mean PCS and MCS scores are shown in Table 1.
2. *VHA geographic setting.* Because we wanted to determine whether any differences found in larger geographic regions had bearing on the VHA's local service delivery, we also used zip codes of residence to locate each respondent within a single Veterans Integrated Service Network (VISN). VISNs are the budgetary and organizational mechanism for VHA health care delivery. At the time of the study, 22 geographically defined VISNs existed. In the figures and text, we identify these regions by the city in which their headquarters are located.
3. *Census region.* To examine regional variation across the United States, we examined the 4 major US census regions: Northeast, South, Midwest, and West. VISNs are approx-

TABLE 1—US Department of Agriculture Rural–Urban Commuting Area (RUCA) Code Definitions

RUCA Code	Definition	Study Grouping	1998 US Population in RUCA Category, %	Veteran Respondents in RUCA Category (n = 767 109), %	Mean PCS Score	Mean MCS Score
1	Metropolitan area	Urban	65.5	56.4	36.80	45.48
2	≥30% commuting to metropolitan area	Suburban	9.8	8.1	34.81	45.08
3	5%–30% commuting to metropolitan area	Suburban	0.3	0.4	34.28	44.40
4	Large town (10 000–49 999 residents)	Suburban	6.6	10.0	34.55	44.79
5	≥30% commuting to large town	Suburban	3.4	3.5	33.85	44.60
6	5%–30% commuting to large town	Suburban	0.3	0.4	33.74	44.10
7	Small town core (2500 to 9999 residents)	Rural	5.0	8.7	33.54	44.40
8	≥30% commuting to small town	Rural	2.3	2.6	32.97	43.96
9	5%–30% commuting to small town	Rural	0.3	0.5	33.81	44.82
10	Primary flow to tract without town of ≥2500 residents	Rural	6.4	9.6	33.35	44.61

Note. PCS = physical health component summary; MCS = mental health component summary.

imately aligned with US census regions as follows: Northeast: Boston, Mass, Albany and the Bronx, NY, and Pittsburgh, Pa; South: Baltimore, Md, Durham, NC, Atlanta, Ga, Bay Pines, Fla, Nashville, Tenn, and Dallas, Tex; Midwest: Cincinnati, Ohio, Ann Arbor, Mich, Chicago, Ill, Minneapolis, Minn, Omaha, Neb, Kansas City and Jackson, Mo; and West: Phoenix, Ariz, Denver, Colo, Portland, Ore, and San Francisco and Los Angeles, Calif.

Statistical Analysis

We examined analysis of variance for continuous variables and the χ^2 test for categorical variables to compare demographic variables among the 3 groups (urban, suburban, and rural). We compared unadjusted mean PCS and MCS scores and 8 subscale scores for the nation and each delivery network using analysis of variance. To compare across degrees of rurality within regional delivery networks, we subtracted suburban and rural scores from urban scores for each network. Multivariate analysis using ordinary least square regression was conducted to examine the association of rural–urban status with Veterans SF-36 controlling for sociodemographic factors (age, gender, employment status, and race), VHA priority status, travel distance to VHA hospitals, comorbidity indices, and US census region. Because data on sociodemographic factors were incomplete, multivariate analysis was limited to 727 536 respondents. Because priority-7 veterans have lower health-related quality-of-life scores, are less reliant on VHA care, and represent different proportions of the service population in a number of VISNs, we repeated the analysis for priority-1 through priority-6 veterans and for priority-7 veterans separately.

TABLE 2—Demographics of Sample: United States, 1999

	Mean (SD)			
	Overall (n = 767 109)	Urban (n = 432 285)	Suburban (n = 168 120)	Rural (n = 166 704)
Age, y	63.4 (13.4)	62.8 (13.9)	63.6 (13.0)	64.7 (12.4)
Comorbidities, no.				
Physical	2.9 (2.8)	2.8 (2.8)	3.0 (2.8)	3.1 (2.8)
Mental	0.46 (0.96)	0.49 (1.00)	0.44 (0.92)	0.41 (0.88)
Miles to VHA hospital care	41.3 (39.8)	29.3 (27.2)	53.1 (37.0)	62.9 (35.9)
Miles to private sector hospital care	8.1 (7.8)	3.8 (3.4)	12.2 (7.9)	15.2 (8.5)
Male, %	95.9	95.3	96.3	97.2
Race, %				
White	77.9	71.6	85.0	87.0
Black	12.3	17.4	6.4	5.4
Hispanic	4.2	5.6	2.8	1.9
Other	5.6	5.5	5.8	5.7
Employment status, %				
Employed	21.8	23.6	20.7	18.5
Retired	41.0	41.3	40.7	40.7
Other	37.1	35.2	38.6	40.8
Priority group, %				
1 (SC ≥ 50%)	15.5	16.1	15.7	14.0
2 (SC 30%–40%)	9.9	10.5	10.0	8.5
3 (SC 10%–20%, POW)	16.5	17.9	15.7	13.7
4 (Catastrophically disabled)	2.7	2.5	2.8	3.1
5 (NSC and 0% SC, low income)	43.7	41.0	44.4	50.2
6 (No copay required)	1.6	1.6	1.8	1.7
7 (Copay required)	10.0	10.5	9.8	9.0

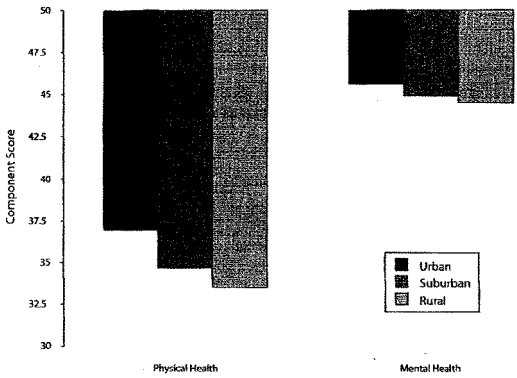
Note. VHA = Veterans Health Administration; SC = military service-connected disability, rated at a particular impairment percentage; NSC = non-military service-connected disability. Differences among urban, suburban, and rural cohorts are significant at $P < .0001$ for all variables.

RESULTS

Veterans who lived in rural settings were somewhat older, had more physical and mental health comorbidities, and lived a greater distance from both private sector and VHA hospital care when compared with those in suburban or urban settings ($P < .0001$ for all) (Table 2). Rural veterans were more likely to be male and White but less likely to be employed ($P < .0001$ for all). Rural veterans were more likely to be in priority groups 3 (service connected 10%–20%, prisoner of war) and 5 (low-income, non–service connected, i.e., indicating a disability that is not related to military service; and 0% service connected, i.e., indicating a disability that has no current adverse impact on veteran's life), and less likely to be in the other priority groups than their suburban or urban counterparts ($P < .0001$ for all).

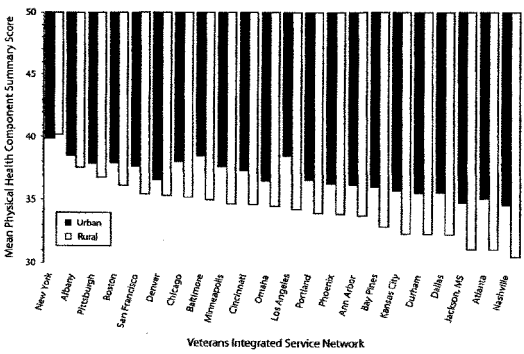
Unadjusted physical and mental health summary scores were significantly lower for veteran respondents who lived in rural settings than for those who lived in suburban or urban settings: rural PCS = 33.53 (95% confidence interval [CI] = 33.48, 33.59) suburban PCS = 34.69 (95% CI = 34.64, 34.75), and urban PCS = 37.00 (95% CI = 36.96, 37.03), $P < .001$; rural MCS = 44.53 (95% CI = 44.47, 44.60), suburban MCS = 44.95 (95% CI = 44.89, 45.02), and urban MCS = 45.62 (95% CI = 45.58, 45.66), $P < .001$ (Figure 1). Veterans who lived in rural settings also had significantly lower scores than their suburban and urban counterparts on all 8 subscale scores ($P < .001$ for all). Veterans who lived in rural settings had more physical health comorbidities (3.07 [95% CI = 3.06, 3.08] for rural, 2.91 [95% CI = 2.90, 2.93] for suburban, and 2.73 [95% CI = 2.72, 2.74] for urban, $P < .001$), but fewer mental health comorbidities (0.401 [95% CI = 0.397, 0.405] for rural, 0.426 [95% CI = 0.423, 0.431] for suburban, and 0.476 [95% CI = 0.473, 0.479] for urban, $P < .001$).

At the regional service delivery network level, veterans who lived in rural settings had



Note. Differences between groups are statistically significant at $P < .001$. Differences of 2.5 points are considered clinically meaningful.

FIGURE 1—Unadjusted health-related quality-of-life scores, by veterans' urban/suburban/rural residence, compared with the general US population scores of 50 for both physical and mental health; a lower score indicates a worse health-related quality of life.



Note. The locations of each network headquarters are shown.

FIGURE 2—Urban and rural physical health component summary scores for each veterans integrated service network, arranged by descending urban score and compared with the general US population scores of 50 for both physical and mental health.

significantly lower PCS scores than their suburban (data not shown) and urban counterparts in every VISN except for that headquartered in Bronx, NY ($P<.001$ for all) (Figure 2). The few veterans who fell within rural zip codes in this delivery network lived in remote parts of Long Island that house relatively wealthy communities and may not be representative of the overall rural population. Although present, differences in scores between rural and urban veterans within networks were not likely to be clinically meaningful in 8 of the 22 VISNs. All VISNs located in the southern US census region and 5 of 7 VISNs in the Midwest had clinically meaningful differences in physical health–related quality of life when we compared rural to urban veterans.

Disparities between rural and urban veterans were much less pronounced when we compared MCS scores across VISNs (Figure 3). Although urban veterans had statistically higher scores than their rural counterparts in 15 of the 22 VISNs at the $P<.001$ level, differences were likely to be clinically meaningful only in the VISN headquartered in Nashville, Tenn. Again, disparities were most evident in the southern US census region.

Differences that we found between rural and urban veterans using unadjusted data persisted after we controlled for other factors in the multivariate analysis. The mean PCS score for the 727 536 respondents with complete demographic information was 35.6, or 1.4 standard deviation lower than US age-adjusted norms; the mean MCS score was 45.2, or about 0.5 standard deviation lower than US age-adjusted norms. Veterans who were male, unemployed, lived in the southern US census region, and had fewer than 12 years of education had lower PCS and MCS scores. In comparison to priority-7 status, all other priority levels were associated with much lower PCS and MCS scores. Multiple physical comorbidities were associated with lower PCS scores. Finally, after we corrected for other variables, when compared with urban status, rural status was associated with a 2.05-point-lower PCS score and a 0.83-point-lower MCS score. These variables explained 28% of the variance of the PCS scores and 25% of the variance seen in MCS scores. Repeat analyses examining only prior-

settings. For instance, the differences we found may be facilitated by restricted access to care in rural settings: it is possible that, because of long distance to care for many veterans in rural settings, only those with the greatest health care needs were enrolled in the VHA system and were therefore part of the survey. Fourth, our study was limited to veterans—a population likely to be older, poorer, and sicker than the general population. Although we replicated findings in the healthiest subgroup of veterans, because of the paucity of females and absence of children in our data set, generalization of our findings to the entire US population may be limited. Finally, our study may underestimate differences between rural and urban veterans; the "floor effect" (as the lower bound of the scoring range is approached, scores may fail to capture those who might have even lower health related quality of life)[31] that exists at the low score levels that we saw may mitigate the true differences that exist.

Despite these limitations, the findings shed light on health care–related quality of life in the rural population, highlight potential disparities in health care needs, and underscore the challenges of health care delivery to rural populations. These results strongly suggest that administrators anticipate greater health care demands from rural populations and pursue innovative strategies, including coordination of federal health benefits, to meet their health care needs. ■

About the Authors

William B. Weeks is with the departments of Psychiatry and of Community and Family Medicine, Dartmouth Medical School, Hanover, NH; Veterans Administration's National Center for Patient Safety, White River Junction, NH; Veterans Administration Outcomes Group, White River Junction; and Veterans' Rural Health Initiative, White River Junction. At the time of the study, Yujing Shen and Zhongxiao Cong were with, and Lewis E. Kazis, Xinhua S. Ren, Donald Miller, and Austin Lee are with, the Center for Health Quality Outcomes and Economic Research, Veterans Administration, Bedford, Mass. Lewis E. Kazis, Xinhua S. Ren, and Donald Miller are also with, and Yujing Shen and Zhongxiao Cong were with, the Boston University School of Public Health, Boston, Mass. Austin Lee is also with the Department of Actuarial Science, Boston University, Boston, Mass. Jonathan B. Perlin is with the Department of Veterans Affairs, Washington, DC.

Requests for reprints should be sent to William B. Weeks, MD, MBA, White River Junction, VT 05009 (e-mail: wbw@dartmouth.edu).

This article was accepted May 8, 2004.

Contributors

All authors contributed to the design, data collection, writing, and article review. All authors have seen and approved the final version of the article.

Acknowledgments

This work was funded by the Veterans Rural Health Initiative, White River Junction, Vt, VAMC, and by the White River Junction VA Outcomes Group Research Enhancement Award Program (VHA Health Services Research and Development award REA–03–098).

The SF-36 is a registered trademark of the Medical Outcomes Trust.

Human Participant Protection

The Dartmouth committee for the protection of human subjects approved the project and designated it as exempt from further review.

References

1. Wray N, Weiss T, Christian C, et al. The health status of veterans using mobile clinics in rural areas. *J Health Care Poor Underserved.* 1999;10:338–348.

2. Auchincloss A, Hadden W. The health effects of rural–urban residence and concentrated poverty. *J Rural Health.* 2002;18:319–336.

3. Blazer D, Landesman L, Fillenbaum G, Horner R. Health services access and use among older adults in North Carolina: urban vs rural residents. *Am J Public Health.* 1995;85:1384–1390.

4. Mainous A, Kohrs F. A comparison of health status between rural and urban adults. *J Community Health.* 1995;20:423–431.

5. Erickson K, Mackenzie K, Marshall A. Advanced but expensive technology. Balancing affordability with access in rural areas. *Can Fam Physician.* 1993;39(1): 29–34.

6. Fakhoury W, Roos L. Access to and use of physician resources by the rural and urban populations in Manitoba. *Can J Public Health.* 1996;87:248–252.

7. Lambert D, Hartley D. Linking primary care and rural psychiatry: where have we been and where are we going? *Psychiatr Serv.* 1998;49:965–967.

8. Horner R. Impact of federal primary health care policy in rural areas: empirical evidence from the literature. *J Rural Health.* 1988;4:13–28.

9. Kukulka G, Christianson J, Moscovice I, DeVries R. Community-oriented primary care. Implementation of a national rural demonstration. *Arch Fam Med.* 1994;3: 495–501.

10. Connor R, Hillson S, Krawelski J. Competition, professional synergism, and the geographic distribution of rural physicians. *Med Care.* 1995;33:1067–1078.

11. Schroeder S, Beachler M. Physician shortages in rural America. *Lancet.* 1995;345:1001–1002.

12. Rabinowitz H, Diamond J, Markham F, Paynter N. Critical factors for designing programs to increase the supply and retention of rural primary care physicians. *JAMA.* 2001;286:1041–1048.

13. Weeks W, Yano E, Rubenstein L. Primary care practice management in rural and urban Veterans Health Administration settings. *J Rural Health.* 2002; 18:298–303.

14. Wadsworth ME, Montgomery SM, Bartley MJ. The persisting effect of unemployment on health and social well-being in men early in working life. *Soc Sci Med.* 1999;48:1491–1499.

15. Beck RW, Ijjon CR, Edwards JB. The relationships among gender, perceived financial barriers to care, and health status in a rural population. *J Rural Health.* 1996; 12:188–189.

16. Leape LL, Hilborne LH, Bell R, Kamberg C, Brook RH. Underuse of cardiac procedures: do women, ethnic minorities, and the uninsured fail to receive needed revascularization? *Ann Intern Med.* 1999;130: 183–192.

17. Mirvis DM, Graney MJ. Variations in the use of cardiac procedures in the Veterans Health Administration. *Am Heart J.* 1999;137(4):706–713.

18. Kazis L, Ren X, Skinner K, et al. Initial results from the 1999 large health survey of veteran enrollees. Paper presented at: VA Health Services Research and Development 19th Annual Meeting. February 14–16, 2001; Washington, DC.

19. Ware J, Bayliss M, Rogers W, Kosinski M, Tarlov A. Differences in 4-year health outcomes for elderly and poor, chronically ill patients treated in HMO and fee-for-service systems. *JAMA.* 1996;176:1039–1047.

20. Perlin J, Kazis L, Skinner K, et al. *Health Status and Outcomes of Veterans: Physical and Mental Component Summary Scores, Veterans SF-36, 1999 Large Health Survey of Veteran Enrollees.* Washington, DC: Office of Quality and Performance, Veterans Health Administration, Department of Veterans Affairs; 2000.

21. Kazis L, Ren X, Lee A, et al. Health status in VA patients: results from the veterans health study. *Am J Med Qual.* 1999;14(1):28–37.

22. Kazis L. The veterans SF-36 health status questionnaire: development and application in the Veterans Health Administration. *Med Outcomes Trust Monitor.* 2000;5:1.

23. Kazis L, Skinner K, Rogers W, et al. *Health Status of Veterans: Physical and Mental Component Summary Scores (SF-36V). 1998 National Survey of Ambulatory Care Patients Mid-Year Executive Report.* Washington, DC: Office of Performance and Quality, Veterans Health Administration; 1998.

24. *1998 Cost Data.* Austin, Tex: Allocation Resource Center, Department of Veterans Affairs; 1998.

25. Selim A, Fincke G, Ren X, et al. The comorbidity index. In: Goldfield N, Pine M, Pine J. *Measuring and Managing Health Care Quality.* Gaithersburg, Md: Aspen Publishers, 2002.

26. *Rural Urban Commuting Area Code.* Washington, DC: Economic Research Service of the US Department of Agriculture; 2001.

27. *ZIP Code RUCA Approximation Methodology.* Seattle, Wash: WWAMI Rural Health Research Center; 2004.

28. Weeks W, Bott D, Lamkin R, Wright S. Veterans Health Administration and Medicare outpatient health care utilization by older rural and urban New England veterans. *J Rural Health.* In press.

29. Parkerson G, Broadhead W, Tse C. Health status and severity of illness as predictors of outcomes in primary care. *Med Care.* 1995;33:53–66.

30. Wright S, Petersen L, Lamkin R, Daley J. Increasing use of Medicare services by veterans with acute myocardial infarction. *Med Care.* 1999;37:529–537.

31. Bindman AB, Keane D, Lurie N. Measuring health changes among severely ill patients. The floor phenomenon. *Med Care.* 1990;28:1142–1152.

Maine Veterans Coordinating Committee

Veterans of Foreign Wars
AmVets
Military Order of t he Purple Heart
Marine Corps League
Disabled American Vets
Korean War Veterans
Viet Nam Veterans of America
WAVES
40/8
Jewish War Veterans
American Legion Auxiliary
Veterans of Foreign Wars auxiliary
Disabled American Veterans Auxiliary
Viet Nam Vigil Committee

Testimony of Gary I. Lawerynson, Chairman of the Maine Veterans Coordinating Committee on rural access to the Veterans Administration in the State of Maine

Honorable Senators and Congressman:

Thank you for allowing me to testify on behalf of the Maine Veterans Coordinating Committee. Our organization is comprised of the above veterans service organizations and represents a united voice working for the veterans of Maine.

The VA's CARES program, short for Capital Asset Realignment Enhanced Services, studied the access to Maine's rural veteran population and concluded more Community Based Outpatient Clinics (CBOC's) were needed along Maine's North - South corridor and Western Maine. These CBOC's would provide a greater number of Maine's rural veterans the much needed access to quality outpatient and specialty care.

Every CBOC site within Maine has filled to capacity and are in need of expansion to be able to continue to provide the quality care Maine's veterans have come to expect.

The CARES study shows Maine is greater in area and rural veteran population than the other entire VISN 1 area. In 2004, the VA 's computer projections were 154,000 veterans in Maine were eligible for care in the VA system. These projections did not take into account the veterans who move to Maine's rural areas to escape the fast life, nor Maine's growing retired veteran population.

Through the efforts of the Maine Veterans Coordinating Committe and its subsidiary organizations, Togus VAMROC enrolled 500 - 700 new veterans each month for over two years. Although this trend has slowed, Togus continues to enroll new veterans each month. Now that Maine's National Guard and Reserve components are returning from Afghanistan and Iraq, many with wounds and illnesses requiring VA care, the need for access will again increase.

Maine's current VA system is stretched to the breaking point and it is imperative new CBOC's are made available to provide timely access to services.

Due to Maine's unique geographical size it is difficult for many of Maine's veterans to travel to the existing sites. Maine has no mass transit system. Maine's veterans rely on the DAV shuttle bus for transport to Togus and the CBOC's. However, in the northern counties there is only one bus available. Many of Maine's rural veterans are on a limited, fixed income and are unable to afford transport to Togus or the nearest CBOC. Nor can these veterans afford health insurance or access to local care.

The Maine Veterans Coordinating Committe believes Togus should be expanded to become a

Maine Veterans Coordinating Committee

Veterans of Foreign Wars
AmVets
Military Order of t he Purple Heart
Marine Corps League
Disabled American Vets
Korean War Veterans
Viet Nam Veterans of America
WAVES
40/8
Jewish War Veterans
American Legion Auxillary
Veterans of Foreign Wars auxillary
Diasbled American Veterans Auxillary
Viet Nam Vigil Committee

full service VA Regional Medical Center, independant of Boston. Maine's rural veterans must now travel several hours one way to obtain care at Togus or a CBOC. To require Maine's veterans to travel three to eight hours more to Boston for tertiary care is unacceptable. Maine has one of the top rated Cardiac Surgery Centers in the nation and is leading the nation in long term care and end of life care provided to our veterans. Sending Maine's veterans to Boston removes the family and local veteran support system sorely needed to effect recovery.

While the majority of the nation is urban or metro and have showed a slower growth, rural Maine has demonstrated a sustained growth pattern and will continue this trend.

Lastly, the Maine Veterans Coordinating Committee would urge the VA to open lines of communiations to all veterans, not just in Maine. In the past, the veterans have not felt the VA was user friendly. As a result, many older veterans and those serving on active duty have failed to avail themselves of the quality care provided by the current VA system.

In Maine, the veterans are banding together to educate our veterans on the many services available to them. " Operation I Served " is a joint project initiated to provide information to Maine's veterans, their spouses and families on services through the VA system, educational benefits, tax relief, financial assistance, employment assistance, housing assistance and long term care options through the VA and Maine's Veterans Homes system. Our program has received requests and been supplied to many other states.

Again, on behalf of the Maine Veterans Coordinating Committe and the Maine veterans we represent, thank you for allowing me this opportunity to speak to you. The Maine Veterans Coordinating Committee looks forward to continuing to work with Congress to enable the VA to provide quality services to all veterans.

Respectfully submitted,

Gary J. Lawerysdn
594 Duck Puddle Road
Waldoboro, Maine 04572
Chairman
Maine Veterans Coordinating Committee

Gary Laweryson
594 Duck Puddle Road
Waldoboro, Maine 04573

Gary Laweryson is a 30 year, retired U.S. Marine Corps veteran who has served in combat in Viet Nam and the Gulf War. Among his personal decorations are 2 Purple Hearts for wounds received in Viet Nam.

Gary has served as Commandant of the Maine Marine Corps League for 6 years, New England Legislative Representative for the Marine Corps League and is currently serving as the Maine Marine Corps League Judge Advocate.
Gary has served as the Chairman of the Maine Veterans Coordinating Committee for 8 years.

Gary was appointed by Governor John Baldacci to serve as an Aide-de-Camp to advise the Governor on military issues within the State of Maine.

Gary is married to his wife, Linda and they have 2 children and 3 grandchildren. Gary is a 100% service connected, disabled veteran and uses the services of the Togus VA system.

STATEMENT OF
RONALD W. BRODEUR
ADJUTANT, DEPARTMENT OF MAINE
of the
DISABLED AMERICAN VETERANS
before the
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
AUGUST 22, 2005

This information regarding health care issues for veterans in rural areas is being presented by the Disabled American Veterans (DAV) Department of Maine to the Subcommittee on Health, Committee on Veterans' Affairs, U.S. House of Representatives. We thank Chairman Henry Brown and Ranking Member Michael Michaud for holding this field hearing in Bangor, Maine, and for addressing the issue of rural veterans' access to Department of Veterans Affairs (VA) health care services.

Access to health care in rural and highly rural areas continues to be a challenge for VA. In many cases, the department has been unable to adequately provide health care services to rural veterans due to budgetary constraints. For many veterans living in rural areas, the nearest VA medical center is hundreds of miles away. Although fully aware of this problem, VA has not developed or implemented a comprehensive strategic plan to adequately meet the needs of veterans living in rural areas. At 36,610 square miles, Maine is larger than all the other five New England states combined serving approximately 150,000 veterans. A comprehensive plan to address the geographic size, unique barriers, and number of veterans in Maine should be developed and implemented, along with sufficient resources to support such a plan.

Consideration must also been given to location and numbers of Community Based Outpatient Clinics (CBOCs), local fee-basis services, and health care specialty services that are not available at the Togus VA Medical and Regional Office Center in Augusta, Maine.

CBOCs are essential to ensuring veterans living in rural areas have reasonable access to basic health care services. The VA has announced plans for new CBOCs in Lincoln, Dover-Foxcroft, Houlton, South Paris, Farmington, and Northern Cumberland County. To date none has opened. It is our understanding that Lincoln will open in 2006, but the others are indefinite. We understand that Houlton will be a part-time facility under the Bangor clinic's supervision, and Lincoln and Dover-Foxcroft will also be satellites under Bangor. Unfortunately, Bangor is bursting at the seams with patients and has already been expanded to its maximum physical capacity. DAV members in Maine are concerned about why it has taken so long to get these new sites opened and question if the Bangor clinic should be moved to a new, larger facility.

There is also some concern if the proposed CBOC locations selected by the VA in South Paris, Farmington, and Northern Cumberland County are appropriate. To veterans of Maine, it seems to make more sense to have a CBOC in the Lewiston-Auburn area where a large

population of veterans is located versus a CBOC in Cumberland. This would also take care of any needs of veterans in South Paris. The CBOC in Rumford and a new CBOC in Lewiston should be able to cover the needs of veterans in Farmington.

Current legislation allows VA to contract for non-VA health care (Fee-Basis) only when VA facilities are incapable of providing the necessary care, when VA facilities are geographically inaccessible to veterans, and in certain emergency situations. The DAV Department of Maine believes more local fee-basis service must be considered for Maine veterans. Having veterans travel to Togus for services is difficult and confusing for many veterans depending on their medical conditions, particularly for older veterans. Veterans that must travel from northern Maine to Togus have to ride 3-5 hours and must get up early in the morning to get in for appointments or stay overnight if they have a very early morning appointment. Others who must travel to Togus from these locations, may be transferred to another van for an additional 3-4 hour trip to the West Roxsbury VA Medical Center in Boston. Some veterans must spend the night when traveling to and from Togus to access available transportation.

A veteran in Millinocket traveling to Augusta is on the road for about 2.5 hours and travels approximately 150 miles one way, or 300 miles round trip. Reimbursement by the VA is approximately $33 dollars at 11 cents per mile versus $122 that would be paid to a federal employee on official travel in a privately own vehicle (POV) at 40.5 cents per mile. For low-end wage earners or retirees in Maine, that money for transportation is being taken from other priorities such as food, family medical-dental care, and prescription medications. We should be able to do better than this for our nations' sick and disabled veterans.

The DAV cannot take care of all the transportation needs for all patients who require care at the VA hospital in Togus. Also, keep in mind that there are veterans who use the CBOCs around the state who have problems getting to those outpatient clinics and there is no organized transportation network to assist them. However, the DAV Transportation Network in Maine and the other states helps close the gap for many veterans who cannot drive or cannot afford to drive to Togus VA for scheduled appointments. In 2003 and 2004, our volunteer drivers drove 11,598 veterans over 811,579 miles, and volunteered 39,382 hours driving to Togus VA in DAV donated vans for appointments. At 40.5 cents per mile paid to federal employees for POV travel, this would be approximately $330,000. We mention this because many veterans do travel to Togus in their own vehicles or get a ride from family and friends and must absorb most of the cost of transportation. For scheduled appointments, VA pays veterans 11 cents per mile minus an established deductible.

Since the programs inception in 1987, the DAV has donated 1,549 vans to VA medical centers, at a cost of $31,563,000. In addition, the Ford Motor Company has donated 98 vans over those years to contribute to the DAV effort. This program continues to show tremendous growth and is an indispensable resource for veterans and the VA. Across the nation, DAV Hospital Service Coordinators operate 183 active programs. They have recruited 9,657 volunteer drivers who logged 26,429,512 miles last year, taking over 725,084 veterans to and from VA medical facilities. Since the programs inception, our volunteer drivers have driven 8,958,755 veterans more than 338 millions miles to and from their VA medical appointments.

Our DAV network in Maine currently operates 12 vans. Just so the committee is aware of how the network is operated, we are providing some background information. In the 1980s, the VA eliminated most of its transportation for veterans. The DAV saw a need and filled it by developing the DAV Transportation Network. Vans are purchased by local DAV chapters and state departments when a need is determined. The DAV National Service Foundation helps DAV departments to cover the full cost of a van. For example, the transportation program in Maine needed to replace 2 vans this year at a cost of $22,000 each. We were able to cover $24,000 of the total $44,000 needed. A grant from the DAV National Service Foundation took care of the remaining $20,000 needed. Once the vans are purchase by the DAV they are donated to the VA. The VA then maintains the vans, and covers costs of gas, maintenance, tolls, etc. The DAV operates the volunteer network and coordinates all the rides and services between veterans and their VA facility. We currently employ two Hospital Service Coordinators to provide these services. They do so for low wages and no benefits as a service to veterans. The DAV Department of Maine pays approximately $30,000 a year for their service.

Recently, we were excited to discover that Senator Susan Collins of Maine co-sponsored S. 1191, the "Vets Ride Act of 2005," introduced by Senator Kenneth Salazar of Colorado. This bill, if approved, would give the DAV Department of Maine and other DAV departments and chapters, as well as other veterans service organizations and State veterans' service officers, an opportunity to obtain a grant of up to $50,000 per year to help expand transportation options to veterans in remote rural areas. We request your support in introducing a companion bill in the House to help make the Vets Ride Act a reality this year.

One other area of concern that often arises relates to veterans who are enrolled for VA care in Maine but experience urgent medical symptoms that require them to obtain emergency care at local hospitals. In many cases, the veteran or family member is required to pay the bill for the local care provided because the VA Fee-Basis program denies reimbursement. This process needs to be improved so that veterans do not have to second guess whether or not they should go to an emergency room for symptoms they believe may be life threatening. This is a difficult area in which to develop black and white rules, but something more specific is needed.

The DAV has a resolution to support legislation to authorize enrolled veterans to receive emergency medical care in private medical facilities at VA's expense when VA facilities are not reasonably available. The DAV believes all enrolled veterans should be eligible for emergency medical services at any medical facility. It is outrageous to penalize a veteran for seeking emergency care when he or she is experiencing symptoms that manifest a life-threatening condition.

We request your support in introducing a bill in the House that would help solve this problem. Veterans enrolled for VA care who believe they are experiencing a medical emergency deserve to have immediate access to care, at a private medical facility if necessary, without the fear of unfair financial burden for such care.

Thank you for this opportunity to provide testimony on some of our concerns about access to VA health care services for veterans living in rural areas.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Disabled American Veterans (DAV) does not currently receive any money from any federal grant or contract.

During fiscal year (FY) 1995, DAV received $55,252.56 from Court of Veterans Appeals appropriated funds provided to the Legal Service Corporation for services provided by DAV to the Veterans Consortium Pro Bono Program. In FY 1996, DAV received $8,448.12 for services provided to the Consortium. Since June 1996, DAV has provided its services to the Consortium at no cost to the Consortium.

STATEMENT

of the

PINE TREE AND SOUTHERN MAINE CHAPTERS,

MILITARY OFFICERS ASSOCIATION OF AMERICA

on

RURAL VETERANS' ACCESS to PRIMARY CARE: SUCCESSES AND CHALLENGES

before the

HOUSE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON HEALTH

August 22, 2005

Presented by

Colonel Edward L. Chase, USAF (Ret.)
Chairman, Legislative Committee
Pine Tree Chapter
Military Officers Association of America

Care for Enrolled Veterans. **VA has budgeted for an increase in demand of veteran system users with disabilities, special needs, Purple Heart recipients and the indigent. One matter of concern, however, is the projection of a decline in lower priority groups. We will discuss this later in the statement.**

Mental Health Care. **Some studies have predicted that 1 out of 6 servicemembers returning from Iraq and Afghanistan will need care at some point in their lives for PTSD and other mental health conditions. The VA budget has begun to address the growing need for additional capacity. As we learned from the Vietnam experience, many combat-associated disorders and illnesses do not become manifest for years, if not decades, later. Early attention to counseling and preventive care can mitigate some of these later developments.**

CARES. **In May, 2004, the Secretary of Veterans Affairs announced the plan to support CARES. A part of the plan in Maine is the opening of five part time clinics (Houlton, Lincoln, Dover-Foxcroft, Farmington and Lewiston). It is critical that these clinics be planned as enhancements to the existing system, and not as an opportunity to eliminate or reduce services at other locations.**

A prime example of how our service organizations "look out for our own" is the American Legion's offer of a building in Houlton to house this clinic. Now, Congress must recognize its responsibility and fund the program.

Exemption from Co-pays and Emergency Care Reimbursement. **We are appreciative of the inclusion in the Budget Request the elimination of co-payments for veterans receiving hospice care and for former Prisoners of War. It also includes a provision to allow the VA to pay for emergency room care received in non-VA facilities for enrolled veterans. This offers a real benefit to some of our veterans distantly remote from a major primary care facility.**

CONCERNS AND CHALLENGES.

Transportation. **41% of Maine's veterans live outside the proximity standards for access to health care facilities. Increased population age of our veterans, rising prices of gas, and unpredictable, adverse weather driving conditions over a six month period (Nov-Apr) make available transportation a key element in providing accessible health care to our veterans. An aversion to driving long distances in inclement weather often results in last minute appointment cancellations with the accompanied "snow-ball" perturbations to the scheduling process. It's often weeks before a rescheduled appointment can be made. Finally, lack of access to care facilities may have an unintended consequence of veterans' reluctance to enroll and, if uninsured, placing unprogrammed demands on other health systems such as MaineCare, the State's MEDICAID program.**

Currently, there are two vans operated by the Maine Disabled American Veterans (DAV) and some volunteer assistance from other service organizations dedicated to alleviating this problem. We believe strongly that a more structured, expanded transportation plan is sorely needed. To this end, we are grateful to Senators Susan Collins, R.ME and Ken Salazar, D.CO for their co-sponsorship of S-1191, The VetsRide Act. This provides rural states grants of $50,000 per year to support an intra-state veterans' transportation system focused particularly on rural areas. This is a relatively low cost initiative which will reap benefits in improved access, timely care, improved administrative efficiencies, and improved safety for our veterans. We strongly urge a member(s) of this subcommittee to sponsor a companion House bill in order to ensure timely enactment. The total cost nationwide is estimated to be $3M annually.

Enrollment Policy During Wartime. **The Veterans Eligibility Reform Act of 1996 distinguished between veterans who "shall" be provided care and those for whom the VA "may" provide care if Congress agrees to fund their care. Under the new enrollment system, two different administrations between 1998 and 2002 invited all honorably discharged veterans to enroll. This policy doubled enrollment and sharply increased demand for care.**

The open enrollment permitted the VA health system to transform from a hospital-based model to an out-patient oriented system with hundreds of new VA community-based clinics. With the exception of severely disabled veterans, all enrollees had to agree to pay drug co-payments for non-service connected prescriptions. Enrollees were not required to pay usage or enrollment fees.

During and after the open enrollment period, funds were insufficient to meet the new demands. Enrollment in a newly created Priority Group 8 category was closed. We further perceive that the VA intends to reduce demand on the system by imposing a $250 usage fee on the lowest priority veterans. The same veterans who earlier had been invited to enroll to help VA meet its transformation goals are now being told, "Not so fast." The VA and, indeed, the Congress should never make a promise to veterans that they are unwilling to commit to for the long term, irrespective of political administrations.

We believe that an imposition of a $250 annual usage fee on some of our enrolled veterans sends a bad signal during a time of war to our nation's warriors, past, present, and future.

We recommend the exemption of annual usage fees and higher drug co pays for all currently enrolled veterans. Finally, this fee may well apply to some of our returning National Guard and Reserve combat veterans which are sorry honor for their extraordinary sacrifice.

Seamless Transition: The Planning, Care and Support for Separating Servicemembers and their Families. **The President's Task Force (PTF) to Improve Health Care**

Delivery for Our Nation's Veterans (May 2003) and efforts of former VA Secretary Tony Principe have resulted in improved coordination of care and services to separating Active Duty, National Guard, and Reserve servicemembers and their families. A Dodd-VA planning and coordination structure is in place, but more needs to be done.

At the State level, we commend Operation "I served" which is an outreach to all Maine's veterans to provide them information on what federal and State benefits they may have earned during their service.

We remain concerned, however, that adequate attention and resources be provided to our returning servicemembers and their families as well, particularly the severely wounded. Navigation through the complicated health care, benefits, employment and transition systems and programs is extremely burdensome for affected families unless they have a functional care management system. Establishment of such a system in a dispersed, rural environment is a real challenge, though no less compelling.

CONCLUSION.

The two chapters of the Military Officers' Association of America greatly appreciate the opportunity to present our views on the unique challenges to the provision of quality health care to our veterans in rural areas. We are appreciative of the support provided to servicemembers and veterans in the past and pledge our full support to this Subcommittee and its distinguished members as you go forward. As we meet the challenges of the future, we must all be mindful of George Washington's observation, "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceived the veterans of earlier wars were treated and appreciated by their nation."

Biography of Edward L. Chase, COL, USAF (Ret.)
Chairman, Legislative Committee, Pine Tree Chapter, Military Officers Association of America (MOAA)

A native of Massachusetts, Ed Chase was born in Hyannis and raised on Cape Cod until leaving in 1954 to attend Phillips Exeter Academy. After graduation in 1958, he attended Kenyon College where he earned a B.A. in political science in 1962. After graduation from college, he was commissioned a second lieutenant in the U.S. Air Force through the ROTC program.

Colonel Chase entered active duty in March, 1963, serving as a Combat Targets Officer before attending pilot training in June, 1964. After earning his wings, he served an abbreviated tour of duty in France before being reassigned to the Republic of Vietnam where he flew 172 combat sorties. After his combat tour, he served in a number of operational assignments in the United States and overseas as an instructor pilot, flight examiner, flight commander, operations officer and squadron commander. He was a command pilot logging over 5,000 flight hours in a variety of fighter aircraft.

Colonel Chase served a tour of duty on the Air Staff at the Pentagon from June, 1982 to June, 1985 where he was responsible for the utilization and training policies for all USAF pilots, navigators, and enlisted aircrew members. In addition, he oversaw procurement programs for some 512 aircrew training devices which was a $3B package. Colonel Chase completed his career as Vice Commander, Third Air Force, which comprised all Air Force personnel in the United Kingdom. He retired in 1991.

In 1993, Colonel Chase joined American Express Financial Advisors as a financial planner. He retired in 2003.

Colonel Chase's military awards include the Distinguished Flying Cross, Meritorious Service Medal with 4 oak leaf clusters, Air Medal with 11 oak leaf clusters, and the Vietnam Service Medal with 2 battle stars.

Colonel Chase is married to the former Eben Burnside of Chevy Chase, Maryland. They have three grown children, two grandchildren and reside in Pittsfield, Maine.

Testimony of Roger Landry, Former Maine State Representative, and Co-Chair of Maine's Task Force on Veterans' Health Services, Before the House Committee in Veterans Affairs Subcommittee on Health August 22, 2005

Congressman Michaud and distinguished members of the Committee. My name is Roger Landry; I am retired from the U.S. Air Force having served honorably for 22 years. I am also 100% disabled with the Veterans Administration with throat cancer derived from exposure to Agent Orange in Southeast Asia during the period of 1967 to 1968. I have spent the last 12 years working extensively with various veterans organizations in an effort to better the lives of our Veterans. Most recently, I served as a State Representative in the 121st Maine State Legislature for District 10 which is Sanford, Maine. During my short tenure in the State House I was able to bring numerous veterans' issues to the attention of our State government the most significant of which is veterans' health care as provided by the Veterans' Administration.

Let me begin by saying that I truly believe that the VA health care system in Maine and its staff are doing their level best to provide adequate health care to our veterans. However, recent developments in the economics, demographics, and ever changing geography of our Maine veterans' world have caused us all to re-examine that level of adequacy in our VA health care system. Namely, the aging of the American Veteran, the increased enrollment of uninsured into the VA, the increasing cost of providing healthcare, including prescription drugs, and a federal budget environment in which – without changes to the VA's funding mechanism – it appears increasingly likely that VA funding will not keep pace with costs faced by the VA, suggests that a 'Perfect Storm' scenario may be brewing for our nation's veterans just at the time when they need the system most.

Further, as has others have mentioned in their testimony, the CARES study found significant access gaps in Maine. The study came up with recommendations to close some – but not all – of the access gaps faced by Maine veterans, but, as you have heard, the CARES recommendations will not be implemented for a number of years.

In addition, Senator Collins of Maine has a bill in to allocate funding to provide better transportation for veterans to existing VA health care facilities. While this bill, if successful, will diminish the problem somewhat, it can by no means eliminate the problem.

For these reasons, it is critical that here in Maine, a state with the one of the nation's highest percentage of veterans (in the 2000 Census, veterans constituted 15.9% of Maine's population age 18 and over, while the average among the 50 states and District of Columbia was 13.5%)[1] and with a population older than the rest of the country,[2] we provide the leadership to a more efficient, more accessible, and more compassionate healthcare system for our national veterans.

In 2003, as part of the Dirigo Health Reform Act, Governor Baldacci and the Maine Legislature created a Task Force to review and assess the needs of the State's veterans for health care services and the availability, accessibility and quality of public and private health care services for veterans, and to make recommendations based on its review and assessment.

Accordingly, a number of bills have been introduced in Congress to allow the VA to fill prescriptions written by community physicians. The VA has opposed these bills for a number of reasons. Two primary reasons are:

- **Cost.** As you are aware, unlike the federal Medicare program, whose funding is mandatory and thus automatically additional increases when enrollment increases, the VA receives a fixed budget that is determined each year through the appropriations process. The VA has pointed out that if Congress expanded the drug benefit without providing additional funds to pay for the expansion, the expansion "would tend to erode the comprehensive medical care benefits that veteran users of the VA health care system now enjoy"[4] by crowding out spending on core services.

- **VA's Drug Benefit is Part of VA's Coordinated System of Care.** The VA has stated that it "strongly believes that drug therapy must be coordinated, monitored, and managed by a single primary care provider. VA has maintained control over the cost of its prescription benefit by using sophisticated formulary management techniques and by assuring that prescriptions written by VA staff are consistent with the formulary management process."[5]

Advocates for these bills have argued that the VA would realize savings from the passage of these bills as a result of a reduction in duplication of services, and that these savings would outweigh any additional costs to the VA. A December 2000 report by the VA Inspector General (IG) estimated the cost of the re-examinations at $1.3 billion in 2001.[6] However, the VA believes that there were significant flaws in the IG's methodology and has indicated that the IG is continuing to examine its methodology. The VA's position is that increase in enrollment would likely outweigh savings from reduction in duplication of services.[7]

Pilot Program Proposal. With these concerns in mind, the Task Force proposes that the VA conduct a three-year state-wide pilot program in Maine to test the feasibility of allowing a limited number of eligible veterans to obtain prescription drugs from the VA through their community physician. The pilot could include an evaluation to help assess whether the pilot might be worthwhile in other rural states.

Under the terms of the proposed pilot, veterans who live at distances greater than the CARES guidelines (i.e., more than 60 miles in a rural area and 30 miles in an urban area) would be eligible to receive VA pharmacy benefits based on an initial visit with a VA physician. After the initial visit, a community physician would manage on-going care, including prescriptions. The veteran would enroll with the VA system and be required to see a VA physician every three years, rather than annually. Veterans enrolled in this program would pay a higher co-pay – to be established by the VA – and in return have the benefits of maintaining a relationship with their community physician, reducing unnecessary travel and duplication of services.

Specific elements of the proposal:

- **Increased co-payments to ensure cost neutrality to the VA, with all participants subject to co-payments, regardless of priority group.** The Task Force proposes that the VA establish a co-payment system that would enable the VA to fully recapture any additional cost to the VA of increased enrollment and prescription drug expenditures. This could include varying co-payments for specific drugs. The VA

could adjust the co-payment schedule annually to account for differences between projected and actual expenditures each year.

- **An enrollment cap set by the VA to limit the size of the pilot, and a program evaluation to assist the VA in monitoring impact of the pilot.** The VA could work with a local organization, such as from the University of Maine system or the University of New England, to design the pilot. This could include establishing an enrollment cap to balance the need to keep the pilot to a limited size while allowing statistically significant analysis, as well as to ensure enrollment of individuals from different parts of the state. The evaluation could answer such questions as:
  - What is the magnitude of savings to the VA from reduction in duplication of services? Does the pilot free up VA resources for veterans needing core services?
  - What is the demand for the program?
  - How do per-enrollee pharmacy expenditures in the pilot compare to per-enrollee outpatient pharmacy expenditures in the VA system?
  - What would the cost to the VA have been in the absence of the increased cost-sharing proposed by the pilot? Would those costs have been outweighed by savings from reduction in duplication of services?
  - How does enrollment break out between veterans who had already been driving to VA facilities for prescription drugs and those who are enrolling with the VA for the first time? Is there a reduction in the number of veterans who begin using VA services solely because they want access to the drug benefit?
- **Requiring Participating Veterans to Use a Single Primary Care Physician.** The enrollee must agree to use one primary-care physician, who would coordinate, monitor, and manage the veteran's care for the duration of their participation on the pilot. Any specialist wishing to write a prescription for the participating veteran would need to consult with the primary care physician before writing a prescription. The purpose of this provision would be to maximize the potential for the effective medication management to ensure cost effectiveness and safe, quality care.
- **The VA would determine which priority groups would be included in the pilot.** The VA might choose to include priority group 8 in the pilot, since there would be no additional cost to the VA.
- **Only veterans who live at distances greater than the CARES guidelines (i.e., more than 60 miles in a rural area and 30 miles in an urban area) would be eligible to participate.**

Potential Benefits of the Pilot Program

- To Everyone:
  - Would free up essential Togus resources as Maine veterans return home from Iraq and Afghanistan and other areas of deployment.
- To Veterans:
  - Continuity of care; ability to maintain relationship with local doctor; easier for veterans to access the lower-priced prescription drugs to which they are entitled, with less travel and delay.
- To Togus and Togus Physicians:

Testimony of

Timothy J. Politis

Chief Executive Officer

Maine Veterans' Homes

on

Rural Veterans' Access to Primary Care: Successes and Challenges

before the

U.S. House of Representatives

Committee on Veterans Affairs

Subcommittee on Health

August 22, 2005

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify today on behalf of the Maine Veterans' Homes ("MVH") on the topic of "Rural Veterans' Access to Primary Care," including the extremely important issue of continued access by veterans to quality long-term nursing care.

I am the Chief Executive Officer of MVH. MVH is a public body corporate created by the State of Maine to provide long-term nursing care to Maine veterans. MVH operates long-term nursing care facilities for veterans at Augusta, Bangor, Caribou, Scarborough, and South Paris, Maine. On September 6, 2005 we will open our sixth long-term care facility at Machias, Maine. In the aggregate, MVH currently operates 610 skilled nursing, long-term nursing, and domiciliary beds for Maine veterans and, with the opening of our new facility at Machias, our system will grow to a total complement of 640 beds. This makes MVH one of the largest chains of long-term nursing facilities in the state of Maine, and we are very proud of the quality long-term care nursing services that we provide to Maine veterans.

Also, as one of the largest and most successful State Veterans Homes systems in the nation, MVH provides a crucial portion of the health care continuum for Maine veterans. Our facilities are each relatively small in size, 30 to 150 beds each, and this allows them to be located, not only at one central location, but throughout the State of Maine, allowing greater ease of access to our facilities by veterans living in the most rural parts of Maine. In the future, we hope to develop additional in-patient and out-patient services at all of our six locations in order to offer rural Maine veterans greater access to all of the services that the Maine Veterans' Homes, the Maine Bureau of Veterans Services, and the United States Department of Veterans Affairs ("VA") provide.

MVH is part of a vital national system of State Veterans Homes. The State Veterans Homes system is the largest provider of long-term care to our nation's veterans. As such, the State Veterans Homes play an irreplaceable role in assuring that eligible veterans receive the benefits, services, and quality long-term health care that they have rightfully earned by their service and sacrifice to our country. We greatly appreciate this Committee's commitment to the long-term care needs of veterans, your understanding of the indispensable function that State Veterans Homes perform, and your strong support for our programs.

We especially appreciate the support of this Committee in restoring funds to the FY06 budget resolution and the House VA appropriations bill to assure that per diem payments by the Department of Veterans Affairs ("VA") to veterans who are residents in our State Homes will continue uninterrupted.

The Maine Veterans' Homes is a leader in this national system of State Veterans Homes and a leader in the National Association of State Veterans Homes ("NASVH"). The membership of NASVH consists of the administrators and staff of State-operated veterans homes throughout the United States. NASVH members currently operate 119 veterans homes in 47 States and the Commonwealth of Puerto Rico. Nursing home care is provided in 114 homes, domiciliary care

in 52 homes, and hospital-type care in 5 homes. These homes presently provide over 27,500 resident beds for veterans of which more than 21,000 are nursing home beds. These beds represent about 50 percent of the long-term care workload for the VA, for veterans receiving long-term care services at both urban and rural locations.

We work closely with the VA, State governments, the National Association of State Directors of Veterans Affairs, veterans service organizations, and other entities dedicated to the long-term care of our veterans. Our goal is to ensure that the level of care and services provided by State Veterans Homes meet or exceed the highest standards available.

Role of the State Veterans Homes

State Veterans Homes first began serving veterans after the Civil War. Faced with a large number of soldiers and sailors in critical need of long-term care, several States established veterans homes to care for those who served in the military.

In 1888, Congress first authorized federal grants-in-aid to states that maintained homes in which American soldiers and sailors received long-term care. At the time, the payments amounted to about 30 cents per resident per day. In the years since, Congress has made several major revisions to the State Veterans Homes program to expand the base of payments to include nursing home, domiciliary, and adult day health care.

For nearly half a century, State Veterans Homes have operated under a program administered by the VA which supports the Homes through construction grants and per diem payments. Both the VA construction grants and the VA per diem payments are essential components of this support. Each State Veterans Home must meet stringent VA-prescribed standards of care, which exceed standards mandated by federal and state governments for other long-term care facilities. The VA conducts annual inspections to assure that these standards are met and to assure the proper disbursement of funds. Together, the VA and the State Homes represent a very effective and financially-efficient federal-state partnership in the service of our veterans.

VA per diem payments to State Homes are authorized by 38 U.S.C. § 1741–1743. Congress intended to assist the States in providing for the higher level of care and treatment required for eligible veterans residing in State Veterans Homes. As you know, the per diem rates are established by the VA annually and may not exceed 50% of the cost of care. They are currently $59.36 per day for nursing home care, $35.17 per day for adult day health care, and $27.44 per day for domiciliary care. Our State Veterans Homes cannot operate without the per diem payments from the VA.

Construction grants are authorized by 38 U.S.C. §§ 8131–8137. The objective of such grants is to assist the States in constructing or acquiring State Veterans Home facilities. Construction grants are also utilized to renovate existing facilities and to assure continuing

compliance with life safety and building codes. Construction grants made by the VA may not exceed 65 percent of the estimated cost of construction or renovation of facilities, including the provision of initial equipment for any project. State funding covers at least 35 percent of the cost. Our program cannot meet our veterans' needs without an adequate level of construction grant funding.

In recent years, State Veterans Homes have experienced a period of controlled growth – the result of increasing numbers of elderly veterans who have reached that point in life when long-term care is needed. In fact, we face the largest aging veterans population in our nation's history. From 2000 to 2010, the number of veterans aged 85 and older is expected to triple from 422,000 to 1.3 million. If the State Veterans Homes program is to fill even a part of this unmet need for long-term care beds in certain States, and to respond to the increase in the number of veterans eligible for such care nationally, it is critical that the State Veterans Home construction grant program be sustained.

The State Veterans Home program now provides about 50% of the VA's total long-term care workload. The VA recently estimated nationally that nursing care beds in the State Homes are 87% occupied. MVH beds are approximately 95% occupied. Many of the State Veterans Homes nationally have occupancy rates near 100%, and some have long waiting lists. The State Veterans Homes provide long-term medical services to frail, elderly veterans at a cost to the VA of only $59 per day, well below the cost of care in a VA nursing home, which exceeds $400 per day.

Although there are no national admission requirements for the State Veterans Homes, there are state-by-state medical requirements for admission. Generally, a State will demand a medical certification confirming significant deficits in activities of daily living (an assessment of basic living functions) that require 24-hour nursing care. Moreover, no per diem is paid by the VA unless and until a VA official certifies that nursing home care is required. Veterans qualifying for long-term nursing care at a State Veterans Home are almost always chronically ill and elderly, and many are afflicted with mental health conditions.

State Veterans Homes as a VA Resource

The Veterans' Millennium Health Care Act ("Mill Bill"), Pub. L. No. 106-117, brought significant changes to veterans' long-term health care. Significantly, the VA is directed to provide long-term care for all veterans who have a 70% or greater service-connected disability or who need nursing care for a service-connected disability. The State Veterans Homes should play a major role in meeting these requirements and be treated as a resource integrated more fully with the VA long-term care program.

We have proposed that our beds be counted toward the VA's overall long-term care census. Doing so would allow the VA to meet the Mill Bill's long-term care bed requirements. A nursing home bed in a State Veterans Home is a very cost-effective alternative to a nursing

home bed in a VA-operated facility. Congress's goal should be to provide long-term care to veterans in a manner that expands the VA's capacity to provide services, while paying the lowest available per capita cost for each eligible veteran. Including State Veterans Homes nursing beds in the mandated VA long-term care totals could allow the VA to meet its legislative mandate, shift some of its maintenance care and other specialty services to the State Veterans Homes, and ultimately increase the capacity of the VA to provide greater short-stay, highly-specialized rehabilitative care.

This goal can be accomplished by the State Homes at substantially less cost to taxpayers than other alternatives. The average daily cost of care for a veteran at a long-term care facility run directly by the VA has been calculated nationally to be $423.40 per day. The cost of care to the VA for the placement of a veteran at a contract nursing home, which is not required to meet more stringent State Veterans Home standards, is approximately $194.90 per day. The same daily cost to the VA to provide outstanding quality long-term care at a State Veterans Home is far less – only $59.36 per day for nursing care.

This substantially lower daily cost to the VA of the State Veterans Homes compared to other available long-term care alternatives led the VA Office of Inspector General to conclude in a 1999 report: "the SVH [State Veterans Home] program provides an economical alternative to Contract Nursing Home (CNH) placements, and VAMC [VA Medical Center] Nursing Home Care Unit (NHCU) care" (emphasis added). In this same report, the VA Office of Inspector General went on to say:

> A growing portion of the aging and infirm veteran population requires domiciliary and nursing home care. The SVH [State Veterans Home] option has become increasingly necessary in the era of VAMC [VA Medical Center] downsizing and the increasing need to discharge long-term care patients to community based facilities. VA's contribution to SVH per diem rates, which does not exceed 50 percent of the cost to treat patients, is significantly less than the cost of care in VA and community facilities.

VA Construction Grant Program

Under current law, there are strict limits and standards for funding the construction and renovation of State Veterans Homes. The system is working very well under the provisions of the Mill Bill, which establishes priorities for funding according to life/safety, great need, significant need, and limited need. Pursuant to these standards, in FY05, only 35 priority construction or renovation projects have been authorized and are underway in Wisconsin, Nebraska, Ohio, New Hampshire, New York, Michigan, Massachusetts, Connecticut, Hawaii, Alaska, Delaware, Rhode Island, Oklahoma, Florida, North Carolina, Colorado, Georgia, Missouri, and Minnesota. Other projects in these and other states have been approved initially for FY06 funding by the VA.

Specifically, the VA has identified 10 states as having either a "great" or "significant" need to build new State Veterans Homes beds immediately. These are Florida, Texas, California, Pennsylvania, Ohio, New York, Hawaii, Delaware, Wyoming, and Alaska. Hawaii expects to open its first State Home next year. Florida has five new homes in the planning stages, and Texas has four homes in the planning stages and two homes in the final stages of construction. California has three new homes approved. Delaware and Alaska are planning their first State Homes. The needs of veterans in these states require that these facilities be built.

Moreover, under the requirements of the Mill Bill, the VA prescribes strict limits on the maximum number of State Veterans Home nursing beds that may be funded by construction grants. This is based on projected demand for the year 2009, which determines which states have the greatest need for additional beds. This process assures that additional State Veterans Home beds are built only in those states that have the greatest unmet need for such beds.

VA Budget Proposal for FY06

The President's FY06 budget would devastate the State Veterans Homes program and deny care to the thousands of veterans who currently utilize the program and the tens of thousands of veterans who will need the program in the future. The budget proposal would: 1) slash per diem payments by revising the eligibility requirements for the State Veterans Homes so that the vast majority of veterans suddenly would be ruled ineligible for per diem benefits; and 2) impose a moratorium on construction grants, terminating plans for many new Homes, life/safety projects, and renovations where a need has been justified in many key States under the standards of the Mill Bill.

The change in the per diem criteria would have the most immediate impact on the State Homes program. Under the President's proposal, per diem payments for nursing care at State Veterans Homes would be limited to veterans in priorities 1–3 and those in priority 4 who are catastrophically disabled (a new and poorly-defined concept of disability).

NASVH concludes, based on a poll of our members, that the Administration's budget proposal would rule ineligible approximately 80% of the current population of the State Veterans Homes. More than 14,000 of the 19,000 veterans in State Veterans Homes would be denied the per diem benefit. This analysis examined the current population of the State Homes. The VA has proposed grandfathering current residents, but that will only delay the full impact of the proposal for months, not years, because we estimate that most current residents of the State Veterans Homes will pass away or be discharged within 12 to 18 months.

The President's proposed budget abrogates the federal government's commitment to the State Veterans Homes program. State taxpayers have paid hundreds of millions of dollars to help construct the State Veterans Homes with the understanding that the Homes would continue to serve the nation's veterans population. However, the President's budget abruptly and

needlessly abandons this arrangement and places the Homes in an untenable financial position. Simply put, it could lead to the closure of many State Homes.

We applaud the House and Senate Veterans' Affairs Committees and Appropriations Committees for rejecting the proposed cuts to the per diem payments, and for restoring full funding for per diem payments under the current eligibility rules for such payments.

More work, however, needs to be done.

The Senate VA Appropriations bill has proposed funding the State Veterans Homes construction and renovation program nationally at $104.3 million for FY '06. This amount of funding is the same amount as that provided for the State Veterans Home construction and renovation program for FY '05, with no increase. The House, however, prior to the time that additional funds were authorized for the VA in July of this year, voted in H.R. 2528 to provide only $25 million of funding for this same construction and renovation program for FY '06, and has restricted this funding only to life/safety projects. In short, the $25 million appropriation authorized by the House to fund all construction projects at all 119 State Veterans Homes nationally is simply inadequate for legitimate needs, and we strongly urge the House to adopt the $104.3 million FY '06 funding level recommended by the Senate Appropriations Committee when the matter is considered by a Conference Committee during the next few weeks.

Conclusion

Thank you for your commitment to long-term care for veterans and for your support of the State Veterans Homes as a central component of that care. In conclusion, I will reiterate the key issues facing the State Veterans Homes.

First, with respect to the President's proposal for cuts to the per diem, we hope to continue working with the Members of this Committee and the House Appropriations Committee to assure that the VA appropriations bill reflects the consensus that preserves sufficient funds for continued per diem payments under current eligibility requirements. We also seek your assistance in directing the Administration not to impose unilateral changes to VA per diem payments through administrative means.

Second, we believe the Committee and the Congress should reject the moratorium on State Veterans Homes construction grants, many of which fund needed renovations or address demonstrated need in certain States for more nursing care beds, and that this construction and renovation grant program be funded for FY '06 at the $104.3 million level recommended by the Senate Appropriations Committee.

Third, we believe that the State Veterans Homes can play a more substantial role in meeting the long-term care needs of veterans. NASVH recognizes and supports the national trend towards deinstitutionalization and the provision of long-term care in the most independent

and cost-effective setting. In a letter to VA Secretary Nicholson dated April 5, 2005, NASVH proposed that we explore together creative ways to provide a true continuum of care to our veterans, both rural and urban, in State Veterans Homes and in the community. We would be pleased to work with the Committee and the VA to explore options for developing pilot programs for innovative care and for more closely integrating the State Veterans Homes program into the VA's overall health care system for veterans.

Written Testimony of Peter W. Ogden,
Director, Bureau of Veterans Services, State of Maine
On Rural Access to Veterans Healthcare in Maine
Before the House Veterans' Affairs Subcommittee on Health

Chairman Brown, Congressman Michaud and distinguished members of the committee thank you for this opportunity to provide written testimony on an extremely important issue for Maine's veterans. I apologize for not being at the hearing in person but I am attending the annual fall meeting of the National Association of State Directors of Veterans Affairs in Seattle, WA. I will be meeting with my fellow State Directors and discussing these same issues as they are pertinent to all 50 states and the four territories where our veterans live.

Maine is a unique state in several ways: In 2000 Maine had the largest per capita veteran population in the nation and is still at number two or three; the Togus Medical Center is the oldest VA hospital in the nation; and Maine's aging veteran population is geographically dispersed across a vast land area.[1]

Maine presently has the distinction of being the oldest state in the nation with a median age of 40.6 years old.[2] When you look at the age of Maine's veterans you will find that 61% or 90,017 veterans are aged 55 and older. [3] These are the veterans that are most likely to need and use the VA health care system. Access for Maine's elderly veterans is of extreme importance.

In testimony to the CARES Commission on access to VA healthcare in Maine Mr. Roland Lapointe stated, "*The CARES market plan (Far North Market) developed in VISN 1 recognized Maine's unique geographic characteristics, limited transportation infrastructure and rural nature.*" The resulting CARES Commission Report made several points about access to VA health care in Maine (Far North Market) that are relevant to this hearing.

"*In the Far North and North Markets, less than 60 percent of enrolled veterans are currently within the VA's access standards for hospital care. The CARES standard is 60 minutes for urban areas; 90 minutes in rural areas; and 120 minutes in highly rural areas. Inpatient medicine workload is projected to increase...The Far North Market has the largest projected increase, with 209 percent over baseline by FY 2012.*" [4]

"*...the Far North Market is currently below the standard for access to primary care. Currently only 59 percent of the veterans residing in this largely rural area are within the CARES guidelines set for access to primary care services.*"[5] The CARES definition for "*Access to Primary Care*" is "*70% of veterans in urban and rural communities must be within 30 minutes of primary care; for highly rural areas, this requirement is within 60 miles.*"[6]

"*The VISN had proposed five new CBOCs*, (Community Based Outpatient Clinics) *all in the Far North Market. These new CBOCs would be located across Maine in order*

to improve access to care and thus address current deficiencies in access in this market... These CBOCs are also crucial to the VISN's plan to expand inpatient capacity at Togus, by reclaiming old inpatient space that has been converted to outpatient services." [7]

Rural access to VA healthcare in Maine will greatly improve if and when the CARES Plan is fully implemented. Even if fully implemented in Maine today, we will still face challenges as the CARES Plan only addresses 70% of the veteran population which means that 30% or 44,578 veterans (2005 numbers) will still be out side of the CARES standard for healthcare access. Former State Representative Roger Landry will be testifying toady on a proposal for a pilot program that can help these veterans who are outside the CARES standard for access to healthcare.

The following table shows the aging of Maine's veteran population over the next 25 years. As you can see we will continue to have the majority of our veteran population over age 55 for many years to come.

Year	Veteran Population *	Veterans > 55	% of Veteran Population
2005	148,593	90,017	61%
2010	138,491	85,674	62%
2015	127,004	80,402	63%
2020	116,441	74,649	64%
2025	107,173	67,578	63%
2030	98,949	59,306	60%

* Based on projections from VA Demographics Program VetPop2001

This aging veteran population coupled with Maine's rural geography presents problems to elderly veterans trying to access VA healthcare especially in Maine's severe winter months. As noted by Mr. Lapointe in his testimony Maine has a limited transportation infrastructure and this compounds the access issue. The majority of elderly veterans live in rural areas while the younger veterans live in the urban areas.

Senator Susan Collins has introduced legislation to improve transportation opportunities for veterans who have a hard time getting to VA healthcare. S.100: Is a bill to expand access to affordable health care and to strengthen the health care safety net and make health care services more available in rural and underserved areas. This bill is designed to assist veterans with transportation to VA healthcare facilities.

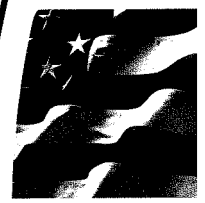
The Veterans Administration at Togus does a remarkable job of taking care of Maine's veterans with their limited resources. The recent influx of new veterans from Iraq and Afghanistan are being serviced well by Togus but this does have an impact on how they can take care of the older veterans that we are identifying and enrolling in the VA healthcare system. VA staffing is based on system user numbers that are two years old. This means they are always behind when it come to having adequate staff to provide healthcare to our veterans. In Maine we will see an increasing number of our aging veterans enrolling and seeking assistance from the VA.

In short, to improve rural access for veterans to VA healthcare in Maine, implement CARES in Maine and implement it sooner than later.

---

[1] Testimony to CARES Commission by Roland M. Lapointe, August 25, 2003.
[2] Churchill, Chris. Maine: The gray state, Maine now has highest median age in the U.S., *Kennebec Journal*, March 11, 2005. Page A-1.
[3] Numbers were taken from the Veterans Administration's Demographics Program VetPop2001 for the year ending September 2005
[4] CARES Commission Report, Chapter 5 VISN Recommendations, Page 5-15
[5] CARES Commission Report, Chapter 5 VISN Recommendations, Page 5-18
[6] CARES Commission Report, Appendix A, Glossary of Acronyms and Definitions, Page A-3.
[7] CARES Commission Report, Chapter 5 VISN Recommendations, Page 5-18, 19

VA HEALTH CARE



Department of Veterans Affairs

inside

- overview
- enrollment
- enrollment priority groups
- copayment requirements
- covered services
  - hospital care benefits
  - outpatient care benefits

building on over 50 years of providing quality health care services to our nation's veterans

DEPARTMENT OF VETERANS AFFAIRS
Togus Medical Center
1 VA Center
Augusta, ME 04330

July 1, 2005

In Reply Refer to: 402/BSL4P

Dear Veteran:

Thank you for your interest in the services the Department of Veterans Affairs (VA) can provide. Enclosed you will find:

- VA HEALTH CARE OVERVIEW booklet
- VA Form 10-10 EZ APPLICATION FOR HEALTH BENEFITS
- Self-addressed return envelope

It is important to understand that VA is a comprehensive system of healthcare, with a staff of highly qualified doctors and other health professionals. It is not a prescription medication plan. VA does not fill prescriptions written by non-VA physicians.

You will find an additional form on the reverse of this sheet. Please complete the required information and return it with your application. To assist you in completing this process and to prevent your application being returned for more information, the following directions are given:

10-10EZ Application for Health Benefits

- ✓ Answer all fields without leaving anything blank
- ✓ Do not use N/A. If None or "0" state as such
- ✓ Next of Kin must be spouse if married; otherwise a blood relative (please state relationship). If no blood relation, state "None". Emergency Contact and Designee may be anyone you choose.
- ✓ Provide income and asset information as requested. VA is currently not enrolling veterans who decline to provide financial information unless other special eligibility factors exist, such as a VA rated service-connected disability, former POW, recent Combat Vet, Purple Heart Recipient, etc.

Discharge Papers (Form DD-214)

- ✓ Must show DATE OF ENTRY into active service (other than Active Duty Training)
- ✓ Must show DATE OF DISCHARGE from active service
- ✓ Must show CHARACTER OF DISCHARGE (i.e. Honorable, General, Medical, etc)

Return ONLY the following items in the self-addressed envelope provided:

- ✓ Completed VA Form 10-10EZ Application for Health Benefits
- ✓ Copy of Discharge Papers (Originals may not be returned to you)
- ✓ Copy of Health Insurance Cards, including Medicare (provide copy of front and back of cards)
- ✓ Complete and return the information on the reverse of this paper

Additional information may be obtained at VA's web site at www.va.gov. Click the "Health" section which appears on the home page. You may also complete the 10-10 EZ on line, using the above web address.

If you have any questions, please contact our Patient Services Assistants at (207) 623-8411, extension 5688 within the Augusta area, or toll free at (877) 421-8263, extension 5688 from 8:30 a.m. to 4:00 p.m. Monday through Friday.

Sincerely,

BRUCE C. DOW, M.B.A.
PATIENT SERVICES MANAGER

A Member of VA New England Healthcare System

VA HEALTH CARE overview

This guide is designed to provide veterans and their families with the information they will need to understand VA's health care system—its enrollment process including enrollment priority groups, required copayments, if applicable, and what services are covered. In addition to a narrative description, we have also added *frequently asked questions* to each segment.

If we have not addressed your specific questions, additional help is available at the following sources.

- your local VA health care facility's Enrollment Office
- the eligibility page on our web site

  www.va.gov/elig
- Veterans Health Benefits Service Center

  1-877-222-VETS (8387)

Over time, VA health care has changed significantly. In recent years, legislative changes have dramatically enhanced veterans' health care benefits as well as access to those benefits. Today's veterans have a comprehensive benefits package which VA administers through an annual patient enrollment system. The enrollment system is based on priority groups to ensure that health care benefits are readily available to all eligible veterans (see *Enrollment Priority Groups* on page 6).

Complementing the expansion of benefits and improved access is our ongoing commitment to providing the very best in quality service. Our goal is to ensure that our patients receive the finest quality of care regardless of the treatment program, regardless of the location. In addition to our ongoing quality assurance activities, we've made it easier for veterans to get the health care they need. More than 350 locations of care have been recently added to the VA health care system—bringing the total number of treatment sites to over 1,200 nationwide.

As explained further in this guide, most veterans must be enrolled to receive VA health care. While some veterans are not required to enroll due to their special eligibility status, all veterans—including those who have special eligibility—are encouraged to apply for enrollment. Enrollment helps us to determine the number of potential veterans who may seek VA health care services and, thus, is a very important part of our planning efforts.

Enrollment in the VA health care system provides veterans with the assurance that comprehensive health care services will be available when and where they are needed during that enrollment period. In addition to the assurance that services will be available, enrolled veterans will appreciate not having to repeat the application process—regardless of where they seek their care or how often.

Veterans Choose the VA Facility

As part of the enrollment process, a veteran may select any VA health care facility to serve as his/her primary treatment facility.

Benefits on the Go

VA enrollment also allows health care benefits to become completely portable throughout the entire VA system. Enrolled veterans who are traveling or who spend time away from their primary treatment facility may obtain care at any VA health care facility across the country.

FAQs

Frequently asked questions

Do I have to enroll to receive VA health care?
While most veterans must be enrolled to receive VA health care, some veterans are exempt from the enrollment requirement due to meeting special eligibility criteria. If you fall into one of the following categories, you are not required to enroll.

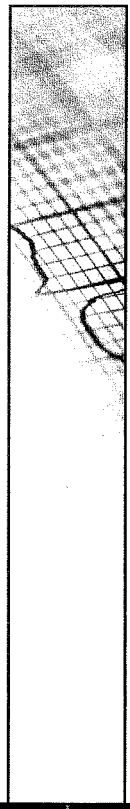
- if you are seeking care for a VA-rated service-connected condition only
- if VA has rated you with a service-connected disability of 50% or more
- if less than one year has passed since you were discharged for a disability that the military determined was incurred or aggravated in the line of duty, but that VA has not yet rated

Why does VA encourage enrollment from those veterans who Congress specifically exempted from the process?
The reason we encourage all potential VA health care patients to enroll is for planning and budgeting purposes. Enrollment numbers help to identify the potential demand for VA services. By including all potential patients in the enrollment count, including those who are exempt, we are in a much better position to identify necessary funding levels to Congress.

What if the demand for VA services exceeds its budget?
When the demand for services exceeds our ability to provide quality and timely health care, decisions will be made to ensure that the level of services for enrolled veterans is not compromised. Those decisions may include suspending enrollment of veterans in lower priority groups or, in more drastic times, removing (*disenrolling*) lower priority group veterans from our enrollment system.

I already receive VA care, but I don't remember enrolling. How can I verify my enrollment?
If you are uncertain of your enrollment status, check with the Enrollment Coordinator at your local VA health care facility.

VA HEALTH CARE enrollment



Veterans can apply for VA health care enrollment by completing VA Form 10-10EZ, *APPLICATION FOR HEALTH BENEFITS.* The application form can be obtained by visiting, calling, or writing any VA health care facility or veterans' benefits office. Forms can also be requested toll-free from VA's Health Benefits Service Center at 1-877-222-VETS (8387) or accessed from our web site at www.va.gov/1010ez.htm. Completed applications must be signed and dated and may be submitted in person or by mail to any VA health care facility.

If you apply in person at a VA health care facility, VA staff will assign you to an initial enrollment priority group as shown on page 6. After your application is processed at the VA Health Eligibility Center in Atlanta, you will receive a notice confirming your enrollment status.

Financial Assessment (Means Testing)

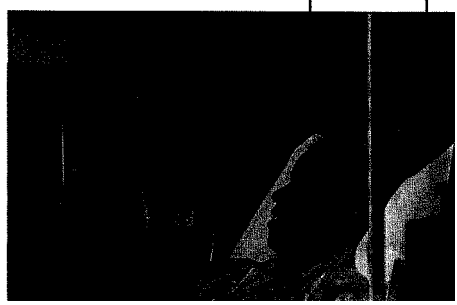
While many veterans qualify for enrollment and cost-free health care services based on a compensable service-connected condition or other qualifying factor, most veterans will be asked to complete a financial assessment as part of their enrollment application process. Otherwise known as the *Means Test*, this financial information will be used to determine the applicant's enrollment priority group (see *Enrollment Priority Groups* on page 6) and whether he/she is eligible for cost-free VA health care. Higher-income veterans may be required to share in the expense of their care by making copayments (see *Copayment Requirements* on pages 8 and 9).

Veterans who choose not to complete the financial assessment must agree to pay the required copayments as a condition of their eligibility.

NEW GEOGRAPHICALLY-BASED MEANS TESTING

Recognizing that the cost of living can vary significantly from one geographic area to another, Congress added income thresholds based upon geographic locations to the existing VA national income thresholds for financial assessment purposes. This change, which became effective October 1, 2002, assists lower-income veterans who live in high-cost areas by reducing their required inpatient copayments.

Please note that the new geographically-based copayment reductions apply ONLY to INPATIENT SERVICES—outpatient services, long-term care, as well as medication copayments are NOT affected by this change.



Health Insurance Coverage?

Since VA health care depends primarily on annual Congressional appropriations, VA encourages veterans to retain any health care coverage they may already have—especially those in the lower enrollment priority groups as further described on the next page. Veterans with private health insurance or with federally funded coverage through the Department of Defense (TRICARE), Medicare, or Medicaid, may choose to use these sources of coverage as a supplement to their VA benefits.

CAUTION! Before cancelling insurance coverage, enrolled veterans should carefully consider the risks.

- There is no guarantee that in subsequent years Congress will appropriate sufficient funds for VA to provide care for all enrollment priority groups.
- Non-veteran spouses and other family members generally do not qualify for VA health care.
- If participation in Medicare Part B is cancelled, it cannot be reinstated until January of the next year and there may be a penalty for the reinstatement.

Reporting Health Insurance Information

By law, VA is obligated to bill health insurance carriers for services provided to treat nonservice-connected conditions. To ensure that current insurance information is on file—including coverage through employment or through a spouse—our staff will ask about the veteran's health insurance coverage during each patient visit. Since collections received from insurance companies help supplement the funding available for providing services to veterans, patients are asked to cooperate by disclosing all relevant health insurance information.

Insurance Collections

Since the start of insurance collections in 1986, veterans' health care services have been supplemented by over $7.7 billion—allowing us to provide services to numerous additional veterans.

FAQs

Frequently Asked Questions

Must I reapply in subsequent years and will I receive an enrollment confirmation?
Your enrollment will be reviewed annually without any action necessary on your part. Depending on your priority group and the availability of funds for VA to offer you services, your enrollment will be renewed. Should there be any change to your enrollment status, you will be notified in writing.

If enrolled, must I use the VA as my exclusive health care provider?
If you have health insurance, you may elect to use those benefits in seeking services from non-VA providers as a supplement to your VA care. Please be aware, however, VA is NOT an insurance plan and that our authority to pay for services from non-VA providers is extremely limited (see page 11).

What income is counted under the Means Test and is family size considered?
Your income is based on your previous year's earnings as well as those of your spouse, and dependent children. If there has been a significant change in earned income from the previous year, projected income may be used on a case-by-case basis. The number of persons in your family will be factored into the calculation to determine the applicable income threshold—both the VA national income threshold and the income threshold for your geographic region.

For those veterans who have more than one residence, which address is used for means testing under the new geographically-based income thresholds?
The address used to determine your geographically-based income threshold is your permanent address. Typically, it is the location in which you declare residency for voting and tax purposes.

How frequently are the thresholds updated?
Income thresholds, used for the national Means Test as well as for geographic adjustments for high cost-of-living areas, are updated annually.

VA HEALTH CARE enrollment priority groups

Upon receipt of a completed application (must include signature and date), the veteran's eligibility will be verified. Based on his/her specific eligibility status, he/she will be assigned to one of the following priority groups. The groups range from 1 through 8 with Priority Group 1 being the highest priority and Priority Group 8 the lowest.

Priority Group 1

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

Priority Group 2

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

Priority Group 3

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

Priority Group 4

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

Priority Group 5

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

Priority Group 6

- Compensable 0% service-connected veterans
- World War I veterans
- Mexican Border War veterans
- Veterans seeking care solely for disorders associated with:
  - exposure to herbicides while serving in Vietnam; or
  - exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or
  - for disorders associated with service in the Gulf War; or
  - for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998

Priority Group 7

Veterans who agree to pay specified copayments with income and/or net worth ABOVE the VA Means Test threshold and income BELOW the geographically-based threshold for their locality

- Subpriority a: Noncompensable 0% service-connected veterans who were enrolled in the VA health care system on a specified date and who have remained enrolled since that date
- Subpriority c: Nonservice-connected veterans who were enrolled in the VA health care system on a specified date and who have remained enrolled since that date
- Subpriority e: Noncompensable 0% service-connected veterans not included in Subpriority a above
- Subpriority g: Nonservice-connected veterans not included in Subpriority c above

Priority Group 8

Veterans who agree to pay specified copayments with income and/or net worth ABOVE the VA Means Test threshold and income ABOVE the geographically-based threshold for their locality

- Subpriority a: Noncompensable 0% service-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date
- Subpriority c: Nonservice-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date
- Subpriority e: Noncompensable 0% service-connected veterans applying for enrollment after January 16, 2003
- Subpriority g: Nonservice-connected veterans applying for enrollment after January 16, 2003

FAQs

How has the application of the new geographically-based income thresholds changed the financial assessment process and the enrollment priority groups?

While the financial assessment procedures have not been changed, application of the geographically-based income thresholds has resulted in a division of the original Priority Group 7 into two separate priority groups. The redefined Priority Group 7 is now limited to nonservice-connected veterans and noncompensable 0% service-connected veterans whose combined income and net worth exceed VA's annually established national means test threshold BUT whose income is below the geographically-adjusted threshold. The new Priority Group 8 includes all other nonservice-connected veterans and noncompensable 0% service-connected veterans whose income and net worth exceed VA's national means threshold AND whose income exceeds the threshold for their geographic location. In addition, Priority Group 8 also includes veterans who have declined to provide financial information and who, as a condition of their eligibility, have agreed to make required copayments.

Prior to the change in priority groups, I was in Priority Group 7. When will I learn of my new priority group assignment?

Beginning in June 2003, veterans who are currently receiving care will receive a notice from the Health Eligibility Center in Atlanta confirming their enrollment and to which enrollment priority group they have been assigned. If you have questions concerning your enrollment priority, contact the Enrollment Coordinator at your primary VA treatment facility.

What is a VA service-connected rating and how do I establish one?

A service-connected rating is an official ruling by VA that your illness/condition is directly related to your active military service. Service-connected ratings are established by VA Regional Offices located throughout the country. In addition to compensation and pension ratings, VA Regional Offices are also responsible for administering educational benefits, vocational rehabilitation, and other benefit programs including home loans. To obtain more information or to apply for any of these benefits, contact your nearest VA Regional Office at 1-800-827-1000 or visit us online at www.va.gov.

Who does the VA consider to be "catastrophically" disabled?

To be considered catastrophically disabled, you must have a severely disabling injury, disorder, or disease which permanently compromises your ability to carry out the activities of daily living. The disability must be of such a degree that you require personal or mechanical assistance to leave home or bed, or require constant supervision to avoid physical harm to yourself or others. To request an evaluation, contact the Enrollment Coordinator at your local VA health care facility. If it is determined that you are catastrophically disabled, your priority will be upgraded to Priority Group 4. If, however, you were previously required to make copayments, that requirement will continue until your financial situation qualifies you for cost-free services.

Priority Groups 7 and 8 both have subpriority groups—a, c, e, and g. Are there subpriority groups b, d, and f?

Although the subpriority group designations (a, c, e, and g) are in descending order based on highest priority to lowest, they deliberately were not put in consecutive order. Since these designations are used exclusively for internal tracking purposes, we reserved b, d, and f for future use in the event of additional changes to the priority groups.

VA HEALTH CARE copayment requirements

While many veterans qualify for cost-free health care services based on a compensable service-connected condition or other qualifying factor, most veterans are required to complete an annual financial assessment or *Means Test* to determine their priority for enrollment and eligibility for cost-free services. Veterans whose household income and net worth exceed the established Means Test threshold as well as those who choose not to complete the financial assessment, must agree to pay required copayments to become eligible for VA health care services. Along with their enrollment confirmation and priority group assignment, enrollees will receive additional information about current copayment rates.

Types of Copayments

Outpatient Copayments*—a single copayment rate based on the highest of two levels of services on any individual day.

- Basic Care Services—services provided by a primary care clinician (basic charge)
- Specialty Care Services—services provided by a clinical specialist such as surgeon, radiologist, audiologist, optometrist, cardiologist, and specialty tests such as magnetic resonance imagery (MRI), computerized axial tomography (CAT) scan, and nuclear medicine studies (specialty charge)

*There is no copayment requirement for preventive care services such as screenings and immunizations.

Inpatient Copayments—in addition to a standard copayment charge for each 90 days of care within a 365-day period regardless of the level of service (such as intensive care, surgical care, or general medical care), a per diem charge will be assessed for each day of hospitalization. Based on the new geographic means testing, lower income veterans who live in high-cost areas may qualify for reduced inpatient copayment charges.

Medication Copayments*—applicable to each medication prescription (including each 30-day supply of maintenance medications) dispensed on an outpatient basis.

*Includes an annual cap for some enrollment priority groups.

Long-Term Care Copayments*—based on three levels of care (see *Long-Term Care Benefits* on page 12 for definitions).

- Nursing Home Care/Inpatient Respite Care/Geriatric Evaluation
- Adult Day Health Care/Outpatient Geriatric Evaluation/Outpatient Respite Care
- Domiciliary Care

*Copayments for Long-Term Care services start on the 22nd day of care during any 12-month period—there is no copayment requirement for the first 21 days. Actual copayment charges will vary from veteran to veteran depending upon financial information submitted on VA Form 10-10EC.

ANNUAL CHANGES TO COPAYMENT RATES

Because of the annual changes to copayment rates—including the annual cap on medication copayments—they are published separately. Current year rates can be obtained at any VA health care facility.

Who it applies to:

Most nonservice-connected veterans and noncompensable 0% service-connected veterans whose household income and net worth exceed the established Means Test or Geographic Means Test income thresholds with the following exceptions.

- veterans described in the *Common Exceptions* block
- veterans in receipt of VA pension benefits
- veterans who are eligible for Medicaid benefits

Most veterans with the following exceptions.

- veterans described in the *Common Exceptions* block
- veterans with a service-connected rating of 50% or greater
- veterans receiving VA pension benefits or whose income does not exceed the maximum VA annual rate of pension

Most veterans with the following exceptions.

- veterans described in the *Common Exceptions* block
- veterans with a compensable service-connected condition
- veterans whose income does not exceed the VA pension rate payable to a single veteran

Copayments COMMON EXCEPTIONS

- veterans requiring services/medications for treatment of a service-connected condition
- veterans requiring services/medications for disorders related to exposure to herbicides in Vietnam, ionizing radiation, or environmental contaminants during Gulf War service
- combat veterans discharged after 11/11/98 who require services/medications within two years of discharge for conditions related to military service
- veterans requiring services/medications for conditions related to sexual trauma experienced while in the military
- veterans exposed to nose or throat radium treatments while in the military who require services/medications for head or neck cancer

FAQs

I am a recently discharged combat veteran. Must I pay VA copayments?

If the services are provided for the treatment of a condition that may be related to your military service, you will not be charged any copayments. This benefit is limited to a two-year period following military discharge. You will, however, be subject to means testing (and copayments, if applicable) for care of any condition clearly not related to your military service such as a broken limb or a problem that existed prior to entering service.

How many copayment charges may be assessed during a single day?

Generally you will be charged only one copayment on a single day, whether it be an inpatient, outpatient, or long-term care copayment, based on the highest level of service provided on that day. Medication copayments, which are applicable only to outpatients, vary depending upon the number of prescriptions filled. If you are an outpatient who has both a specialty care visit as well as a basic care visit on the same day, you will be charged for the specialty care visit since it is the more expensive level of care. Inpatient copayments are based on both a standard charge for each 90 days of care within a 365-day period as well as a per diem (daily) charge. Since long-term care copayments can apply for inpatient or outpatient-type services, the copayments vary based upon the service provided and your ability to pay.

Who qualifies for the annual cap on medication copayments?

The annual cap on medication copayments applies to Priority Groups 2 through 6 (Priority Group 1 is exempt from ALL copayments). Because of their higher financial status, veterans in Priority Groups 7 and 8 do NOT qualify for the medication copayment annual cap. For those who qualify, once the annual limit is reached, all subsequent prescriptions filled during the calendar year will be free of the copayment requirement.

VA HEALTH CARE covered services

Acute Care Benefits

Standard Benefits

The following acute care services are available to all enrolled veterans.

Preventive Care Services

- Immunizations
- Physical Examinations (including eye and hearing examinations)
- Health Care Assessments
- Screening Tests
- Health Education Programs

Ambulatory (Outpatient) Diagnostic and Treatment Services

- Medical
- Surgical (including reconstructive/plastic surgery as a result of disease or trauma)
- Mental Health
- Substance Abuse

Hospital (Inpatient) Diagnostic and Treatment Services

- Medical
- Surgical (including reconstructive/plastic surgery as a result of disease or trauma)
- Mental Health
- Substance Abuse

Prescription Drugs (when prescribed by a VA physician)

Limited Benefits

General Exclusions (partial listing)

- Abortions and abortion counseling
- Contraceptives not requiring physician's prescriptions such as condoms, spermicidal foams, and jelly
- Cosmetic surgery except where determined by VA to be medically necessary for reconstructive or psychiatric care
- Drugs, biologicals, and medical devices not approved by the U.S. Food and Drug Administration
- Gender alteration
- Health club or spa membership, even for rehabilitation
- Infertility services, such as artificial insemination, in vitro fertilization, or embryo transfer, unless related to a service-connected condition
- Reproductive sterilization/reversal of sterilization (except when determined to be medically necessary)
- Services not ordered and provided by licensed/accredited professional staff
- Special private duty nursing

Hearing aids and eyeglasses are listed as "limited" benefits. Under what circumstances do I qualify?
To qualify for hearing aids and eyeglasses you must have a VA service-connected disability rating of 10% or more. You may also qualify if you are a former prisoner of war or are receiving increased pension based on your need for regular aid and attendance or being permanently housebound.

Am I eligible for dental care?
You are eligible for dental services if your care is for a service-connected condition or if you have a service-connected rating of 100 percent. You may also qualify if you are a former prisoner of war, a participant in a VA vocational rehabilitation program, or if your dental condition is aggravating a medical problem under VA treatment. In addition, you may also qualify for one-time dental treatment if you have been recently discharged from military service, had a documented dental condition while in service, and your discharge certificate does not include certification that all appropriate treatment had been rendered prior to being released.

Am I limited to a specific number of inpatient days or outpatient visits during a given period of time?
For acute care services (inpatient days of care and outpatient visits) there are no limits.

Do I qualify for routine health care at non-VA facilities at VA expense?
To qualify for routine non-VA care at VA expense (otherwise known as *fee-basis* care), you must first be given specific authorization. Included among the factors in determining whether such care will be authorized is your medical condition and availability of VA services within your geographic area.

Am I eligible for emergency care at non-VA facilities?
You are eligible if the non-VA emergency care is for a service-connected condition or, if enrolled, you have been provided care by a VA clinician or provider within the past 24 months and have no other coverage or ability to pay for the services. Also, it must be determined that VA health care facilities were not feasibly available, that a delay in medical attention would have endangered your life or health, and tha you are personally liable for the cost of the services

Is VA approval needed before I obtain non-VA emergency services?
While approval is not required, notification to the nearest VA health care facility must be made withi 48 hours if hospitalization is required. Since VA payment is limited up to the point your condition i stable for transportation to a VA facility, transfer arrangements should be made as soon as possible.

Does the VA offer compensation for travel expenses t and from a VA facility?
If you meet specific criteria (see next question), yo are eligible for travel benefits. In most cases, travel benefits are subject to a deductible. Exceptions to the deductible requirement are: 1) travel for a compensation and pension examination; and 2) travel b an ambulance or a specially equipped van. Because travel benefits are subject to annual mileage rate and deductible changes, we publish a separate document each year. You can obtain a copy at any VA health care facility.

Do I qualify for travel benefits?
You may qualify for beneficiary travel payments if you fall into one of the following categories.

- you have a service-connected rating of 30 percent or more
- you are traveling for treatment of a service-connected condition
- you receive a VA pension
- you are traveling for a scheduled compensation or pension examination
- your household income does not exceed the maximum annual VA pension rate
- your medical condition requires an ambulance o a specially equipped van, you are unable to defray the cost, and the travel is pre-authorized (authorization is not required for emergencies if a delay would endanger your life or health)

VA HEALTH CARE covered services

Long-Term Care Benefits

Standard Benefits

The following long-term care services are available to all enrolled veterans.

Geriatric Evaluation
Geriatric evaluation is the comprehensive assessment of a veteran's ability to care for him/herself, his/her physical health, and social environment, which leads to a plan of care. The plan could include treatment, rehabilitation, health promotion, and social services. These evaluations are performed by inpatient Geriatric Evaluation and Management (GEM) Units, GEM clinics, geriatric primary care clinics, and other outpatient settings.

Adult Day Health Care
The adult day health care (ADHC) program is a therapeutic day care program, providing medical and rehabilitation services to disabled veterans in a group setting.

Respite Care
Respite care provides supportive care to veterans on a short-term basis to give the caregiver a planned period of relief from the physical and emotional demands associated with providing care. Respite care can be provided in the home or other noninstitutional settings.

Home Care
Skilled home care is provided by VA and contract agencies to veterans who are homebound with chronic diseases and includes nursing, physical/occupational therapy, and social services.

Hospice/Palliative Care
Hospice/palliative care programs offer pain management, symptom control, and other medical services to terminally ill veterans or veterans in the late stages of the chronic disease process. Services also include respite care as well as bereavement counseling to family members.

Financial Assessment for Long-Term Care Services
For veterans who are not automatically exempt from making copayments for long-term care services (see *Copayment Requirements* on page 8), a separate financial assessment (VA Form 10-10EC, *APPLICATION FOR EXTENDED CARE SERVICES*) must be completed to determine whether they qualify for cost-free services or to what extent they are required to make copayments. For those veterans who do not qualify for cost-free services, the financial assessment is used to determine the amount of the copayment requirement. Unlike copayments for other VA health care services which are based on fixed charges for all, long-term care copayment charges are individually-adjusted based on each veteran's financial status.

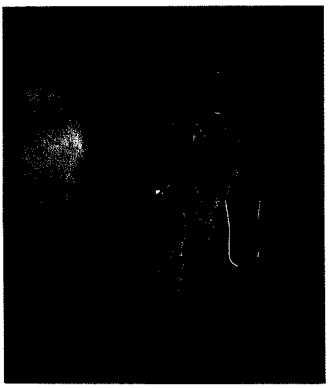
Limited Benefits

Nursing Home Care

While some veterans qualify for indefinite nursing home care services, other veterans may qualify only for short-term services. Among those who automatically qualify for indefinite nursing home care are veterans whose service-connected condition is clinically determined to require nursing home care and veterans with a service-connected rating of 70% or more. Other veterans—with priority given to those with service-connected conditions—may be provided short-term nursing home care if space and resources are available.

Domiciliary Care

Domiciliary care provides rehabilitative and long-term, health maintenance care for veterans who require some medical care, but who do not require all the services provided in nursing homes. Domiciliary care emphasizes rehabilitation and return to the community. VA may provide domiciliary care to veterans whose annual income does not exceed the maximum annual rate of VA pension or to veterans who have no adequate means of support.



FAQs

Frequently asked questions

I already provided financial information on my initial VA application. Why is it necessary to complete a separate financial assessment for long-term care?

Unlike the information collected from the Means Test which is based on your previous year's income, the 10-10EC is designed to assess your *current* financial status, including current expenses. This in-depth analysis provides the necessary monthly income/expense information to determine whether you qualify for cost-free care or a significant reduction from the maximum copayment charge.

Once I submit a completed VA Form 10-10EC, who notifies me of my long-term care copayment requirements?

The social worker or case manager involved in your long-term care placement will provide you with an annual projection of your monthly copayment charges.

Assuming I qualify for nursing home care, how is it determined whether the care will be provided in a VA facility or a private nursing home at VA expense?

Generally, if you qualify for indefinite nursing home care, that care will be furnished in a VA facility. Care may be provided in a private facility under VA contract when there is compelling medical or social need. If you do not qualify for indefinite care, you may be placed in a community nursing home—generally not to exceed six months—following an episode of VA care. The purpose of this short-term placement is to provide assistance to you and your family while alternative, long-term arrangements are explored.

For veterans who do not qualify for indefinite nursing home care at VA expense, what assistance is available for making alternative arrangements?

When the need for nursing home care extends beyond the veteran's eligibility, our social workers will help family members identify possible sources for financial assistance. Our staff will review basic Medicare and Medicaid eligibility and direct the family to the appropriate sources for further assistance, including possible application for additional VA benefit programs.

additional VA health care

Veterans

In addition to the VA health care system which administers benefits to veterans residing within the United States, VA also provides benefits to service-connected veterans outside the country.

VA Foreign Medical Program—a health care benefits program for US veterans with VA-rated service-connected conditions who are living or traveling abroad. Foreign benefits are administered by three separate offices (as indicated below) depending on where the health care services are obtained.

in Canada

address
VAM&RO Center (136FC)
North Hartland Road
White River Junction VT 05009-0001

e-mail
vavbawrj/ro/vse@vba.va.gov

fax
802.296.5174

in the Philippines

address
VA Outpatient Clinic (358/00)
2201 Roxas Blvd.
Pasay City 1300
Republic of the Philippines

e-mail
manlopc.inqry@vba.va.gov

fax
011-632-838-4566

all other countries

address
Foreign Medical Program
PO Box 65021
Denver CO 80206-9021

e-mail
hac.fmp@med.va.gov

telephone
303.331.7590

fax
303.331.7803

web site
www.va.gov/hac

resources

Dependents & Survivors

CHAMPVA—a health care benefits' program for:

- dependents of veterans who have been rated by VA as having a permanent and total disability;
- survivors of veterans who died from VA-rated service-connected conditions, or who at the time of death, were rated permanently and totally disabled from a VA-rated service-connected condition; and
- survivors of persons who died in the line of duty and not due to misconduct and not otherwise entitled to benefits under DoD's TRICARE program.

address
CHAMPVA
PO Box 65023
Denver CO 80206-9023

e-mail
hac.inq@med.va.gov

telephone
800.733.8387

fax
303.331.7804

web site
www.va.gov/hac

Spina Bifida Health Care Benefits—a program designed for Vietnam veterans' birth children diagnosed with spina bifida and who are in receipt of a VA Regional Office award for spina bifida benefits.

address
Spina Bifida Health Care
PO Box 65025
Denver CO 80206-9025

e-mail
spina.inq@med.va.gov

telephone
888.820.1756

fax
303.331.7807

web site
www.va.gov/hac

Children of Women Vietnam Veterans Health Care Benefits—a program designed for women Vietnam veterans' birth children who are determined by a VA Regional Office to have one or more covered birth defects.

address
Children of Women Vietnam Veterans
PO Box 469027
Denver CO 80246-9027

e-mail
cwvv.inq@med.va.gov

telephone
888.820.1756

fax
303.331.7807

web site
www.va.gov/hac

ADDITIONAL REQUIRED INFORMATION

Veteran's Name _____ Social Security Number _____

1) Veteran's **FATHER'S** full name (even if deceased) _____

2) Veteran's **MOTHER'S** full name (even if deceased) _____

3) If you were in combat, provide the dates and location:

_____ Date: MM/DD/YY to MM/DD/YY Location

_____ Date: MM/DD/YY to MM/DD/YY Location

4) If you served in Vietnam, do you request an Agent Orange Exam? ☐ YES ☐ NO

5) If you served in the Perisan Gulf, do you request a Persian Gulf Exam? ☐ YES ☐ NO

Please check one of the following:

☐ At this time **I do not need** an appointment with a VA Primary Care Provider. (I wish **to enroll in VA healthcare only.** I understand this means that I have signed up with VA and I will be eligible to receive services from VA in the future.)

OR

☐ At this time, I request an appointment with a VA Primary Care Provider

Signature_____ Date_____

IF YOU CHECKED THE FIRST BOX AND DO NOT NEED AN APPOINTMENT, STOP HERE AND RETURN THIS WITH YOUR APPLICATION

If you are requesting an appointment with a VA Primary Care Provider, please respond to the following:

I currently have an outside doctor. ☐ Yes ☐ No

If yes, continue to see your own health care provider until you receive an apointment from VA.

Please check the site at which you would like to receive care:

☐ Bangor Clinic ☐ Calais Clinic

☐ Caribou Clinic ☐ Rumford Clinic

☐ Saco Clinic ☐ Womens Clinic (Togus)

☐ Togus

PLEASE RETURN THIS FORM WITH THE

Department of Veterans Affairs

INSTRUCTIONS FOR COMPLETING APPLICATION FOR HEALTH BENEFITS

Step 1: Before You Start...

What is VA Form 10-10EZ used for?

- To apply for enrollment in the VA health care system, or for nursing home, domiciliary or dental benefits.
- To update your personal, insurance, or financial information.

Where can I get help filling out the form?

- Contact a National or State Veterans Service Organization.
- Ask VA to help you fill out the form by calling or visiting a VA health care facility. Before you call or go to the VA health care facility, gather the necessary materials identified in Step 2 of the instructions and complete as much of the form as you can.

How can I contact VA if I have questions?

- Look in your telephone book blue pages under "United States Government, Veterans" to locate your local VA health care facility.
- Call VA's Health Benefits Service Center toll-free at 1-877-222-VETS (8387).
- Access our website at http://www.va.gov and select "Contact the VA."
- If you desire a health care appointment, contact the Enrollment Coordinator at your local VA health care facility for assistance in scheduling an appointment.

Definitions of terms used on this form

- SERVICE-CONNECTED (SC): A veteran with a VA determination that an illness or injury was incurred or aggravated while on active duty.
- COMPENSABLE: A determination by VA that a service-connected disability is severe enough to warrant monetary compensation.
- NONCOMPENSABLE: A determination by VA that a service-connected disability is not severe enough to warrant monetary compensation.
- NONSERVICE-CONNECTED (NSC): A veteran who does not have a VA determined service-related condition.

Which sections of VA Form 10-10EZ should you complete?

If you are applying for enrollment in the VA health care system, or for nursing home, domiciliary or dental benefits, look at the table below to find out which sections of VA Form 10-10EZ you should complete. The shaded sections should be completed only if you answer "Yes" to Section VI agreeing to provide income and asset information to establish eligibility for care. You may agree to copayments without providing this detailed financial information.

If you are...	Complete the sections marked with an X ...						
	I-IV	VI	VII	VIII	IX	X	XII
Service-connected 50% to 100%.	X						X
Service-connected 30-40%. *Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for cost-free medications for treatment of your nonservice-connected conditions assessed.*	X	X	X	X	X		X
Service-connected 0% (compensable) or service-connected 10-20%. *Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for cost-free medications and beneficiary travel for treatment of your nonservice-connected conditions assessed.*	X	X	X	X	X		X
A Former POW. *Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for beneficiary travel assessed. Also, complete Section X if applying for long-term care.*	X	X	X	X	X		X
A veteran discharged from the military due to a disability incurred or aggravated in service, Purple Heart Medal recipient or WWI veteran. *Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for cost-free medications and beneficiary travel assessed. Also, complete Section X if applying for long-term care.*	X	X	X	X	X		X
Receiving nonservice-connected VA Pension, Aid and Attendance or Housebound benefits. *Answer YES in Section VI and complete Sections VII-X to have your financial eligibility for long-term care assessed. Unmarried VA Pensioners are excluded from this requirement.*	X	X	X	X	X	X	X
Service-connected 0% (noncompensable) or nonservice-connected with no special eligibilities listed above. *Answer YES in Section VI and complete Sections VII-X to have your priority for enrollment and financial eligibility for cost-free medical care, medications, long-term care and beneficiary travel for treatment of your nonservice-connected conditions assessed.*	X	X	X	X	X	X	X

Complete only the sections that apply to you and sign and date the form.

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION II - INSURANCE INFORMATION (Use a separate sheet for additional information)

1. ARE YOU COVERED BY HEALTH INSURANCE? *(Including coverage through a spouse or another person)* ☐ YES ☐ NO	2. HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
3. NAME OF POLICY HOLDER	
4. POLICY NUMBER / 5. GROUP CODE	

	YES	NO	
6. ARE YOU ELIGIBLE FOR MEDICAID?	☐	☐	
7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?	☐	☐	7A. EFFECTIVE DATE *(mm/dd/yyyy)*
8. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B?	☐	☐	8A. EFFECTIVE DATE *(mm/dd/yyyy)*
9. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD			10. MEDICARE CLAIM NUMBER
11. IS NEED FOR CARE DUE TO ON THE JOB INJURY? *(Check one)* ☐ YES ☐ NO			12. IS NEED FOR CARE DUE TO ACCIDENT? *(Check one)* ☐ YES ☐ NO

SECTION III - EMPLOYMENT INFORMATION

1. VETERAN'S EMPLOYMENT STATUS *(Check one)* ☐ FULL TIME ☐ NOT EMPLOYED ☐ PART TIME ☐ RETIRED ***If employed or retired, complete item 1A*** *Date of retirement (mm/dd/yyyy)*	1A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
2. SPOUSE'S EMPLOYMENT STATUS *(Check one)* ☐ FULL TIME ☐ NOT EMPLOYED ☐ PART TIME ☐ RETIRED ***If employed or retired, complete item 2A*** *Date of retirement (mm/dd/yyyy)*	2A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

SECTION IV - MILITARY SERVICE INFORMATION

1. LAST BRANCH OF SERVICE	1A. LAST ENTRY DATE	1B. LAST DISCHARGE DATE	1C. DISCHARGE TYPE	1D. MILITARY SERVICE NUMBER

2. CHECK YES OR NO	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	E1. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	F. WERE YOU EXPOSED TO ENVIRONMENTAL CONTAMINANTS WHILE SERVING IN SW ASIA DURING THE GULF WAR?	☐	☐
C. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐	G. WERE YOU EXPOSED TO AGENT ORANGE WHILE SERVING IN VIETNAM?	☐	☐
C1. IF YES, WHAT IS YOUR RATED PERCENTAGE? %			H. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	☐	☐
D. DID YOU SERVE IN COMBAT AFTER 11/11/1998?	☐	☐	I. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
E. WAS YOUR DISCHARGE FROM MILITARY FOR A DISABILITY INCURRED OR AGGRAVATED IN THE LINE OF DUTY?	☐	☐	J. DO YOU HAVE A SPINAL CORD INJURY?	☐	☐

SECTION V - PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 45 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C., sections 1705, 1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA may be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION VI - FINANCIAL DISCLOSURE

Failure to disclose your previous year's financial information may affect your eligibility for health care benefits. Your financial information is used by VA to accurately determine if you should be responsible for copayments for office visits, pharmacy, inpatient, nursing home and long term care, and for some veterans, priority for enrollment. You are not required to provide this information. However, completing the financial disclosure section results in a more accurate determination of your eligibility for health care services/benefits.

☐ **NO,** I DO NOT WISH TO PROVIDE INFORMATION IN SECTIONS VII THROUGH X. **I understand that VA is currently not enrolling veterans *who decline to provide financial information unless other special eligibility factors exist.*** However, if I am enrolled, I agree to pay the applicable VA copayments. Sign and date the application in Section XII.

☐ **YES** I WILL PROVIDE SPECIFIC INCOME AND/OR ASSET INFORMATION TO ESTABLISH MY ELIGIBILITY FOR CARE. Complete all sections below that apply to you with last calendar year's information. Sign and date the application Section XII.

SECTION VII. DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*		2. CHILD'S NAME *(Last, First, Middle Name)*	
1A. SPOUSE'S MAIDEN NAME		2A. CHILD'S RELATIONSHIP TO YOU *(Check one)* ☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter	
1B. SPOUSE'S SOCIAL SECURITY NUMBER		2B. CHILD'S SOCIAL SECURITY NUMBER	2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*
1C. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*	1D. DATE OF MARRIAGE *(mm/dd/yyyy)*	2D. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*	
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP)*		2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO	
		2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO	
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR ENTER THE AMOUNT YOU CONTRIBUTED TO THEIR SUPPORT. SPOUSE $ CHILD $		2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)* $	

SECTION VIII - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
3. LIST OTHER INCOME AMOUNTS *(Social Security, compensation, pension, interest, dividends.)* EXCLUDING WELFARE.	$	$	$

SECTION IX - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home)* VA will calculate a deductible and the net medical expenses you may claim.	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VII.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials)* DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.	$

SECTION X - PREVIOUS CALENDAR YEAR NET WORTH *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. CASH, AMOUNT IN BANK ACCOUNTS *(e.g., checking and savings accounts, certificates of deposit, individual retirement accounts, stocks and bonds)*	$	$	$
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. *(e.g., second homes and non-income producing property. Do not count your primary home.)*	$	$	$
3. VALUE OF OTHER PROPERTY OR ASSETS *(e.g., art, rare coins, collectables)* MINUS THE AMOUNT YOU OWE ON THESE ITEMS. *Exclude household effects and family vehicles.*	$	$	$

SECTION XI - CONSENT TO COPAYMENTS

If you are a 0% service-connected veteran and do not receive VA monetary benefits or a nonservice-connected veteran (and you are not an Ex-POW, Purple Heart Recipient, WWI veteran or VA pensioner) and your household income (or combined income and net worth) exceeds the established threshold, this application will be considered for enrollment, but only if you agree to pay VA copayments for treatment of your nonservice-connected conditions. **If you are such a veteran by signing this application you are agreeing to pay the applicable VA copayment as required by law.**

SECTION XII - ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. section 1729, VA is authorized to recover or collect from my health plan (HP) for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT	DATE

*U.S. GPO: 2004 - 715 - 478

Step 2: Completing your application ... Review the table in Step 1 to find out what sections you should complete.

Answer all questions in those sections. If you need more space to answer a question, attach a sheet of paper to the form containing your name and Social Security Number. For each question that you need more room, write "Continuation of Item" and write the section and question number.

Section II - Insurance Information. Include information for all health insurance policies that cover you. If you have more than one health insurer, provide this information on a separate sheet of paper and attach to the application. If you have access to a copier, attach a copy of your insurance cards, Medicare card and/or Medicaid card (Medicaid is a federal/state health insurance program for certain low-income people). Bring these cards with you to each health care appointment.

Section IV - Military Service Information. If you are not currently receiving benefits from VA, you should attach a copy of your discharge or separation papers from the military (such as DD 214 or, for WWII veterans, a "WD" Form), with your signed application to expedite processing of your application.

If you indicate that you received a Purple Heart Medal, we will check our records for confirmation of your status. If we are unable to confirm your status as a Purple Heart Medal recipient, we will ask you to provide VA a copy of your DD-214 or other military service records or orders indicating you were awarded the medal. To reduce processing time, you may submit a copy of this documentation with your signed application.

Section VI - Financial Disclosure. The financial assessment is used to determine whether certain veterans qualify for cost-free health care services for their nonservice-connected conditions and to assign their priority for enrollment. You should review the table in Step 1 to see if your eligibility for health care benefits requires or may be based on a financial assessment.

If your financial information is used to determine your priority for enrollment and you choose not to disclose this information, you must agree to make copayments. However, please be aware that even if you agree to pay copayments, you may not be eligible for enrollment and other health care benefits for your nonservice-connected conditions, if you are placed in a priority group that is not eligible for enrollment.

If a financial assessment is not used to determine your priority for enrollment, you may choose not to disclose your information and agree to make copayments for treatment of your nonservice-connected conditions. If a financial assessment is used to determine your eligibility for travel assistance, and you do not disclose your financial information, you will not be eligible for this benefit for your nonservice-connected conditions.

Section VII - Dependent Information. Use a separate sheet of paper for additional dependent children.

- You may count your spouse as your dependent even if you did not live together, as long as you contributed $600 or more in support last calendar year.
- You may count your biological children, adopted children, and stepchildren as dependents. But these children must be unmarried and under the age of 18, or be at least 18 but under 23 and attending high school, college or vocational school on a full or part-time basis, or have become permanently unable to support themselves before reaching the age of 18.
- Count child support contributions even if not paid in regular set amounts. Contributions can include tuition payments or payments of medical bills.

Section VIII - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children.

Use a separate sheet of paper for additional dependent children.

- Report: gross annual income from employment, except for income from your farm, ranch, property or business, including information about your wages, bonuses, tips, severance pay and other accrued benefits and your child's income information if it could have been used to pay your household expenses
- Report: net income from your farm, ranch, property or business.
- Report: other income amounts, including retirement and pension income, Social Security Retirement and Social Security Disability income, compensation benefits such as VA disability, unemployment, Workers and black lung, cash gifts, interest and dividends, including tax exempt earnings and distributions from Individual Retirement Accounts (IRAs) or annuities
- Do Not Report: Welfare, Supplemental Security Income (SSI) and need-based payments from a government agency, profit from the occasional sale of property, income tax refunds, reinvested interest on Individual Retirement Accounts (IRAs), scholarships and grants for school attendance, disaster relief payment or proceeds of casualty insurance, loans, Agent Orange and Alaska Native Claim Settlement Acts Income and payments to foster parents.

Section IX - Previous Calendar Year Deductible Expenses. Report nonreimbursed medical expenses paid by you or your spouse. Include expenses for medical and dental care, drugs, eyeglasses, Medicare, medical insurance premiums and other health care expenses paid by you for dependents and persons for whom you have a legal or moral obligation to support. Do not list expenses if you expect to receive reimbursement from insurance or other sources.

Section X - Previous Calendar Year Net Worth. Use a separate sheet of paper for additional dependent children.

Your net worth is the market value of all the interest and rights you have in any kind of property. However net worth does not include your single-family residence and a reasonable lot area surrounding it. It also does not include the personal things you use every day like your vehicle, clothing and furniture.

Step 3: Submitting your application ...

What do I do when I have finished my application?

- Read Section V (Paperwork Reduction and Privacy Act Information), Section XI (Consent to Copayments), and Section XII (Assignment of Benefits).
- Make sure you sign and date VA Form 10-10EZ in Section XII. You or an individual to whom you have delegated your Power of Attorney must sign and date the form. If you sign with an "X", then you must have 2 people you know witness you as you sign. They must then sign the form and print their names. If the form is not signed and dated appropriately, VA will return it for you to complete. This will result in a delay in processing your application.
- Attach any continuation sheets and necessary material to your application.

Where do I send my application? Mail the original application with a copy of your supporting materials to your local VA care facility. You can find the address in your local telephone book, by calling toll-free 1-877-222-VETS (8387), or on the Internet at http://www.va.gov.

OMB Approved No. 2900-0091
Estimated Burden Avg. 45 min.
Expiration Date 6/30/2007

Department of Veterans Affairs — APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

1. VETERAN'S NAME *(Last, First, Middle Name)*
2. OTHER NAMES USED
3. MOTHER'S MAIDEN NAME
4. GENDER ☐ Male ☐ Female

5. ARE YOU SPANISH, HISPANIC, OR LATINO? ☐ YES ☐ NO

6. WHAT IS YOUR RACE? *(You may check more than one.) (Information is required for statistical purposes only.)* ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

7. SOCIAL SECURITY NUMBER
9. DATE OF BIRTH *(mm/dd/yyyy)*
10. RELIGION

8. CLAIM NUMBER
9A. PLACE OF BIRTH *(City and State)*

11. PERMANENT ADDRESS *(Street)*
11A. CITY
11B. STATE
11C. ZIP CODE *(9 digits)*

11D. COUNTY
11E. HOME TELEPHONE NUMBER *(Include area code)*
11F. E-MAIL ADDRESS

11G. CELLULAR TELEPHONE NUMBER *(Include area code)*
11H. PAGER NUMBER *(Include area code)*

12. TYPE OF BENEFIT(S) APPLIED FOR *(You may check more than one)* ☐ HEALTH SERVICES ☐ NURSING HOME ☐ DOMICILIARY ☐ DENTAL

13. IF APPLYING FOR HEALTH SERVICES OR ENROLLMENT, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER?

14. DO YOU WANT AN APPOINTMENT WITH A VA DOCTOR OR PROVIDER AS SOON AS ONE BECOMES AVAILABLE? ☐ YES ☐ NO I am only enrolling in case I need care in the future.

15. HAVE YOU BEEN SEEN AT A VA HEALTH CARE FACILITY? ☐ YES, **LOCATION:** ☐ NO

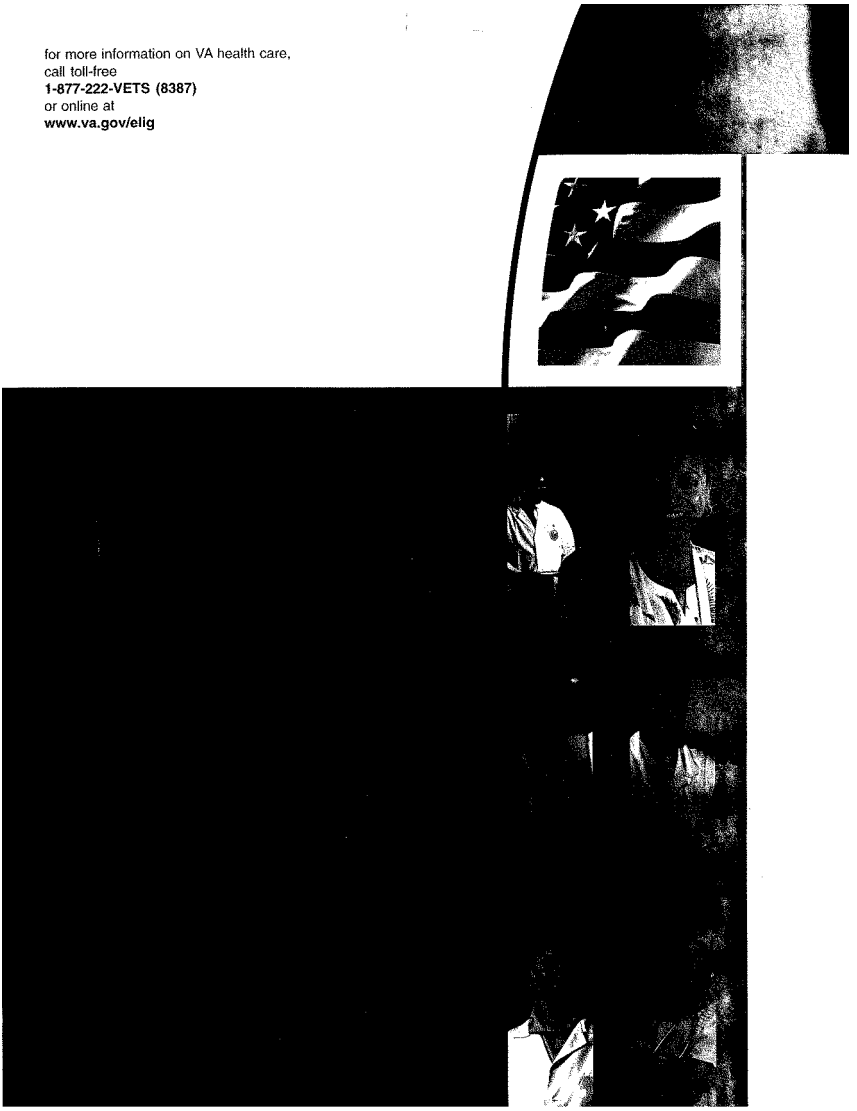
16. CURRENT MARITAL STATUS *(Check one)* ☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN

17. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN
17A. NEXT OF KIN'S HOME TELEPHONE NUMBER *(Include area code)*
17B. NEXT OF KIN'S WORK TELEPHONE NUMBER *(Include area code)*

18. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT
18A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER *(Include area code)*
18B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER *(Include area code)*

19. INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH. NOTE: THIS DOES NOT CONSTITUTE A WILL OR TRANSFER OF TITLE *(Check one)* ☐ EMERGENCY CONTACT ☐ NEXT OF KIN

for more information on VA health care,
call toll-free
1-877-222-VETS (8387)
or online at
www.va.gov/elig



August 2005 field hearing in Maine.
Rep. Michaud, asked Mr. Jack Sims, Director of the Togus VAMC, if he could provide the Subcommittee with the cost for clinics in Lincoln, Dover-Foxcroft and the other recommended sites (e.g, Lewiston-Auburn). Mr. Sims replied that yes, he could provide preliminary costs which are provided below.

CBOC Name	Start Up Costs
Unnamed (TBD) CBOC (4,000 uniques)	$1,433,865
Lincoln (1,168 uniques)	$822,000 - $1,027,500
Dover-Foxcroft (768 uniques)	$555,298
Houlton (300 uniques)	$525,662
S. Paris (300 uniques)	$525,662
Farmington (300 uniques)	$525,662

Start Up Costs Est from $4,388,149 to $4,593,649

○